

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345460</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/21/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2041 WILLOW ROAD</b> <b>GREENSBORO, NC 27406</b>	
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E 000	Initial Comments  An unannounced Recertification survey was conducted 6/18/19 through 6/21/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #5B7Z11.	E 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)  §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to assess and determine whether the self-administration of medications was clinically appropriate for 1 of 1 sample resident (Resident #39) who was observed to have medications at bedside.  The findings included:  A review of the facility policy on 'Self-Administration of Medication at Bedside' (dated 2/1/15) included the following information, in part: Policy: A licensed nurse will assess patient ' s ability to self-administer medication. Procedure: " ...2. Verify physician ' s order in the patient ' s chart for self-administration of specific medications under consideration. 3. Complete Self-Medication Request/Evaluation form. 4. The Interdisciplinary Team will review the	F 554	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.  How Corrective Action will be accomplished for those residents found to have been affected by the deficient practice: 06/19/2019 medications removed from bedside placed in cart for safe keeping. New orders received for the medications she wanted to continue to receive, and	7/19/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/11/2019

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 554	<p>Continued From page 1 assessment and will document during care plan. 5. Complete the Care Plan for approved self-administered drugs. 6. Self-administration of meds must be reviewed by the Interdisciplinary Team quarterly and PRN (as needed) if change in status is noted ..."</p> <p>Resident #39 was admitted to the facility on 3/15/19. Her cumulative diagnoses included unspecified psychosis and age-related nuclear cataract (unspecified eye).</p> <p>A review of Resident #39 ' s most recent quarterly Minimum Data Set (MDS) dated 5/7/19 revealed the resident had intact cognitive skills for daily decision making. She required supervision only for eating and personal hygiene; extensive assistance from staff for bed mobility, transfers, and dressing; and was totally dependent on staff for locomotion on/off the unit, dressing, toileting, and bathing.</p> <p>A review of the resident ' s current Care Plan (revised 5/16/19) was completed. The Care Plan included the following area of Focus, in part: "The resident exhibits adverse behavioral symptoms (feeling anxious, inability to sleep, mood changes) r/t (related to) admitted with diagnosis of depression, anxiety, and psychosis. She exhibits med seeking behaviors. Resident receives antianxiety, antidepressant, and sedative/hypnotic medication." (Created on: 12/26/18; Revision on: 05/16/19). Resident #39 ' s care plan did not address the self-administration of medications.</p> <p>A review of Resident #39 ' s current physician orders (as of 6/18/19) included the following, in</p>	F 554	<p>loose medication found in room returned to family member. Resident #39 did not express desire to self-administer medication. How the facility will identify other residents having the potential to be affected by the same deficient practice: All patient rooms were checked for medications (prescription or over-the-counter) on 07/10/2019, to ensure that no other medications were found at bedside. When a medication during the initial audit was identified it was removed from the patients room until determination by the Interdepartmental Team and could evaluate the abilities of the resident to safely administer medication. A patient with a BIMS score of 12 or less will not, be considered for self-administration due to patients inconsistent cognitive function. Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Nurses, CNA's and Department Heads were educated on Nursing Policy 1805, Self-Administration of Medication at bedside and making sure that attention is paid to in resident rooms when providing care and making rounds for any medications (prescription or over-the-counter), by Regional Nurse Consultant and Staff Development Coordinator, and were educated to notify the Director of Nursing or Administrator of any medications seen at bedside. Administrator or Director of nursing will review so that appropriate steps are taken to properly determine the patient's ability</p>		

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F 554	<p>Continued From page 2</p> <p>part: --1000 milligrams (mg) omega-3 fatty acid capsules (nutrients that are thought to prevent and manage heart disease) to be given as one capsule by mouth every day for supplement (ordered on 3/15/19); --250 mg Saccharomyces boulardi (a probiotic) to be given as one capsule by mouth every 12 hours related to the long-term use of antibiotics (ordered on 5/17/19). There were no orders for biotin (a B-vitamin), PB Assist + (a prebiotic and probiotic product), Alpha CRS+ (a dietary supplement containing natural botanical extracts), Cognium (a dietary supplement, or Terra Zyme (a dietary supplement containing digestive enzymes). The current physician orders did not include an order for the resident to self-administer any of her medications.</p> <p>On 6/18/19 at 3:15 PM, Resident #39 was observed to be asleep in her bed. At the time of this observation, a 28-compartment (7-day) pill box was visible on the resident ' s nightstand. Multiple tablets and capsules were observed to be stored in the pill box.</p> <p>An interview was conducted on 6/19/19 at 4:10 PM with Resident #39. During the interview, the pill box was not within view. When asked where the pill box was, the resident reported "a nurse" came in that morning (6/19/19) and told her she could not have it in her room. The resident stated she had the pill box containing supplements and vitamins in her room ever since she was admitted to the facility, and she did not understand, "why it was a problem all of a sudden."</p> <p>A review of the resident ' s electronic medical</p>	F 554	<p>to safely administer medications and properly secured in a lock box if determination is made by the IDT that the patient can safely administer the medications. Rounds observing medications at bedside was started on July 16, 2019. If medications are found then the medications are removed and given to the DON or Administrator so that they can ensure that the patient is evaluated as to their ability to self-administer medications. All new hired employees will be educated on the process for Self-Administration of Medication at bedside and making sure that attention is paid to in resident rooms when providing care and making rounds for any medications (prescription or over-the-counter). A letter was drafted to families and patients outlining the necessity for patients and families, to notify the facility of medications that are brought into the facility. This letter was mailed to the Responsible Party on July 10, 2019 and given to patients residing in facility and a patient list checked to ensure all had been sent the letters. Patients and families during the admission process will be given a letter explaining the self-administration process to begin July 19th, 2019. How facility plans to monitor its performance to make sure that solutions are sustained: Department Heads will do and complete daily round sheet for assigned rooms Monday through Friday for a period of 3 months, observing for medications (prescription or over-the-counter) at</p>		

