PRINTED: 05/15/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE : COMPL	
		345460	B. WI			02/	C <b>03/2012</b>
	PROVIDER OR SUPPLIER RD HEALTH CARE CE	NTER		204	EET ADDRESS, CITY, STATE, ZIP CODE 41 WILLOW ROAD REENSBORO, NC 27406	1 021	03/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
SS=G	recommended to up to uphold F 309 but F 323. CMS reques submitted written ID CMS informed the s decision is to keep a G for all 3 tags. Am BW 483.10(b)(11) NOTII (INJURY/DECLINE/A facility must imme consult with the resiknown, notify the resor an interested fam accident involving the injury and has the pointervention; a signification in health status in either life the clinical complications significantly (i.e., an existing form of treat consequences, or to treatment); or a decithe resident from the §483.12(a).  The facility must also and, if known, the resor interested family in change in room or respecified in §483.15 resident rights under	i 3/26/12. The IDR panel shold F 157 but lower it to a G, lower it to a G, and to delete sted a review of the facility R materials. On 5/15/12 tate survey agency the final all 3 tags and the s/s would be ended 2567 sent to facility.	F 1		The statements included are not an and do not constitute agreement we alleged deficiencies herein. The procrection is completed in the comstate and federal regulations as out remain in compliance with all fede state regulations the center has take take the actions set forth in the folloof correction. The following plan of correction constitutes the center's a of compliance. All alleged deficien have been or will be completed by indicated.  F157 Failure to notify MD  How corrective action will be accifor each resident found to have be affected by the deficient practice—  Resident #2 had an or x-ray of the left lower extremity to fracture on 12/25/11. Mobile X-ray 12/25 and 12/27, X-ray obtained 12. Results were sent via fax to the Faci 12/27/11 and the Physician was noti results on 12/27/11. New orders we received from MD. Letter received ray Company dated January 5, 2012 received an apology letter from the recompany stating there was a breakd their system which caused the delay ray being completed. Verbal Coachi completed for Licensed nurse involvinvestigation process on resident #2 Resident #2 discharged home on 2/3	ith the blan of pliance of lined. To ral and en or will owing plan of allegation neces cited the dates  omplished been blance of called on blance of called on blance of called of the dates  litty on fied of the called of the c	2/6/12
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	TURE		TITLE		(X6) DATE

Any efficiency 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.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	IULTIPL LDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		345460	B. WIN	1G	The state of the s	1	C 03/2012
	PROVIDER OR SUPPLIER	NTER		204	ET ADDRESS, CITY, STATE, ZIP CODE IT WILLOW ROAD EENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
-	this section.  The facility must recithe address and phelegal representative  This REQUIREMENT by:  Based on resident is staff interviews and did not re-notify the x-ray could not be dephysician order, resident for two completed on 12/27 had a fractured ankled of 3 residents, Resinotify the resident's residents that fell and (Resident #7 and #8)  The findings include Resident #2 was addressed mellitus, ce (CVA), dysphagia, hygastrointestinal bleed right-above-the-kneed Review of the reside Data Set (MDS), data resident had short-aproblems and was medecision making. The required one-person	cord and periodically update one number of the resident's or interested family member.  IT is not met as evidenced one number as evidenced one on the date of the original ulting in a delay of treatment days. The X-ray when one on the date of the resident e in two places, This is for 1 dent #2. The facility failed to physician for 2 of 3 sampled d hit their heads during falls of the diagnoses including rebrovascular accident of the provision, history of ding, foot ulcer, status-post	F 1	•	Resident #7 fell on 12/31/11 swell on right side of head, ice applied, rehecks done every 15 minutes x or every 30 minutes x two hours, then hour x four hours, doctor notified communication form and placed in doctor's box. Resident #7 got out did not buckle his "Smart Auto Reseatbelt on immediately. The seat halarming because the alarm had no activated by buckling. The alarm is when each end of the seatbelt is bubelt will then alarm when disconne Belt checked on 2/3/12 after return Dialysis and the device was function properly.  Resident #8 received cut to foreheatfall on 12/12/11. The nurse notified via a communication form and place doctor's box. The supervisor was nemail. The cut was cleansed, Antibiointment, and bandaged was placed checks done every 15 minutes x one every 30 minutes x two hours, then hour x four hours. Site now healed.  How corrective action y	neuro ne hour, n every via n the of bed and set" belt was not t been s activated ckled. The cted. Seat ed from oning ad during a t the doctor red it in the otified via iotic l. Neuro e hour, every	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE	CONSTRUCTION	(X3) DATE S COMPLI	
		345460	B. WIN	IG			C <b>3/2012</b>
	PROVIDER OR SUPPLIER  RD HEALTH CARE C	ENTER		2041	T ADDRESS, CITY, STATE, ZIP COD WILLOW ROAD EENSBORO, NC 27406		3/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE
	and bathing. The Manuscional limitation upper and lower extensive at times. extensive-to-depending a side of the confused at times. extensive-to-depending a side of the confused at times. extensive-to-depending a side of the confused at the conformation."  The resident's ADL part: "per medical resident at risk for information."  The resident's ADL part: "per medical resident at risk for information."  The resident's Care indicated "resident at risk for information."  The resident's Care indicated "resident and functional status."  The resident's Care indicated "resident approaches include administering medical arranging the environ functioning.  Record review reverse incident/Accident Rescription of the in out of bed during All bedside mat." The resident had no approach and incident approaches include a side of the incident and incident and incident and incident approaches include a side of the incident and inciden	toilet use, personal hygiene, ADS indicated the resident had a in range of motion of his stremities on one side.  Care Area Assessment (CAA), ad in part: "per medical record doriented, however is Requires adent assistance with transfers. ess secondary to CVA noted. falls due to above  CAA, dated 12/21/11, read in ecord resident has right-sided of findings - Requires dent assistance with most risk for complications related l/or further decline in ADL  Plan, dated 12/8/11, is at risk for fall." The domonitoring vital signs, cations as ordered, and onment for maximum	F1	57	accomplished for thoshaving potential to Be affected by the san practice  > 4 Step Plan of Corre 12/28/11 which included fall current resident 12/28/11 for outstanding found. New process part of plan of correct 12/28/11: Upon new ray to rule out fracture call mobile company them of new order. Thask mobile company rule out fracture will the same day. If mobile unable to perform x-reday, an order will be send resident out to he obtain x-ray. If mobile states the x-ray will be the same day, the nurse document conversation mobile company and frensure x-ray is perforn Completion 01/17/201	ction initiated ided: Review its on ding x-rays initiated as ition on order for x-re, nurses will to notify the nurse will if x-ray to be performed le company ay the same obtained to ospital to e company e performed e will n with follow-up to ned.	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	IULTIPLE CON LDING	STRUCTION	(X3) DATE S COMPLI	
		345460	B. WI	1G		i	C 3/2012
	PROVIDER OR SUPPLIER	ENTER	1	2041 WILI	DRESS, CITY, STATE, ZIP CODE LOW ROAD BBORO, NC 27406		3/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	CR	PROVIDER'S PLAN OF CORR EACH CORRECTIVE ACTION SI COSS-REFERENCED TO THE AF COST DEFICIENCY)	HOULD BE	(X6) COMPLETION DATE
	Nursing notes dated part, "resident aler distress. Resident if falls during the shift unlabored."  Nursing notes dated part, "patient is ale Respiration non-lab Nursing notes dated part, "resident aler Complained of left a swelling noted, tendereceived new order x-ray called and awagiven as needed. No Record review of tel dated 12/25/11 at 5: ankle related to pair Nursing notes dated resident alert and versident alert and versident alert and versident complaine ordered for left ankle complaint of pain. Complained in the region of the distal tibla is prenoted in the region of Nursing notes dated received x-ray result and fibular metaphysignificant displacements."	d 12/23/11 at 6:22 pm read in ret and verbal. No signs of had no further complications or and no further complications or and ret and verbal. Voiced no pain. Ored. " d 12/24/11 at 10:48 am read in ret and verbal. Voiced no pain. Ored. " d 12/25/11 at 5:54 pm read in the and able to voice needs. In the pain, assessed area, der to touch. Medical director for x-ray of left ankle. Mobile are of order. Pain medication of further pain voiced. " dephone physician's order of the pain and swelling. " dephone physician's order of the left ankle pain. X-ray and swelling. " dephone physician's order of left ankle pain. X-ray and swelling. " diology report dated 12/27/11: al fibula is noted. Fracture of seent. Soft tissue swelling is of the ankle joint. " 12/27/11 read in part, " s. Fracture of the distal tibia	F 1	A A		ve, stated ystem which scheduling orning isten to ed x-rays are d nurses rovided ed a written edure.  ray, nurses any to notify e nurse will ny if x-ray same day. If le to e day, an to send to obtain npany performed will with	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE S	
		345460	B. WII	/G _			C
	PROVIDER OR SUPPLIER	NTER		24	REET ADDRESS, CITY, STATE, ZIP CODE 1041 WILLOW ROAD GREENSBORO, NC 27406		3/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	for further evaluation ambulance."  An Emergency Departure and the resider fall on 12/22/11 result fracture.  Nursing notes dated resident back from eaton to the left leg. New of [medication used to pain] 1-2 tablets by needed and to follow 1-2 days. No pain or Received x-ray result and fibular metaphysis significant displacem."  Review of radiology part, "the bones are the distal metaphysis Fracture of distal metaphysis Fracture of distal metaphysis fracture of orthopedic 12/29/11 read in part Follow up 2 weeks for Record review of the dated 1/5/12 read in CVA with resultant dy weakness who is see The patient had a fra fibular metaphysis on the dated metaphysis or the dated metaphysis or the dated metaphysis or the patient had a fra fibular metaphysis or the dated metaphysis or the date	artment report dated 12/27/11 at was seen for an accidental alting in distal tibia and fibula 12/27/11 read in part, "emergency department. Splint order for norco 5/325 mg relieve moderate to severe mouth every 4-6 hours as y up with orthopedic doctor discomfort upon return. Its. Fracture of the distal tibia sis are noted with no nent. Medical director notified.  Teport dated 12/27/11 read in the demineralized. Fracture of sof the the fibula is noted. Itaphysis of the tibia is swelling is noted in the region consultation report dated "Recommendation 4.	F	157	ensure x-ray is perform  MD will be notified we there is a change related care of the resident by nurse. Routine/Non end nursing information we communicated on the Communication to MD placed in the nursing communication MD for nurse's station. MD we notified of any falls, end acute episode, change condition, or critical latelephone, this is for cut well as new admissions.  The Unit Manager is reto ensure that notificati MD has occurred and he documented accurately. Manager will review the report daily to ensure the appropriate notification occurred. In the event of Unit Manager is not available to the Unit Manager or In (Director of Nursing) of Supervisor will assume	thenever ed to the the Charge mergency ill be "Nursing "Nursing "Nursing "or form and older at ill be mergency, in b result by arrent as s. esponsible on of the has been . The Unit he shift hat has that the ailable, the DON r	

OTATCLICA	7.05.055.055.0	I WILD OF TO OF THE OF				OWR MC	) <u>. 0938-039</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A. BU		TIPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
		345460	B. WI	NG_	to this to the second state of the second stat	II.	C )3/2012
	PROVIDER OR SUPPLIER  RD HEALTH CARE CE	NTER		:	REET ADDRESS, CITY, STATE, ZIP CODE 2041 WILLOW ROAD GREENSBORO, NC 27406		33/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF THE PROPRIES OF	OULD BE	(X5) COMPLETION DATE
	left lower extremity.  In an interview on 1, administrator stated was obtained from the 12/25/11. This x-ray because on 12/25/1 only doing stats and the mobile unit forgoto the schedule. I has importance of having manner. My expectate pisode that might received the transportance of having manner. My expectate pisode that might received the reasonable director should be not should be sent out to administrator added. In a telephone interview medical director are that if an order is on-call physician for on the day it was write mobile unit normally requested, so it shout the x-ray is not done communications from the resident can be a department.  In an interview on 1/1 the nurse responsible 12/25/11, stated "I we resident's family ment the resident] had falled.		F	157		will be punges made nt ssurance udes lected, comes and al 4 step s, which fications, concerns roblem eeting ality ssurance r review	

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	IULTII	PLE CONSTRUCTION G	(X3) DATE : COMPL	
		345460	B. WI	NG		02/	C 03/2012
	PROVIDER OR SUPPLIER  RD HEALTH CARE CE	ENTER		20	REET ADDRESS, CITY, STATE, ZIP COD 041 WILLOW ROAD REENSBORO, NC 27406		03/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	the medical director an x-ray. I called the told me that [name the following day be I made the nurse of "  In an interview with 2/1/12 at 6:55 pm, I and unacceptable the timely manner. But on the ankle and the so it did not impact Hopefully, they wou x-ray was not done, attending physician monitor x-ray results doctors visit the faci critical matter, the fall the situation is not results in a box to be	and it was swollen. I called and he gave me an order for a mobile x-ray unit and they of the resident] would be seen ecause it was not a stat order. I was not a stat order. I was not a stated, "I think it was bad not he stated, "I think it was bad not he x-ray was not done in the resident was not walking a fracture was not displaced, his bone exceptionally. It call and notify me that the but they never called. "The was asked, "How do you a?" He answered that two lity 5 days a week; if there is a notify calls one of the doctors. I critical, the facility puts the ereviewed. The results box for up to two days, no	F	157	communication, are ordered, the be placed on the encompass two Block one: a) Ty b) location of x-to be done. One is obtained the ninitial. Nurse we annotate in medit the order obtained and save to shift The second bloc annotate when recompleted and p notified. In-service completed on 2/6	order will MAR to entries 1) pe of x-ray, ray, c) date the x-ray turse will fill then fical record ed for x-ray report. 2) k to esults are hysician fice	
	#1, a Licensed Prace " came and told me the floor. She stated and the resident rolle to the room, he was was extended. The re experiencing no pair no pain. I did not do I believe I gave him pure were not bigger that routine edema]. Before	isit 2/2/12 at 9:30 am, Nurse tical Nurse stated that NA #1 told that the resident rolled to she was turning the resident ed to the floor. When I went on his right side and his leg resident said that he was an I touched his legs; he had any range of motion checks. Dain medication. His legs normal [Resident #2 has bre we removed him from off signs and checked his			Indicate how the facto monitor its performake sure solutions a sustained. The facilit develop a plan for enthat correction is ach sustained. The plan n	mance to are y must suring dieved and	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE	E CONSTRUCTION	(X3) DATE S	
		345460	B. WII	4G		02/	C 0 <b>3/2012</b>
	PROVIDER OR SUPPLIER  RD HEALTH CARE CE	ENTER		2041	ET ADDRESS, CITY, STATE, ZIP CODE 1 WILLOW ROAD EENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HÖULD BE	(X5) COMPLETION DATE
	pupils and I asked I assess him again. fall is witnessed, we but if it is not witnes resident for 3 days. me that the residen have an x-ray, and x-ray company, and the x-ray. "Record not taken until 12/2."  In an interview on 2. # 12, she stated, "resident had a fall. Omember came and and no one was doin DON and my nurse concerns. I looked it where they were elea pillow. I checked to already elevated so him pain medication pain. On December medication, he had a swollen. I did not do because his arm and She added, "as far done. "Surveyor an nursing notes; there swollen ankle.  2. Resident #8 was readmitted on 3/18/1 diagnoses included if The quarterly Minimut 11/14/11, assessment had short term and lease and the state of the same and lease in the same and short term and lease in the same and short term and lease in the same and short term and lease in the same and	nim if he had pain. I did not The expectation is that if the edo not have to assess again, sed, we have to assess the On the 26th, the family told it fell, and he was supposed to it was not done. I called the they came out that day to do review showed the x-ray was 7/11.  1/2/12 at 11:29 am with Nurse no one told me that the On 12/24/11 the family told me that the resident felling anything about it. I told my manager about the family's in the nurses notes and I saw vating the resident 's leg with the resident, and his leg was I did nothing. I did not give because he said he had no	F	157	implemented and the corrective action evaluates effectiveness. The integrated into the quassurance system of facility:  Unit Managers of Supervisor will collect anyellow carbon copies of the orders for x-ray orders and checked to ensure that ordered placed on the MAR, daily weeks, 3x a week for 2 weeks, 3x a week for 2 weeks a week times one month concerns are reviewed for resolution at the weekly Quassurance Risk Management and Assurance for further review and resolution that the Assessment and Assurance for further review and resolution date.  Completion date 2	d review elephone d MARs er has been X 2 eks, and h. Any problem uality ent e Quality meetings lution x 3	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1''	MULTIPLE CONSTRUCTION		(X3) DATE S COMPL	
		345460	B. WII	NG		02/0	C 0 <b>3/2012</b>
GUILFO	PROVIDER OR SUPPLIER  RD HEALTH CARE CE			STREET ADDRESS, CITY, STATE 2041 WILLOW ROAD GREENSBORO, NC 274		1 0210	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG	CROSS-REFERENCED	EACTION SHOP	ULDBE	(X6) COMPLETION DATE
	Review of Nurses N Nurse #15 on 12/12 documented that Rethe fall mat beside to 3:15am. The reside wheelchair and refu Nurse #15 documer cut on the middle of that the cut was clear a bandage was apply pain. The Nurse documented communication was doctor), email sent to (responsible party) to morning. A Nurses N Nurse #15 spoke to fall earlier in the night An interview with Nutelephone and at the 3:10pm and again at the nurse worked on A Review of the Incide 12/12/2011 at 3:15am was notified by "communication" on 1 documented.  A review of the clinical 2/03/2012 at 10:00 arcopy of a communication physician related to Fe 12/12/2012. An interview on 2/03/conducted with the Irconducted with Irconduc	lotes revealed written by /2011 at 3:53am. The Nurse resident #8 was found lying on the roommate's bed around int was previously in her sed to be helped to her bed. Inted that there was a 1/2 inch Resident #8's forehead and aned, antibiotic ointment and ied, the resident stated no rumented vital signs and were within normal limits. It sent to the MD (medical to unit manager and RP to be notified later in the Note at 6:55am indicated that the RP about the resident's int.  It see #15 was unsuccessful by It facility on 2/03/2012 at It fopm. The Administrator said Inpm-7am shift.  Ident/Accident Report dated in, revealed the Physician munication " (fax It in the interval of the int	F	157			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	ULTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
		345460	B. WIN	G	—     02//	C 0 <b>3/2012</b>
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZII 2041 WILLOW ROAD GREENSBORO, NC 27406		JUIZU 12
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	form was not in the the physician shoul a fax communication injury. The Administ with an injury for the RN on call by telep for orders.  3. Resident # 7 was 4/19/11, the Minimudiagnosis include a disease, hypertensicisease, gastroeso stage renal disease disease. He had go memory and was a judgments for his disorganized thinkir symptoms, towards  Review of the Incide Saturday 12/31/11 at 3:30p.m and the responsible During an interview #12 indicated she he completed a communifall 12/31/11 (Saturda into a folder for the che made rounds (duindicated she did not forms were filed afted doctor 's folder. The	ed that the communication chart. The Administrator said to have been called instead of on form because this was an trator said she would expect to Charge Nurse to notify the hone and the MD to be called as admitted to the facility on am Data Set dated 2/3/12, anemia, coronary artery ion, peripheral vascular phageal reflux disease, end and any arthritis, cerebral vascular bod iong and short term be to make his decisions and ally care. He had fluctuating any, and had no behavioral others.  The Accident Report dated at 3:15p.m., indicated at 3:15p.m., indicated alis room which result in right eye. The nurse in notified via telephone in, the doctor was not notified.  The Administrator said the said of the sai	F 1	57		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		LE CONSTRUCTION	(X3) DATE COMPI	
		345460	B. WI	1G		02/	C 03/2012
	PROVIDER OR SUPPLIER  RD HEALTH CARE CE	ENTER		20	EET ADDRESS, CITY, STATE, ZIP CODE 41 WILLOW ROAD REENSBORO, NC 27406	<u>J UZI</u>	00120 12
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X6) COMPLETION DATE
F 157	she had called the call the responsible	itten a note. She indicated nurse supervisor. She did not party.	F1	157			
F 309 SS=G	#9(nurse supervisor the fall on 12/31/12 doctor or the responsabout the fall on Sa 483.25 PROVIDE CHIGHEST WELL BI Each resident must provide the necessary or maintain the high mental, and psycho	ARE/SERVICES FOR EING receive and the facility must ary care and services to attain est practicable physical,	F3	09	F 309 - Failure of Radiology promptly assess condition of resulting in delay of treatmen Address how the corrective will be accomplished for the residents found to have been affected by the deficient pra	resident it action ose n	2/6/12
	by: Based on resident is taff interviews, and facility failed to asse 12/22/11 resulting in X-Ray of 12/27/11 sidistal fibula is noted metaphysis of the tike swelling is noted in the This is for 1 of 2 residacility failed to asse				Resident #2 had an o an x-ray of the left lower extratorule out fracture on 12/25/1 Mobile X-ray called on 12/25/12/27, X-ray obtained 12/27/1 Results were sent via fax to the	emity 1. and 1.	

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		PLE CONSTRUCTION	(X3) DATE S	
		345460	B. WII	NG		02/	C 0 <b>3/2012</b>
GUILFO	PROVIDER OR SUPPLIER  RD HEALTH CARE CE			2	REET ADDRESS, CITY, STATE, ZIP CODE 041 WILLOW ROAD BREENSBORO, NC 27406	1 02/	JU/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	12/2/11 with multiple diabetes mellitus, co (CVA), dysphagia, h gastrointestinal blee right-above-the-kneed Review of the reside Data Set (MDS), dair resident had short-aproblems and was not decision making. The required one-person activities of daily living mobility, dressing, to and bathing. The MI functional limitation is upper and lower extra the resident's fall Cadated 12/21/11, read resident is alert and confused at times. Rextensive-to-depend Right sided weakness Resident at risk for fainformation."  The resident's ADL Capart: "per medical reweakness, analysis of extensive-to-dependent ADLs. Resident at risk to ADL function and/of functional status."	admitted to the facility on a diagnoses including prebrovascular accident ypertension, history of ading, foot ulcer, status-post amputation.  Int's admission Minimum and long-term memory moderately impaired in a MDS indicated the resident aphysical assistance for ang (ADLs), including bedoilet use, personal hygiene, DS indicated the resident had an range of motion of his remities on one side.  In part: "per medical record oriented, however is sequires ent assistance with transfers. It is secondary to CVA noted. In part: "additional and the cord resident has right-sided of findings - Requires ent assistance with most sk for complications related or further decline in ADL	F	309	Facility on 12/27/11 and the Physician was notified of res 12/27/11. New orders were from MD. Letter received firay Company dated January facility received an apology from the x-ray company statis was a breakdown in their systematic was a breakdown in their systematic was completed. Verbal Coase was completed for licensed in involved during investigation process on resident #2 12/28/Resident #2 discharged home 2/3/2012.  Resident #7 fell on 11 swelling noted on right side of ice applied. Frequent checks or resident as evidenced by neurological checks done even minutes x one hour, every 30 minutes x two hours, then every four hours, doctor notified y communication form and place the doctor's box; Supervisor in and Resident is his own responsarty. Resident reminded to lea harness on. Nurse involved resident reminded to least the supervisor was a supervisor of the supervisor of the supervisor in and Resident reminded to least the supervisor of the supervi	sults on received om X- 5, 2012, letter ing there tem ex-ray ching urse 11. on 2/31/11 f head, lone on y 5 ry hour ia ed in otified, insible ave	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345460	B. WING			C <b>3/2012</b>
	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COI 2041 WILLOW ROAD GREENSBORO, NC 27406		3/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	administering med arranging the environment of the cord, indicated the record, indicated the resident #2 on 12. 12/15/11, 12/19/11 the brand name for hydrocodone which was administered the resident/Accident Fedescription of the induction of the	ed monitoring vital signs, ications as ordered, and conment for maximum the medication administration that Vicodin was administered to 12/11 to 12/13/11. On and 12/20/11 Narco x 1 [this is a acetaminophen and is used for moderate pain] to the resident.  Paled a facility Report dated 12/22/11. The incident read, "Resident rolled DL care, Resident rolled on a report indicated that the	F 309	corrective action and ed nursing documentation a assessment 1/6/12. Re 1/2/12. Resident assess to have skin tear to left if tear cleansed and dressed notified, resident is his of in addition an interested member was notified. Frochecks done on resident by neurological checks december to a standard to hours, the resident resident for assistance. Harnest discontinued, Smart Alarms seat belt and bed alarm and the same deficient practical standard to he after the same deficient practical standar	and post fall sident fell on ed and noted forearm. Skin d. MD wn RP, and family equent as evidenced one every very 30 n every hour minded to ss n auto reset ided.  ill be residents fected by ce: initiated wality which er residents	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER:  A. BUIL			(X3) DATE SURVEY COMPLETED	
		345460	B. WIN	G		C 3/2012	
	PROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CO 2041 WILLOW ROAD GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		V SHOULD BE	(X5) COMPLETION DATE	
F 309	9:00 pm Vicodin wa level 7/10; recheck, am Vicodin was adminis 7/10; recheck, 2/10; Vicodin was adminis 8/10; recheck, 2/10; Vicodin was adminis 8/10; recheck, 2/10. Vicodin was adminis 8/10; recheck, 2/10. Vicodin was adminis 8/10; recheck, 2/10. due to the resident's amputation on the letter on 12/23/11 at 1: [patient] rolled off be on 12/2211. Pt recal place wing mattress Physical therapy is comobility skills/transfet Nursing notes dated part, "resident alert distress. Resident hafalls during the shift. unlabored."  Record review of physical therapy is comobility skills/transfet Nursing notes dated part, "resident alert distress. Resident hafalls during the shift. unlabored."  Record review of physical therapy is comobility skills/transfet Nursing notes dated part, "resident alert distress. Resident hafalls during the shift. unlabored."	el was 2/10. On 12/23/11 at s administered (reason: pain 2/10). On 12/24/11 at 8:30 ministered (reason: pain level a. On 12/25/11 at 8:30 am atered (reason: pain level a.). On 12/25/11 at 4:00 pm atered (reason: pain level a.). On 12/26/11 at 8:00 am atered (reason: pain level a.). On 12/26/11 at 4:00 pm atered (reason: pain level a.). On 12/27/11 at 4:00 pm atered (reason: pain level a.). On 12/27/11 at 4:00 pm atered (reason: pain level a.). Vicodin was administered a phantom pain from his aft leg.  Typical therapy progress notes are also to reduce risk of further falls. Angoing to improve bed are skills and wheel mobility. "  12/23/11 at 6:22 pm read in and verbal. No signs of and no further complications or Respiration even and and a sical therapy progress notes are a sical therapy progress notes and a sical therapy progress notes and a sical therapy progress notes are a sical therapy progress notes and a sical therapy progress notes are a sical therapy progress notes and a sical therapy progress notes are a sic	F3	12/28/11. All were four outstanding x-rays at the December 1, 2011 to D 12/31/2011. Completion and 02/01/12.  3 4 Step POC data included:  5 No other reside have outstanding x-rays on the nurses concerning following to rule out fracture, order for x-ray the nurse order for x-ray the nurse of the new of the new of the nurse will mobile company if the x performed the same day mobile company is unab perform the x-ray on the then,  3. An order will be send resident out to the hobtain x-ray. If the mobils states the x-ray will be performed and follow-up to the company and the company a	ted 12/28/11  te		

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245460	B. WING		c	;
NAME OF DO	WIDED OD GUDDI IED	345460			02/03	/2012
	OVIDER OR SUPPLIER  HEALTH CARE CI	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 WILLOW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
the time is a second of time i	ne distal metaphysisue swelling is not oint. "  lursing notes dated art, "received x-ristal tibia and fibulio significant display of the facility via ambuting the facility of facility and facility and facility of facility of facility and facility of facility	stal fibula is noted. Fracture of is of the tibia is present. Soft oted in the region of the ankle of 12/27/11 at 10:30 pm read in ay results. Fracture of the ar metaphysis are noted with ocement. Medical director to send resident to r further evaluation. Resident	F 30	1. Provide immedia address any injuries, and safety 2. Evaluate resident additional injury which w require medical interventi Evaluation includes but is to:  O Vital Signs O Skin Evaluation O Musculoskeletal a O Change of Condit O Pain Assessment O Neurological asse indicated 3. Thoroughly docur clinical findings in medica 4. Interview resident to determine if cause of fal determined. 5. Notify MD in persitelephone of all falls and do in medical record. 6. Notify On-Call Administrative RN in persitelephone of all falls and do	for any ould on. not limited assessment as ment and staff and staff and staff ocument on or by	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1' '	AULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345460		NG		l l	C
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·	3/2012
GUILFOR	RD HEALTH CARE CE	NTER		20	41 WILLOW ROAD REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Record review of the dated 1/5/12 read in CVA with resultant of weakness who is see The patient had a fribular metaphysis of He denies any sympleft lower extremity.  Record review of Nusubmitted as part of 1/12/12 read in part, longer works in the filter on December 23rd 24th fallen on December came to work Friday shift nurse had given and he had no pain. Resident 's extremit most of the time. On had no pain all durin resident complained nurse. An order recent the x-ray company (name of the nurse), that the x-ray company (1/26/11). On 12/26/11 first shift that the x-ray was not done until 12 attempted three time unable to contact Nurse in the tray of the time unable to contact Nurse in the tray of the time unable to contact Nurse in the tray of the time unable to contact Nurse in the tray of the time unable to contact Nurse in the tray of the time unable to contact Nurse in the tray of the time unable to contact Nurse in the tray of the tra	rt "Recommendation 4. for cast change."  e physician progress notes part, "admitted status-post lysphasia and right-side en today for routine follow-up. acture of the distal tibial and in the left side and is in a cast. otoms except for pain in his "  arse #5 's statement the investigation dated "I [name of nurse, who no facility] was the scheduled of the resident] on 1, 25th, and 26th. He had 22nd on 1st shift. When I right the 23rd the second 1 pain medication at 8:30 pm He slept through the shift. The sappear to be edematous a Saturday the 24th resident g shift. On Sunday the 25th of pain to the second shift sived for x-ray to left ankle. Was called by Nurse #2  "This nurse told Nurse #3 any would not come out until 11 Nurse #2 told Nurse on the pay was not done. The x-ray 2/27/12. "The surveyor as during the survey but was	F	309	in medical record.  7. Notify family (Redocument in medical records.  8. Complete post far assessment and formulate interventions based off exclinical information.  9. Communicate essinterventions to the care of 10. Document on falting x 24 hours, then daily x 4.  The assessment of the called to the physician call administrative nurse. completed 2/6/2012.  In-service provides staff to contact nursing and the 24 hour shift report for communicating any change condition identified during resident's therapy session  Address what measures in place or systemic change to ensure that the deficient practice will not occur:  All new hired lice	ord.  all  valuated  tablished giving staff I every shift 8 hours. indings will and the on- In-service  ed to rehab d use of te in g a daily.  will be put ges made nt	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONSTRUCTION LDING	(X3) DATE S COMPL	
		345460	B. WIN	(G	-   02/0	C 03/2012
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIF 2041 WILLOW ROAD GREENSBORO, NC 27406		TOTAL TAL
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	stated that " on 12/resident while doing rolled off the bed or got the nurse [Nurse assisted the resident that when the nurse experiencing pain, if further stated that "  In an interview on 1/#1, she stated that rolled off the bed to care. The aide that rolled off the resident I did ne him if he was having was able to move hi upper extremity." In no bleeding, no bruifrom fall, and NA #1 signs.  In an interview on 1/administrator stated rolled out of the bed I went to the the resincident with the resincident with the resincident with the resincident with the resincident of the sedema to left lower edifferent from any other resident had a histor prior to admission. Nothe extremity. The factors is set to the sedema to left lower edifferent from any other sedema to left lower edifferent from any other sextremity. The factors is set to the sextremity is sextremity is sextremity in the sextremity in the sextremity is sextremity in the sextremity in the sextremity is sextremity in the sextremity	ge 17  In and who witnessed the fall, 22/11, I was trying to turn the shis [morning] care and he is to the floor mat. I went and the shift to the bed. I was asked the resident if he was ne denied any pain. She I took his vital signs. I went and asked the resident the fall mat during morning was giving care got me, we it back to the bed. I assessed urological checks and asked pain. He denied pain. He is lower extremity as well as furse #1 added that there was sing, no skin tears or swelling took the resident 's vital  17/12 at 2:44 pm the interim that I [name of the resident] to the floor mat on 12/22/11. In the floor mat on 12/22/11. It is to the floor mat on 12/22/11.	F3	nurses will receive orientation on: To start 02/02/12 at hires thereafter.  1. MD (Medibe notified whenever change related to the resident by the Characteristic of the "Nursing Communication will be on the "Nursing Communication MD station. MD will be emergency, acute eprondition, or critical Telephone.	cal Doctor) will er there is a he care of the rge nurse. gency nursing communicated mmunication to he din nursing the D folder at nurse's he notified of any bisode, change in h results by erviced to stay er the fall. The moved until se. If a fall h initiate the call hy notify a Nurse motified change related to	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		0.45400	B. WI				С
		345460				02/0	3/2012
	PROVIDER OR SUPPLIER	NTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 2041 WILLOW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	the nurse who was care that the reside he was experiencin was obtained from 12/25/11. This x-ray because on 12/25/1 only doing stats and the mobile unit forgeto the schedule. I had importance of having manner. My expected episode that might received that might received that might received the schedule of the x-ray must be done x-ray company is now within a reasonable director should be sent out the administrator added further stated NA #1 proper procedure for weakness in one or that the resident has In an interview on 1 #2 stated "I fell off my ankle." He add hurting.  In a telephone interthe medical director are that if an order is on-call physician for on the day it was wr mobile unit normally requested, so it should be x-ray is not done communications from the day it was wr mobile unit normally requested, so it should be x-ray is not done communications from the day it was wr mobile unit normally requested, so it should be x-ray is not done communications from the day it was wr mobile unit normally requested, so it should be x-ray is not done communications from the x-ray is not x-ray is x-	ge 18 in charge of the resident 's nt 's ankle was swollen and g pain. An order for an x-ray the medical director on was not done until 12/27/11 1 the mobile x-ray unit was I on 12/26/11 the scheduler for ot to add the resident 's name ave in-serviced my staff on the g x-rays done in a timely ations are that for any acute rule out bone fracture the the same day. In event the ot able to come the same day time frame, the medical otified and the resident o the hospital. " The interim I that this was not done. She had been in-serviced on the r ADL care of residents with both sides. She further stated is not had another fall.  (17/12 at 3:44 pm, Resident my bed to the floor and broke ed the ankle was swollen and  view on 1/18/12 at 8:30 am stated that his expectations is written by himself or an r an x-ray, it should be done iften. He added that the comes to the facility when uld be done within the day. If when ordered he expects in the facility immediately so sent to the emergency	F	309	nurse. Routine/Non eme nursing will be communi "Nursing Communication tool and placed in nursing communication MD fold station. MD will be notified admission, emergency, as episode, change in conditional lab result by telep.  Indicate how the facility monitor its performance sure solutions are sustained facility must develop a pensuring that correction achieved and sustained must be implemented as	cated on n to MD" g er at nurse's fied of any cute tion, or shone. y plans to e to make sined. The plan for n is d. The plan for n is d. The plan at the valuated e POC is ity e facility: er is sure that he MD ition) has at daccurately	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLI LDING	E CONSTRUCTION	(X3) DATE SU COMPLE	
		345460	B. WII			1	C
NAME OF I	PROVIDER OR SUPPLIER	343400				02/0	3/2012
	RD HEALTH CARE CE	NTER	:	204	ET ADDRESS, CITY, STATE, ZIP CODE  1 WILLOW ROAD  EENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	stated that "I was recare on 12/24/11; he while I was giving cand I elevated the a During a follow up to at 11:40am NA #2 set to elevate the resides she does not remend In an interview on 1/2 the nurse responsib 12/25/11, stated "I resident's family me the resident's family me the resident was in pain assessed his ankle at the medical director an x-ray. I called the told me that [name of the following day bed I made the nurse co."  During a telephone i pm Nurse #4 who we 12/26/11, stated that verbal. The resident his phantom pain. The fany ankle pain, not in a telephone interversident in the pain and after washing his him because he has	/18/12 at 9:52 am, NA #2 responsible for the resident 's a did not experience any pain are, but his ankle was swollen nkle with a pillow. " relephone interview on 1/27/12 he stated that an aide told her ent 's ankle with a pillow but	F3	309	review the shift ro to ensure that app notification has of the event that the Manager is not av other Unit Manag (Director of Nursi Supervisor will as responsibility of th Manager for notific Completion 02/02 daily thereafter. Cl Condition audit wi 2/02/12, completed or Unit Manager of Supervisor, daily 2/ 3x a week for 2 we 1x a week times of Any concerns are re for problem resolut weekly Quality Ass Risk Management and monthly at the Assessment and Ass meetings for furthe and resolution x 3 re The Director of Nu the Unit Managers are response.	ropriate courred. In Unit vailable, the er or DON ing) or sume the he Unit ication. /12 and hange in as started d by DON in X 2 weeks, and he month. reviewed tion at the surance meeting Quality surance in review months. rsing and	an international control of the cont

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345460	B. WII	٧G			C 3/2012
	PROVIDER OR SUPPLIER RD HEALTH CARE CE	NTER	<b>L</b>	20	REET ADDRESS, CITY, STATE, ZIP CODE 041 WILLOW ROAD BREENSBORO, NC 27406	0270	3/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X6) COMPLETION DATE
F 309	bed. My hands were him but I was unable the floor. I called my off the floor with the indicated the bed rawhere she would turn the resident held on attempted to turn. To position; she reiteration position.  In a telephone interwith the interim adm. Resident #2 slid out performed on 12/22 reflected a 1-person mobility. NA #1 is were resident #2 as she occasions prior to the administrator further in bed. NA #1 was in both sides of the bed bath on the resident towards his complete the bed batturn the resident, the out of the bed. NA # resident but she was rolled on the fall main assessment of the redeclined pain. There	ge 20 cody began to slide off the greasy; I attempted to catch eto, and the resident slid to nurse, and she assisted him help of 2 aides. NA#1 further ills [small rails] opposite to me the resident were lowered, ray from her were raised, and to the small rail and he bed was in the normal ted that the bed was not in the view on 1/27/12 at 12:20 pm inistrator, she stated that of bed while ADL care was /11. The resident care plan assist with ADLs for bed ell aware of the care for has cared for him on multiple incident. "The interim stated that Resident #2 was in his room with a fall mat on d. NA #1 was performing a dent and moisturizer his skin ter bathing and moisturizing side, NA #1 began to turn the left side as she needed to ath. When NA #1 began to eresident 's lower body slid 1 attempted to catch the sunable, and the resident was no new swelling or and the medical director were	F;	309	for the implementation and monitoring of the Falls Ma Program. All fall occurrence reviewed daily (Monday-Fatand up meeting, weekly in Assurance Risk Management meeting by the DON/Unit I and the Week-end Supervist Call Administrative Register Nurse on Saturday and Sumproblems noted will be taken Quality Assurance Weekly Management Meeting and Quality Assurance meeting review and resolution, time and quarterly times two quality thereafter, for further review resolution.  Therapy to report Condition to the floor nurse 24 shift report. Rehab Direct review 10% of Therapy Proposes to verify change of condition to the floor nurse 24 shift report daily 3x a week for 2 weeks, and week times one month. Any are reviewed for problem reat the weekly Quality Assurance meeting problem reat the weekly Quality Assurance proposed for problem reat the weekly Quality Assurance reviewed for problem reat the weekly Quality Assurance meeting problem reat the weekly Quality Assurance proposed for problem reat the weekly Quality Assurance proposed for problem reat the weekly Quality Assurance meeting proposed for problem reat the weekly Quality Assurance proposed for problem for the propose	nagement res are riday) at n Quality ent Managers sor/On ered day. Any en to the Risk Monthly for so I month earters w and Change of and on ector will ogress ondition (2 weeks, 1x a y concerns esolution	

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	ULTIPLE CONSTRUCT	TION	(X3) DATE S COMPLI	
		345460		G	P		C 13/2012
GUILFO	PROVIDER OR SUPPLIER	CENTER		2041 WILLOW RO	D, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	K (EACH C	FIDER'S PLAN OF CORRECTOR SHOPE ACTION ACTIO	OULD BE	(X5) COMPLETION DATE
F 309	In a follow-up inter Nurse # 2, the nur the first time I eve resident 's family to look at the resident main. I did not know the resident was an distress. I gave the afterwards he only called the attending resident a had swe had fallen a couple pain. The attending order. Because it was considered to the complete the x-ray. I did not back because we done and because would be coming to the nurse who was In a follow-up inter Nurse #4, he state 12/23/11 the reside bruising. Later in the pain medication for surveyor asked the was phantom pain pointed to his stum. In an interview with 2/1/12 at 6:55 pm, and unacceptable timely manner. But	rview on 2/1/12 at 5:50 pm with se stated that." 12/25/11 was a worked with the resident. The member came and asked medent 's ankle because it was a to the touch. The resident was now that he had a fall until the dime. Vital signs were done; not hollering or in any acute e resident Vicodin, and had a small amount of pain. I giphysician and told him the collen ankle. I explained that he ed days prior, and he was in giphysician gave me an x-ray was not a stat and it was a x-ray company stated that he following the morning to do call the attending physician normally wait until the x-ray is the x-ray company stated they he following day. I told this to be coming on the next shift. "  view on 2/1/12 at 6:16 pm with d, " to my knowledge on ent had no swelling, no pain, no ne shift the resident requested or phantom pain." When the enurse, " How do you know it, " he stated that the resident	F 3	Risk Mamonthly and Assireview a was star DON, U daily X weeks, a month. A for prob Quality meeting Assessm for furth months.	anagement meeting y at the Quality Assurance meetings for and resolution x 3 m. Change in Conditional Change in Conditional Change in Conditional Manager or Support of the Anagement of the Anagement of the Assurance Risk May and monthly at the nent and Assurance for review and resolution 2/6/12 Completion 2/6/12	essment r further nonths on audit eted by pervisor c for 2 s one eviewed the weekly unagement Quality meetings ution x 3	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345460	B. WI				C 3/2012
	PROVIDER OR SUPPLIER	:NTER			TREET ADDRESS, CITY, STATE, ZIP CODE 2041 WILLOW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X6) COMPLETION DATE
F 309	Hopefully, they wou x-ray was not done, surveyor asked the you monitor x-ray re two doctors visit the is a critical matter, t doctors. If the situal puts the results in a results normally stadays, no more.  In a follow-up interv 2/2/12 at 9:00 am [in nurse #3,] the reside and hurt his ankle s of people came in the them that my ankle anything until that nibefore they took car.  During a follow-up in Nurse #1 stated that told that the resident stated she was turniresident rolled to the room, he was on his extended. The reside experiencing no pain to pain. I did not do I believe I gave him were not bigger that that Resident #2 has removed him from on and checked his puppain. I did not assessis that if the fall is with the survey of the total series with the fall is with the survey of the total series with the fall is with the survey of the total series with the fall is with the fa	his bone exceptionally. Ild call and notify me that the but they never called. "The attending physician, "How do esults?" He answered that facility 5 days a week; if there the facility calls one of the tion is not critical, the facility box to be reviewed. The y in the box for up to two  iew with the resident # 2 on the presence of NA #1 and ent stated that he had fallen ometime in December. "A lot he room, "he said. "I told hurt, but they did not give me ight. I hurt for many days	F	309	9		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345460	B. WII	4G		02/	03/2012
	PROVIDER OR SUPPLIER  RD HEALTH CARE CE	NTER		20	EET ADDRESS, CITY, STATE, ZIP CO 41 WILLOW ROAD REENSBORO, NC 27406		
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ıx	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	the family told me the was supposed to had done. I called the x-out that day to do the showed the x-ray was a linear interview on 2th 12, she stated, "resident had a fall. Comember came and and no one was doin DON and my nurse concerns. I looked it where they were elea pillow. I checked the already elevated so him pain medication pain. On December medication, he had a swollen. I did not do because his arm and she added, "as far done." Surveyor an nursing notes; there swollen ankle docum In an interview on 02 physical therapy sup 12/24/11 the resident be swollen; it was big resident stated that I the ankle and the phwas working on a permorning nurse immedication to a support of the physical therapy immediately and the physical therapy immedia	ent for 3 days. On the 26th, nat the resident fell, and he we an x-ray, and it was not ray company, and they came e x-ray. "Record review as not taken until 12/27/11.  12/12 at 11:29 am with Nurse no one told me that the con 12/24/11 the family told me that the resident felling anything about it. I told my manager about the family 's in the nurses notes and I saw vating the resident 's leg with the resident, and his leg was I did nothing. I did not give because he said he had no 25, I gave him his no pain, and his ankle was anything to the ankle dileg were always puffy. "as I know the x-ray was dileg were always puffy. "as I know the x-ray was dileg were always puffy. "as I know the x-ray was dileg were always puffy. "as I know the x-ray was dileg were always puffy. "on the tilegal the	F	309			

	FOF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		ULTIPLE LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345460	B. WIN	IG		1	C )3/2012
	PROVIDER OR SUPPLIER	NTER		2041	ET ADDRESS, CITY, STATE, ZIP CODE 1 WILLOW ROAD EENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	with the interim adn facility was trying to therapy assistant to further stated that 'and whenever we k know." The adminisurveyor on that made burning a telephone with the family mem 12/25/11 at about 10 he had fallen a couphurting and swollen she told me she woo back on 12/26/11, a came back on 12/26/11, included a disease, gastroesop stage renal disease, disease, gastroesop stage renal disease disease. Review of impaired cognitive s memory problems. Sehavioral symptom #7 required extensive physically assist him the surfaces and toil Review of the Incided 12/31/11, indicated I unwitnessed fall in her surfaces and toil services with the surfaces and toil review of the Incided 12/31/11, indicated I unwitnessed fall in her surfaces and toil services with the surfaces and toil review of the Incided 12/31/11, indicated I unwitnessed fall in her surfaces and toil review of the Incided 12/31/11, indicated I unwitnessed fall in her surfaces and toil review of the Incided 12/31/11, indicated I unwitnessed fall in her surfaces and toil review of the Incided 12/31/11, indicated I unwitnessed fall in her surfaces and toil review of the Incided 12/31/11, indicated I unwitnessed fall in her surfaces and toil review of the Incided 12/31/11, indicated I unwitnessed fall in her surfaces and toil review of the Incided 12/31/11, indicated I unwitnessed fall in her surfaces and toil review of the Incided I unwitnessed fall in her surfaces and toil review of the Incided I unwitnessed fall in her surfaces and toil review of the Incided I unwitnessed fall in her surfaces and toil review of the Incided I unwitnessed fall in her surfaces and toil review of the Incided I unwitnessed fall in her surfaces and toil review of the Incided I unwitnessed fall in her surfaces and toil review of the Incided I unwitnessed fall in her surfaces and toil review of the Incided I unwitnessed fall in her surfaces and toil review of the Incided I unwitne	nterview on 2/2/12 at 3:30 pm ninistrator, she stated that the get in touch with the physical see who he spoke to. She we have not heard from him now something we will let me istrator never got back to the atter.  Interview on 2/2/12 at 4:12 pm aber, he stated that on 0:30 am, the resident told him ble days ago and his leg was will spoke with the nurse and all get an x-ray order. I came and the x-ray was not done. It is facility. If as admitted to the facility on we diagnosis retrieved from a seminal coronary artery on, peripheral vascular the MDS revealed moderately kills, long and short term on the sessistance of one person to a with transferring between leting.	F3	09			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION		(X3) DATE S COMPLI	ETEO
		345460	B. WIN	IG			1	C 3/2012
	ROVIDER OR SUPPLIER	NTER		204	ET ADDRESS, CITY, STATE, ZIP I1 WILLOW ROAD REENSBORO, NC 27406	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOU HE APPR	JLD BE	(X5) COMPLETION DATE
F 309	Review of the media Neurological Assess 12/31/11, began at 3 at 10:00p.m.  No Post Fall Asses 12/31/11.  Review of the nursin continued monitorin on 12/31/11 reveale No nursing note add 12/31/11.  No nursing note 12/p.m. shift.  No nursing note 1/1 shift.  A nursing noted date part, " patient is al fall,"  No nursing note dur  An Incident Acciden indicated Resident falls is room at 2:48a.m. skin tear to his left at A Neurological Asses began at 2:45a.m., a 9:30a.m.  A Post Fall Assessm 1/2/12.  Review of the nursin p.m., read, " was wand heard a thumpir coming(sic) from his	cal record revealed the sment was completed 3:15p.m and was completed 3:15p.m and was completed sment was completed for a note of the complete	F3	09				

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION NG	(X3) DATE : COMPL	
		345460	B. Wil	NG_		02/	C 03/2012
	ROVIDER OR SUPPLIER	NTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 2041 WILLOW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	what happened, sta the toilet and fell, as out for help, residen	ge 26 black eye, asked resident ted he was trying to get onto sked why didn't (sic) he yell it stated " I don ' t know. ", now to use the call lightcont	F	309		÷	
	11:46a.m read in pa swollen rt eye from(	ng note dated 1/2/12 at rt, "Bruised, discolored sic)post fall this morning. Rt t covered eye with 4x4 gauze.					
7	Review of the nursir 5:55p.m. in part "R complaints voiced."	ng note dated 1/2/12 at esident alert and verbalNo			•		
	No nursing note date	ed 1/3/12, or 1/4/12.					
	# 12 indicated she was to the fall dated 12/3 Post Fall assessme	on 2/3/12 at 10:52a.m., nurse //as the nurse who responded to 1/11, she did not complete a ent form, and she thought she te on 12/31/11 but it did not					
	nurse#9 indicated th Assessment docume monitoring dated 12/ 1/3/1 or 1/4/12. She	on 2/3/12 at 11:18a.m., ere was no Post Fall ent or nursing notes for /31/11, 1/1/12 during 3rd shift, concluded nurses notes empleted per the policy for					
	The facility did not endocument Resident at the first 24 /48 hours their policy.	valuate, monitor and #7 response per the policy for , after the fall as indicated in					

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		LE CONSTRUCTION	(X3) DATE S COMPL	
	345460	B. WIN	IG		02/0	C 0 <b>3/2012</b>
NAME OF PROVIDER OR SUPPLIER GUILFORD HEALTH CARE C			20	EET ADDRESS, CITY, STATE, ZIP CODE 41 WILLOW ROAD REENSBORO, NC 27406	,	
PREFIX (EACH DEFICIENCE	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
environment rema as is possible; and	RVISION/DEVICES  nsure that the resident ins as free of accident hazards leach resident receives ion and assistance devices to	F3	323	F-323 – Failure to super prevent accidents.  Address how the correct will be accomplished for	ctive action	2/6/12
by: Based on resident record reviews, state interview, the facility resident a bed batter resident [resident# fractured ankle. The fracture of the distent the distal metaphystissue swelling is no joint. "The facility was in place to presof 3 residents. (Resident #2 was 12/2/11 with multip diabetes mellitus, of (CVA), dysphagia, gastrointestinal ble right-above-the-known Review of the residents.	led: s admitted to the facility on le diagnoses including cerebrovascular accident hypertension, history of eding, foot ulcer, status-post					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345460	A. BUIL B. WIN			C 3/ <b>2012</b>	
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2041 WILLOW ROAD GREENSBORO, NC 27406		012012	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	resident had short- problems and was decision making. T required one-perso activities of daily liv mobility, dressing, t and bathing. The M functional limitation upper and lower ex  The resident's fall of dated 12/21/11, rea resident is alert and confused at times. extensive-to-depen Right sided weaknes Resident at risk for information."  The resident's ADL part: "per medical re weakness, analysis extensive-to-depen ADLs. Resident at r to ADL function and functional status."  The resident's Care indicated "resident approaches include administering medic arranging the enviro functioning.  Record review reve Incident/Accident R description of the in	and long-term memory moderately impaired in he MDS indicated the resident n physical assistance for ing (ADLs), including bed oilet use, personal hygiene, DS indicated the resident had in range of motion of his tremities on one side.  Care Area Assessment (CAA), d in part: "per medical record l oriented, however is Requires dent assistance with transfers. ass secondary to CVA noted. falls due to above  CAA, dated 12/21/11, read in ecord resident has right-sided of findings - Requires dent assistance with most isk for complications related /or further decline in ADL  Plan, dated 12/8/11, is at risk for fall." The d monitoring vital signs, cations as ordered, and orment for maximum	F 3	residents found to h	ient practice: colled towards tremities began using fall to mat of Daily /2011. Resident ted by LPN #1 urse) and no ne. MD fied 12/22/11. with wings anned and vas updated. vas reviewed in 2/23/11 ess notes, Assessment, heet. Resident y Quality ement nent Meeting) Certified n ADL care 19/11 with instration for ide to reduce	and the same of th	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	/SUPPLIER/CLIA (X2) M TION NUMBER: A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345460	B. WIN			I	C 3/2012
	PROVIDER OR SUPPLIER  RD HEALTH CARE CI	ENTER		20	EET ADDRESS, CITY, STATE, ZIP CODE 941 WILLOW ROAD REENSBORO, NC 27406	<b>~</b>	V/AV 1-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	bedside mat. " The resident had no apply Record review of readministration record as follows: On was administered for recheck of pain level 9:00 pm Vicodin was administered for recheck of pain level 7/10; recheck, 2/10 Vicodin was admini 7/10; recheck, bland Vicodin was admini 8/10; recheck, 2/10 Vicodin was admini 8/10; recheck	e report indicated that the parent injury.  esident 's medication ord dated 12/22 to 12/27/11 in 12/22/11 at 9:00 pm Vicodin for pain, level 8 out of 10; rel was 2/10. On 12/23/11 at as administered (reason: pain level 1). On 12/25/11 at 8:30 am instered (reason: pain level 1). On 12/25/11 at 4:00 pm istered (reason: pain level 1). On 12/26/11 at 4:00 pm istered (reason: pain level 1). On 12/26/11 at 4:00 pm istered (reason: pain level 1). On 12/27/11 at 4:00 pm istered (reason: pain level 1). On 12/27/11 at 4:00 pm istered (reason: pain level 1). On 12/27/11 at 4:00 pm istered (reason: pain level 1). On 12/27/11 at 4:00 pm istered (reason: pain level 1). On 12/27/11 at 4:00 pm istered (reason: pain level 1). On 12/27/11 at 4:00 pm istered (reason: pain level 1).	F3	323	care by the Rehabilitation I Resident #2 was discharged 2/3/12.  Resident #7 fell on swelling noted on right side ice applied. Frequent check resident as evidenced by neurological checks done exminutes x one hour, every 3 minutes x two hours, then ex four hours, doctor notified communication form and plathe doctor's box; Supervisor and Resident is his own resparty. Resident reminded to harness on. Nurse involved corrective action and educat nursing documentation and passessment 1/6/12. Resident assessed at to have skin tear to left foreatear cleansed and dressed. Mnotified, resident is his own in addition an interested fammember was notified. Frequenchecks done on resident as every supervisor and the second supervisor and supervisor	d home on 12/31/11 e of head, s done on very 15 0 every hour d via laced in r notified, sponsible leave received tion for post fall nt fell on nd noted arm. Skin fD RP, and nily ent videnced every	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
	·	345460	B. WII			1	C <b>3/2012</b>	
	PROVIDER OR SUPPLIER	NTER	<b></b>	20	REET ADDRESS, CITY, STATE, ZIP CODE 041 WILLOW ROAD REENSBORO, NC 27406	1 0210	0/2012	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	dated 12/24/11 at 1 in bed for bed mobil [+1] max[imum] romoda/mina [person 40% or less] to righ Low-level exercises swollen, resident re Thursday and injure ankle. Nsg [nursing Nursing notes dated part, " patient is ale Respiration non-lab Nursing notes dated part, " resident aler Complained of left a swelling noted, ten received new order x-ray called and aw given as needed. N Record review of te dated 12/25/11 at 5 ankle related to pain Nursing notes dated part, " resident aler distress. Resident of X-ray ordered for le complaint of pain. O Nursing notes dated in part, " received x distal tibia and fibulation of the complaint of pain. O	0:07 am read, "resident seen lity tasks requires plus one liling to left side and performing 50% or more or trusing right rail to pull self. It to left leg that appears ports sliding out of bed on ed, started to feel pain in the lot lot of this input."  d 12/24/11 at 10:48 am read in each and verbal. Voiced no pain. ored. "  d 12/25/11 at 5:54 pm read in the lot and able to voice needs. It and service of order. Pain medication of further pain voiced. "  dephone physician's order compared in part, "x-ray left in and swelling."  d 12/26/11 at 1:29 pm read in the lot and verbal. No signs of complained of left ankle pain. It and verbal in the left ankle pain. It ankle. Medication x 1 for continue to monitor."  d 12/27/11 at 10:30 pm read left ar metaphysis are noted with cement. Medical director	F:	323	minutes x two hours, then x four hours. Resident rem ask for assistance. Harness discontinued, Smart Alarm seat belt and bed alarm add Smart alarm auto reset sea activates when each end of seatbelt is buckled. The seathen alarm when disconned Resident #7 Seat belt chect 2/3/12 after returned from and the device was function properly.  How corrective action with accomplished for those resident practice.  A falls audit was con 2/3/12 of all in-house resident had a fall in the past sitto ensure they were properly assessed with overview and assessment by the RN. No missed assessments were for A complete audit of residents with devices was	n auto reset ded. The t belt f the at belt will cted. ked on Dialysis ning  II be esident ected by ce: completed esidents x months ly d other ound. of all		

				DATE SURVEY COMPLETED			
		345460	1	lG			C <b>3/2012</b>
	PROVIDER OR SUPPLIER	ENTER		2041	T ADDRESS, CITY, STATE, ZIP CO WILLOW ROAD ENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X6) COMPLETION DATE
F 323	emergency room for left facility via ambour Record review of rate of the distal metaphystissue swelling is migoint. "  An Emergency Deprevealed the resident fall on 12/22/11 resident backgrature.  Nursing notes date part, "resident backgrature.  Nursing notes date part, "resident backgrature. Splint norco 5/325 mg [mmoderate to severe every 4-6 hours as orthopedic doctor 1 upon return."  Review of radiology part, "the bones at the distal metaphys Fracture of distal mpresent. Soft tissue of ankle joint."  Review of orthoped 12/29/11 read in pare Follow up 2 weeks  Record review of the dated 1/5/12 read in CVA with resultant of the distal metaphys follows a severe of the dated 1/5/12 read in pare follows and the distal metaphys follows a severe of the dated 1/5/12 read in pare follows and the distal metaphys follows are follows as a severe of the dated 1/5/12 read in pare follows and the distal metaphys follows are follows as a severe of the dated 1/5/12 read in pare follows are follows.	adiology report dated 12/27/11: stal fibula is noted. Fracture of sis of the tibia is present. Soft oted in the region of the ankle cartment report dated 12/27/11 and was seen for an accidental ulting in distal tibia and fibula distal tibia and f	F	323	Licensed Staff and Co Aides was completed	devices for all ertified Nurse on 2/6/12 neach resident Assessment ins are checked the resident is falls, they care assessment in the resident is falls, they care assessment in the resident is falls, they care all Quality is gement ement on going in #3.  The resident is fall in the resident is fall in the fall. The resident is fall in the resident is fall in the resident in the fall. The resident is fall in the resident in the in	S

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE LDING	PLE CONSTRUCTION (X3) DATE S COMPL		
		345460	B. WIN			į.	C 3/2012
	PROVIDER OR SUPPLIER	ENTER		2041	ET ADDRESS, CITY, STATE, ZIP CODE 1 WILLOW ROAD EENSBORO, NC 27406	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	STEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	The patient had a fibular metaphysis of the denies any sym left lower extremity. Record review of N submitted as part of 1/12/12 read in particular partic	racture of the distal tibial and on the left side and is in a cast- ptoms except for pain in his "  urse #5 's statement f the investigation dated to it. "I [name of nurse, who no facility] was the scheduled to of the resident] on the 25th, and 26th. He had to 22nd on 1st shift. When I by night the 23rd the second on pain medication at 8:30 pm and the He slept through the shift. Ities appear to be edematous in Saturday the 24th resident the shift. On Sunday the 25th dof pain to the second shift eived for x-ray to left ankle. Was called by Nurse #2 to it. "This nurse to it Nurse #5 any would not come out until 1/11 Nurse #2 to it Nurse on the ray was not done. The x-ray 12/27/12. "The surveyor es during the survey but was	F3	323	light and immediately noticed by calling for assistance. In completed 2/6/2012.  The charge nurse information for injuries, confirmation for injuries, confirmation for injuries, confirmation, pain assessment in condition, pain assessment as This information will be can Medical Doctor for orders/instruction. The on-Administrative Nurse will of the physician's instruction the Responsible Party will notified of the incident and orders. Nurses and Certified Assistants were in-serviced beginning 2/4/2012. This paid be placed in the oriental packets for all new nurses a Certified Nursing Assistant on 2/4/2012. The signature will be placed in the individed action file, starting 2/4/2012. In-service provided charge nurses on 2/2/12. If a signature will be placed in the individed charge nurses on 2/2/12. If a signature will be placed in the individed charge nurses on 2/2/12. If a signature will be placed in the individed charge nurses on 2/2/12. If a signature will be placed in the individed charge nurses on 2/2/12. If a signature will be placed in the individed charge nurses on 2/2/12. If a signature will be placed in the individed charge nurses on 2/2/12. If a signature will be placed in the individed charge nurses on 2/2/12. If a signature will signature will be placed in the individed charge nurses on 2/2/12. If a signature will signature will signature will see the signature will see	m-service will gather onsisting ion, nt, change ent, and indicated. alled to the call be notified ons and be physician ed Nursing l process ation and s starting e sheet dual 2012	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	ULTIPLE CONSTRUCTION LDING	(×	X3) DATE SU COMPLE	TED
		345460	B. WIN	łG			C 3/2012
	PROVIDER OR SUPPLIER RD HEALTH CARE CE	:NTER		STREET ADDRESS, CITY, 2041 WILLOW ROAD GREENSBORO, NO		, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION SHOULI ECTIVE ACTION SHOULI ENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	experiencing pain, I further stated that In an interview on Nurse #1, she state resident rolled off the morning care. The ame, we assisted the assessed the reside and asked him if he pain. He was able to well as upper extrer there was no bleedi or swelling from fall s vital signs.  In an interview on 1 administrator stated rolled out of the bed I went to the the resincident with the resincident with the resincident with the resincident to his heel. Thave edema to the edema to left lower different from any or resident had a histo prior to admission. In to the extremity. The On 12/25/11 the fame the nurse who was in care that the resident he was experiencing was obtained from the 12/25/11. This x-ray because on 12/25/1	he denied any pain. She "I took his vital signs."  1/17/12 at 11:00 am with that " on 12/22/11 the he bed to the fall mat during he aide that was giving care got he resident back to the bed. I hent. I did neurological checks have was having pain. He denied ho move his lower extremity as mity. " Nurse #1 added that hing, no bruising, no skin tears hand NA #1 took the resident.  1/17/12 at 2:44 pm the interim hat " [name of the resident.] hat to the floor mat on 12/22/11. hident's room to discuss the hident. I performed a visual hident's body, the resident's he resident was noted to hupper right arm and a trace of hextremity. This was no her day since admission. This hard of lower extremity edema ho misalignment was noted he family member was notified. hily member complained to hin charge of the resident's hat's ankle was swollen and hard pain. An order for an x-ray he medical director on has not done until 12/27/11 has not 12/26/11 the scheduler for	F3	occurs the reperform the actions:  1. Properties and safety 2. Evaluation and the require median Evaluation to:  O Vito Skion Muon Charles on Neuronicated  3. The clinical find 4. Interest to determined determined. 5. Not	nurse on duty will- e following post far ovide immediate car injuries, and resident for njury which would dical intervention. includes but is not al Signs in Evaluation asculoskeletal asse ange of Condition and Assessment urological assessment oroughly document lings in medical re- erview resident and e if cause of fall ca- tify MD in person f ALL falls and do	are to dent any d t limited essment nent as  t ecord d staff an be or by	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	IULTIPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		345460		NG		C 03/2012	
	PROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, Z 2041 WILLOW ROAD GREENSBORO, NC 27406	ZIP CODE	7012012	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	the mobile unit forg to the schedule. I ha importance of havin manner. My expect episode that might is x-ray must be done x-ray company is now within a reasonable director should be reshould be sent out to administrator added further stated NA #1 proper procedure for weakness in one or that the resident has In an interview on 1. #2 stated "I fell off my ankle." He add hurting.  In a telephone intenthe medical director are that if an order if on-call physician for on the day it was wormobile unit normally requested, so it should the x-ray is not done communications frow the resident can be department.  In an interview on 1. stated that "I was recare on 12/24/11; he	ot to add the resident 's name ave in-serviced my staff on the gay actions are that for any acute rule out bone fracture the the same day. In event the ot able to come the same day time frame, the medical otified and the resident of the hospital. "The interimal that this was not done. She had been in-serviced on the rappear of residents with both sides. She further stated is not had another fall.  17/12 at 3:44 pm, Resident my bed to the floor and broke ed the ankle was swollen and view on 1/18/12 at 8:30 am stated that his expectations is written by himself or an ran x-ray, it should be done itten. He added that the roomes to the facility when all be done within the day. If when ordered he expects in the facility immediately so sent to the emergency	F3	Administrative telephone of Alin medical record. 7. Notify document in m 8. Comple assessment and interventions be clinical informa 9. Comminterventions to 10. Document in the complete of the conference of the conference of the conference of the complete	On-Call RN in person or by LL falls and docum ord. family (RP) and edical record. lete post fall I formulate ased off evaluated ation. unicate established to the care giving state nent on all fall every s, then daily x 48 ricing completed for es and C.N.A's on the care properly turn and lents in bed" includes and care for onlysical impairment	ent  iff y  ing ty  ts	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		345460	B. WING	<del></del>		C 3/2012	
	PROVIDER OR SUPPLIER	INTER		STREET ADDRESS, CITY, STATE, ZIP 2041 WILLOW ROAD GREENSBORO, NC 27406		VI-2 ( -	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD BE 'HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	at 11:40am NA #2 elevate the resident does not remember In an interview on 1 the nurse responsib 12/25/11, stated "I resident's family me the resident was in pair assessed his ankle the medical director an x-ray. I called the told me that [name the following day be I made the nurse co."  During a telephone pm Nurse #4 who w 12/26/11, stated that verbal. The resident his phantom pain. Tof any ankle pain, nor In a telephone interved in the following his phantom pain. Tof any ankle pain, nor In a telephone interved in the floor was unable the floor. I called my off the floor with the	telephone interview on 1/27/12 stated that an aide told her to t 's ankle with a pillow but she	F 33	and pain assessment findings.  Any areas of defice corrected. The star provided education action as indicated.  Nursing Administory progress notes, Plan of Care, Post Fall Assessment Medication Administory caseload.  Therapy will scree a fall if the resident therapy caseload.  The Unit Manager will inform direct new intervention undit tool.  The Weekly Falls Meeting: consist of Administrator, Direct Care givers and Include  Direct care givers and attend the meeting.	ciency noted will of involved will be and or corrective.  It aration will review the instration Record reumentation. It is not already of the care staff of any utilizing the Device Management of the ector of Nursing, erapy described Safety Director.  When possible. If the not available to	er in	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Γ΄΄	ULTIPLE CONSTRUCTION LDING	(X3) DATE SI COMPLE	
		345460	B. WIN	IG	<b>I</b>	C <b>3/2012</b>
	PROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP 2041 WILLOW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	where she would tu but the small rail aw the resident held or attempted to turn. position; she reiteral low position.  In a follow up telep 12:20 pm with the ir stated that Resident care was performed care plan reflected for bed mobility. Notice	rn the resident were lowered, vay from her were raised, and to the small rail and. The bed was in the normal sted that the bed was not in the hone interview on 1/27/12 at a sterim, administrator she t #2 slid out of bed while ADL to n 12/22/11. The resident a 1-person assist with ADLs A #1 is well aware of the care she has cared for him on orior to the incident. " The or further stated that Resident to was in his room with a fall of the bed. NA #1 was ath on the resident and used kin on the front side. After rizing the resident towards needed to complete the bed began to turn the resident, the ady slid out of the bed. NA #1 the resident but she was ident rolled on the fall mat. If a full assessment of the ent declined pain. There was pruising. The family and the	F3	other staff member will be done with the resident's physical cues, in add of the pain scale. Administrator and Development Coolin-servicing of all certified staff on 2 process will be placed orientation packet and Certified Nursistarting on 2/4/201 sheet will be placed education file, start Any staff members be removed from training is completed. Address what mein place or system to ensure that the practice will not repractice will not reprac	consideration for sical symptoms and lition to utilization Interim  Staff rdinator complete licensed and 1/6/2012. This need in the for all new nurses sing Assistants  12. The signature and in the individual ting 2/4/2012 red trained will the schedule until eted.  asures will be purice changes made deficient recur: es are reviewed Administration, ration will validate	d d

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		345460	B. WIN	G <u>·                                     </u>	C 02/03/2012	
	GUILFORD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP C 2041 WILLOW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF C  (EACH CORRECTIVE ACTIVE ACTIV	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 323	doctors. If the situate puts the results in a results normally stated days, no more.  In a follow-up interved 2/2/12 at 9:00 am [inurse #3], the resident hurt his ankless of people came in the stated stated stated that the that my ankle anything until that in before they took care.  During a follow-up in Nurse #1 stated that told that the resident stated she was turn resident rolled to the room, he was on his extended. The resident rolled to the room, he was on his extended. The resident pain. I did not do I believe I gave him were not bigger that that Resident #2 ha removed him from and checked his pupain. I did not assess that if the fall is we assess again, but if to assess the reside the family told me the was supposed to had one. I called the xout that day to do the service of the state of the service of the supposed to had one. I called the xout that day to do the service of the service of the supposed to had one. I called the xout that day to do the service of the service of the supposed to the suppo	the facility calls one of the tion is not critical, the facility in box to be reviewed. The ty in the box for up to two riew with the resident # 2 on in the presence of NA #1 and ent stated that he had fallen cometime in December. "A lot the room, "he said. "I told hurt, but they did not give me ight. I hurt for many days	F 3:	office. Education of occurrences that invoduring ADL care will taken to daily stand tweekly Quality Assumangement Meeting Committee Meeting) Quality Assurance mareview and resolution and quarterly thereaff Falls Management Chassessment of falls is new hire orientation at on the education specinformation, this will the employee education Licensed Nurses and Nursing Assistants.  2/2/12  All new employees was services to include, but to,  care of resider physical impaired turning and portalis Manager.  Falls Manager.	olve safety il be will be up meeting, arance Risk g (Falls , and Quarterly acting for a times 1 month are times 3. committee and included in and documented be placed in on file for Certified Completion will receive in- at not limited atts with irments, osition	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345460	B. WII	B. WING		C 02/03/2012		
	ROVIDER OR SUPPLIER	NTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 2041 WILLOW ROAD GREENSBORO, NC 27406				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	In an interview on 2 # 12, she stated, "resident had a fall. of member came and and no one was doi DON and my nurse concerns. I looked i where they were elea pillow. I checked talready elevated so him pain medication pain. On December medication, he had swollen. I did not do because his arm an She added, "as far done." Surveyor ar	/2/12 at 11:29 am with Nurse no one told me that the On 12/24/11 the family told me that the resident felling anything about it. I told my manager about the family 's in the nurses notes and I saw evating the resident 's leg with he resident, and his leg was I did nothing. I did not give in because he said he had no 25, I gave him his no pain, and his ankle was anything to the ankle d leg were always puffy. "I as I know the x-ray was and Nurse # 12 checked the was no documentation of a	F	323	The Unit Manager and update the device List make copies for each nurse certified nurse aide. The New Will do a check on each of assigned residents to ensure placement and functionality device is not in place or dofunction the Nurse Aide with Charge Nurse. The nurse obtain the appropriate device placement on the resident. The process will be included in orientation for all licensed Surse Aides.	daily and use aide their  y. If the es not ll notify the will ce for		
	In an interview on 02 physical therapy sup 12/24/11 the resider be swollen; it was bi resident stated that the ankle and the phwas working on a pemorning nurse immemade to the physical never returned the company of the physical facility was trying to therapy assistant to	2/2/12 at 3:00 pm with the pervisor, he stated, "On at's ankle was observed to gger than normal. The he was experiencing pain in anysical therapy assistant, who ar diem basis, told the ediately. Several calls were all therapy assistant, but he			Indicate how the facility p monitor its performance t sure solutions are sustaine facility must develop a pla ensuring that correction is achieved and sustained. The must be implemented and corrective action evaluated effectiveness. The POC is integrated into the quality assurance system of the face	o make d. The n for he plan the l for its		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED		
		345460	B. WING			C 02/03/2012	
	PROVIDER OR SUPPLIER	NTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 2041 WILLOW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		ULD BE	(X5) COMPLETION DATE
F 323	know." The admin surveyor on that material buring a telephone pm with the family reduced to the family reduced to the had fallen a coupling and swollen she told me she wo back on 12/26/11, a came back on 12/2 got mad and left the Review of the facility Program effective procedure in the Fapart,  Notify the physion EMS as well as the personal as approped.  Resident # 7 was 4/19/11 current actification the quarterly Minimal 12/29/11, included a disease, hypertension disease, gastroesop stage renal disease disease. Review of impaired cognitive signer memory problems. behavioral symptom #7 required extensions.	now something we will let me istrator never got back to the latter.  Interview on 2/2/12 at 4:12 member, he stated that on 0:30 am, the resident told him ole days ago and his leg was . "I spoke with the nurse and uld get an x-ray order. I came and the x-ray was not done. I ofacility."  If y documentation revealed:  If y policy "Falls Management and dated 10/12/11, per the last Occurrence section, in the Supervisor / Administrative riate.  In admitted to the facility on the diagnosis retrieved from the diagnosis retrieved from the last of the moderately on, peripheral vascular on the MDS revealed moderately skills, long and short term. The assessment revealed no not to with transferring between	F	323	Therapy to report Condition to the floor in 24 shift report. Rehab review 10% of Therapy notes to verify change on 24 hr shift report day weeks, 3x a week for 2 1x a week times one me concerns are reviewed for resolution at the weekly Assurance Risk Manage meeting and monthly at Assessment and Assurance tings for further reviewed for resolution x 3 months  The Director of Nursing Managers will audit deviewer 2 weeks, 3X a week for 2 1X a week times one mo concerns are reviewed for resolution at the weekly Assurance Risk Manager meeting and at the month Assurance and Assessme for further review and resmonths.  The Director of Nursing and the month of the process of the pr	urse and on Director wide Progress of conditionality X 2 weeks, and onth. Any for problem y Quality ement the Quality riew and word word word word word word word wor	d

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	ļ	345460	B. WIN	NG		C 02/03/2012	
	PROVIDER OR SUPPLIER	INTER		204	EET ADDRESS, CITY, STATE, ZIP CODE 41 WILLOW ROAD REENSBORO, NC 27406	<u> </u>	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	The most recent C Summary (CAA) da findings included in while in the hospital since admission, an arm related to falls. with both PT (physic (occupational theragin place. Staff will complain the most recent Capart, Problem Fall-A history of fall r/t (relative knee amputation complaint behaviors transfer without noti Resident continues release harness and Goal: Resident will I next review. Approaresident needs. 2. Fibed. 3. Frequent moself-releases harnes that resident can rewheelchair every nigwings. 6. Supervise indicted. 7. (Name chair with self released ue to bilateral AKA prevention of falls. 1 assistance when ge 11. Call bell with reaframe moved to batt privacy. 13. Bed alar Review of the Incide 12/31/11, revealed Review of the Incide 12/31/11, reveal	Care Area Assessment ated 5/2/11, triggered falls, part; Resident had one fall I. Resident has had 3 falls and did have some pain in his Resident is currently working cal therapy) and OT py). He also has a chair alarm ontinue to monitor.  The Plan dated 12/23/11 in ACT: Actual falls related to ated to) bilateral AKA (above n) and history of non s. Resident continues to ifying staff for assistance. To get up without using self d also removes it. The free from falls or injury by exches: 12/23/11, 1. anticipate frequent bed checks while in onitoring for placement of ss (a hook and loop harness move) 4. Charge motorized ght. 5. (Name brand) matt with & assist with transfers as brand) fall mat. 8. Motorized se harness for trunk control a. 9. Low bed position to aid in 10. Instruct resident to call for ofting out of bed or out of chair. ach. 12. Bedside commode hroom so resident can have	F	323	Managers are responsible implementation and monithe Falls Management Profall occurrences are review (Monday- Friday) at standmeeting, weekly in Qualit Assurance Risk Managem meeting by the DON/Unit and the Week-end Supervicall Administrative Regis Nurse on Saturday and Suproblems noted will be tak Quality Assurance Weekly Management Meeting and Quality Assurance meeting review and resolution, tim and quarterly times two quality thereafter, for further review resolution.  Completion 2/6/12.	toring of ogram All wed daily i up is y nent imagers isor/On tered inday. Any ken to the ranger ison to the ranger ison the ranger ison the ranger ison is nontheranger is nontheranger is not in the ranger is nout in the ranger is not in the ranger is not in the ranger is nou	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y41) PROVIDER (SUPPLIER OF LATELACHIA OF DECICIONICIES (Y41) PROVIDER (SUPPLIER OF LATELACHIA OF LATEL

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A.	BUILDING	C 02/03/2012	
345460 B.	WING		
NAME OF PROVIDER OR SUPPLIER  GUILFORD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2041 WILLOW ROAD GREENSBORO, NC 27406	)E -	
	ID PROVIDER'S PLAN OF CORRE REFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLÉTION	
Continued From page 42 incident was alert and chairbound. Restraint ordered restraint applied: (brand name) hook and loop safety strapes(sic) Description of incident: "Patient was found on floor in room by c.n.a. Patient stated he fell asleep and fell out chair. He took his safety belt a loose." Localion of injury: picture indicated swollen above right eye. Result of Incident: ice applied to area on right side of head. No Post Fall assessment dated 1/31/12 was completed by the nursing staff for the fall dated 12/31/11.  Review of the second incident report dated 1/2/12, revealed revealed resident fell in his bathroom at 2:45a.m. Type of Incident check one or more: Fall/ Bruise Description of incident: Nurse was walking past room down the hall and heard a thumping knocking sound opened the door to ask if Resident #7 was alright his wheelchair was in the bathroom and Resident #7 was on the floor. Vital signs were taken Location of injury: Black eye, skin tear left arm. Result of Incident: First Aid Skin tear cleaned /dressed: Comment and follow up Skin tear on Left upper forearm and right black eye. A Post Fall Assessment dated 1/12/12 was completed by nursing.  Falls Risk Assessment dated 1/12/12, revealed Risk areas medications (pain medications listed), Mobility bilateral AKA, unsafe behavior observed or history tries to stand, transfer, or walk alone unsafely. Tries to climb out of bed alone unsafely. History of falls the last six (6) months, chair bound and requires assistance with toileting, poor balance in wheelchair.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′	iultipi Ilding	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345460	B. WI	1G		<b>—</b>	C 02/03/2012	
	ROVIDER OR SUPPLIER RD HEALTH CARE CE	NTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2041 WILLOW ROAD GREENSBORO, NC 27406					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		(EACH CORRECTI CROSS-REFERENCE	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE DEFICIENCY)		(X6) COMPLETION DATE
F 323	Continued From pa	ge 43	F:	323				
	Nurse #9 revealed renal disease, diabe bilateral above the lartery disease, and Symptoms: Poor batimes. Devices: ass Purpose of the Dev wings to help define	t dated 1/12/12, completed by I Medical Diagnosis: end stage etes mellitus, hypertension, knee amputations, coronary cerebral vascular disease. alance, forgetful, confused at ist bars, bed alarm seat belt. ices: (name brand) matt with a parameters of bed. Alarming falls. Bed position against wall	•• ·					
	motorized wheelchaknee amputations, of forgetfulness and conformation of the motorized Reason for forgetfulness, international Resident /RP(response Resident is aware the motorized wheelchassistance. Resident seat belt on comma harness to motorize Resident Response	nfusion at times. Restraint: Poor balance, nittent confusion nsible party) Education, "nat seat belt with alarm is on air to remind him to ask for nt is currently able to release and." Alternative: Self release and wheelchair. Resident would release in the chair or attempt to						
	motorized wheelcha knee amputations, v	red 1/12/12 Seat belt alarm to hir due to bilateral above the with poor balance, onfusion at times. Release						
		served on 2/2/12 at om sitting in his motorized d in watching a television						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				A. BUILDING B. WING		С	
		345460				02/0	3/2012
NAME OF PROVIDER OR SUPPLIER  GUILFORD HEALTH CARE CENTER				20	EET ADDRESS, CITY, STATE, ZIP CODE 041 WILLOW ROAD REENSBORO, NC 27406		
PREFIX (EACH D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUTH AND CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)			(X5) COMPLETION DATE
the wheelchair seat I wheelchair seat I wheelchair at this observed. It wheelchair alarm box of the was sup would forget several fall but it was represented the covering it, chuckled, represented the seat be observed. It was represented the seat be observed. It was represented the facility in this bed to recommend the covering and the seat be observed. It was represented the seat be observed. It was represented the facility in this bed to represented the seat be observed. It was represented the seat because the seat	turned the hair arouse the left hand belt was. No alared forward for the version of the side of the version of the versi	ne television down and turned and. It was noted he was a knee amputee; he had a and forearm. The wheel dangling at the sides of the m box was noted on the chair. When asked if he had fallen ed he had, but could not recall to turn on the radio sitting at the end of his bed. He rolled wheelchair and hit his head on and gave himself a black eye. ow he leaned forward, he then have his seat belt fastened gether. He indicated he knew keep his seatbelt fastened but kle it. He indicated he had se he thought it was buckled tated he fell once when he is buckled, his shirt was had to go to the hospital. He used by saying he used to use im stay in the chair. The belt ir. He concluded by saying he	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345460	B. WIN	G	39446	C 02/03/2012	
	NAME OF PROVIDER OR SUPPLIER  GUILFORD HEALTH CARE CENTER			2041 WIL	DRESS, CITY, STATE, ZIP CODE LOW ROAD SBORO, NC 27406		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY)		SHOULD BE COMPLÉTIO	
F 323	wheelchair. This w was attempting to to was checking on Ro when he was in bee placed out of his re assistance when tra when they transfer wheelchair was pla reach to prevent hir  During an interview #12 indicated Resic could remove. He for chair. We would rer buckled.  During an interview director of nursing in belt was supposed unbuckled. She indi the belt was not ala observation the day  During an interview #9 indicated the sel was discontinued be the harness. The sel because it alarmed, other residents with know where the fac indicated there was monitoring tool to en monitored. When the his seat belt yestere there was no alarm, know why the belt he	ransfer. The assigned staff ransfer. The assigned staff ransfer. The assigned staff resident #7 more often and his wheelchair would be ach, to remind him to call for ansferring. The aids check it him it will alarm. The ced against the wall out of his in from transferring alone.  on 2/3/12 at 10:52p.m., Nurse lent #7 used a harness that he rell asleep and he fell out of the mind him to keep his harness on 2/3/12 at 11:49 a.m., the reliable he him him to keep his harness on 2/3/12 at 11:49 a.m., the reliable he him him to keep his harness on 2/3/12 at 12:13p.m., Nurse frelease hook loop harness recause there was no alarm on this type of belt she did not this type of belt she did not this type of belt she did not lility had gotten it. She no documentation or resure the belt was working or the resident told had buckled lay during the observation and She indicated she did not	F 3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l' '	IULTIPLE CONSTRU LDING	(X3) DATE SURVEY COMPLETED		
		345460	B. WI			C 02/03/2012	
	PROVIDER OR SUPPLIER	ENTER	<b></b>	2041 WILLOW	S, CITY, STATE, ZIP CODE ROAD RO, NC 27408	1 0210	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH	OVIDER'S PLAN OF CORRE I CORRECTIVE ACTION SH REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	and off prior to the for this week. She i seatbelt that he rem seatbelt alarm woul She indicated the s morning. She was a she indicated Resid Aid # 3 indicated shresidents with that it she does not check removed it from the sound it makes was She indicated the wreach when he was getting into his chair she checked the alashe removed it to give During an interview physical therapy directly one physical therapy department screening does not picked up for an evaluation of the scr	worked with Resident #7 on last week and had him steady indicated he had a self release noved. She indicated the ld go off if it was unlatched, eat belt alarm worked this asked to demonstrate the belt, dent #7 was out of the building, he did not know of any other type of alarm. She indicated the alarm unless she resident to provide care. The stifferent from the bed alarm, wheelchair was kept out of his in bed to prevent him from ron his own. She indicated arm about lunch time, when ive him a whirl pool bath.  on 2/3/12 at 4:21p.m., ector indicated a fall occurred lay) and 1/2/12(Monday) and y screen covered both falls. In meeting nursing had going to implement a bed alt alarm. He was not picked apy services because he had rranted physical therapy the screened by the physical the next business day, a lindicate a resident will be aluation. The self release harness, be the new belt and indicated of department had not supplied	F	323			

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IULI ILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		345460	B. WII	۷G _		02/	C 03/2012
	PROVIDER OR SUPPLIER	NTER	<b>I</b> .	2	REET ADDRESS, CITY, STATE, ZIP CODE 2041 WILLOW ROAD GREENSBORO, NC 27406	1 021	OOLOTE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	During an interview 10:00a.m., Aide #4 back from the hosp current room. Up ur #7 was able to translonger allowed to do wheelchair out of hi assistance. She we in the wheelchair a that crisscrosses actook it off it would alvest goes around hi She indicated it was indicated when the a loud noise. Recall indicated Resident at transferring at that the floor, he had a better to his left arm. We had a better to his left arm. We put a brief urinal and a bedpan bell for help. He was recall falling or how watched him closely had been no change belt does not alarm. alarm and the pad the she could not recall. Since he fell on 1/2/keep the chair out of everything was the second of the point of the puring a telephone in the pad the puring a telephone in the puring a telephone in the pad the puring a telephone in the puring a telephone in the pad the puring a telephone in the pad the puring a telephone in the puring a telephone in the pad the puring a telephone in the pad the puring a telephone in the puring a telephone in the pad the puring a telephone in the puring and the puring a telephone in the puring	via telephone on 2/4/12 at indicated Resident #7 came ital and was moved to his ntil two weeks ago Resident afer him self. He was no o so, the staff was to keep his is reach and he was to call for int on to say to keep him safe hook and loop vest was used tross him and the chair. If he arm, "it always works". The is shoulders and his waist. In not checked regularly. She was taken off and makes ing the fall on 1/2/12 she if was independent with his ime. She indicated he had toilet and was found by the oilet and the wheelchair on lack eye left eye and a skin we got him up and put him to on him, and gave him a we told him to use the call is very confused he could not he had gotten the bruise. We the rest of the night. There is in the type of belt and the The changes were the bed in the sits in his wheel chair the date this was changed. It, the only difference was to finis reach. Otherwise	F	323			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BU		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345460	B. Wil			C 02/03/2012	
	PROVIDER OR SUPPLIER	NTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 1041 WILLOW ROAD BREENSBORO, NC 27406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 323	had been independ mobility. He had no him safe. She alway him. A bed alarm when chair was to be kep indicated she did not chair worked or not Nurse #13 indicated wears a harness be wheelchair and falls. The belt on the chair pad alarm in the same chair p	ge 48 ent with transferring and measures in place to keep ys kept his door open to watch as put on his bed and the t away from his reach. She of know if the alarm in the it was disabled at night. If during the day Resident #7 reause he falls asleep in his is forward and out of the chair. In doesn't alarm. There was a the wheelchair, it is flat and he lifts himself forward off of the	F:	323			