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F 554	<p>Continued From page 3</p> <p>record included a Nursing Note dated 6/19/19 at 2:10 PM. The notation reported vitamins were kept at the resident ' s bedside. The Director of Nursing (DON) was noted to have spoken with the resident on this date and informed her that all medications should be on cart along with a physician ' s order so that the facility could monitor for any potential adverse reactions. The Nurse Practitioner (NP) was notified and orders received for several of the vitamins. The note indicated the NP recognized the resident already had an order for two of the vitamins/supplements and this was explained to the resident.</p> <p>A review of the resident ' s electronic medical record also included a Nursing Note dated 6/19/19 at 2:32 PM. This notation included the brand names and number of pills/capsules found in the resident ' s bottles of the vitamins and supplements. After being counted, the medications were reported to have been labeled for the resident and placed in the medication cart.</p> <p>Further review of Resident #39 ' s medical record included new orders for the following vitamins/supplements: --6/19/19 Biotin 5000 capsule to be given as one capsule by mouth one time a day for supplement; --6/19/19 PB Assist + tablet to be given as one tablet by mouth daily for supplement; --6/19/19 Alpha CRS+ tablet to be given as one tablet by mouth twice daily for supplement; --6/19/19 Cognium tablet to be given as one tablet by mouth twice daily for supplement; and, --6/19/19 TerraZyme tablet to be given as one tablet by mouth twice daily for supplement.</p> <p>An interview was conducted on 6/20/19 at 8:57 AM with the DON in the presence of the facility ' s</p>	F 554	<p>bedside and report findings in morning Stand-up meeting. Administrator or Director of nursing will ensure that the appropriate evaluation is completed to ensure the patient is able to safely self-administer medications and ensure that the room has appropriate secured storage placed in the patients room. These audits will be completed Monday through Friday will be reviewed during Quarterly Quality Assurance and Improvement meeting X 1 to review for further problem resolution if needed. The title of the person responsible for implementing the acceptable plan of correction Director of Nursing</p>		

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F 554	<p>Continued From page 4</p> <p>corporate consultant. During the interview, the DON was asked about the pill box containing tablets and capsules observed in Resident #39 ' s room. The DON stated on 6/19/19, the nurses reported Resident #39 had a pill cup and pill box containing vitamins and minerals in her room. She was not aware of the resident having any tablets or capsules in her room prior to 6/19/19. The DON stated she talked with the resident and told her that she could not self-medicate without a physician ' s order for the vitamins. The DON reported she removed the pill box and bottles of the vitamins/minerals from the resident ' s room and consulted with the NP to determine which ones would be appropriate for the resident; new orders were then received. The DON stated upon review, the NP identified two supplements that were duplicates of medications already ordered for the resident so orders were not written for these. Upon request, the contents of Resident #39 ' s pill box previously observed to be in her room were reviewed. The compartments labeled for morning administration contained 4-5 capsules with two tablets each (for 6 of the 7 days in the pill box); the compartments labeled for evening administration included 5 capsules and two tablets each (for 6 of the 7 days in the pill box).</p> <p>The interview with the DON continued on 6/20/19 at 8:57 AM with a discussion of the facility ' s policy regarding the self-administering of medications by a resident. The DON reported if a resident wished to self-administered medications, the interdisciplinary team (IDT) would need to do a self-administration assessment and obtain permission/orders from the provider to do so. The self-administration of meds would also be incorporated into the resident ' s care plan and</p>	F 554			

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F 554	<p>Continued From page 5</p> <p>the medication would either be kept in a lock box in the resident ' s room or on the med cart (depending on the individual). However, the DON stated Resident #39 was not asking for the privilege to self-administer the medications at this time. The DON reported the resident just wanted to make sure she could continue to take the supplements.</p> <p>Accompanied by the DON, an observation and review was conducted on 6/20/19 at 9:15 AM of the hall medication cart. The pill bottles removed from Resident #39 ' s room (on 6/19/19) were currently stored on the locked med cart and included the following:</p> <ul style="list-style-type: none"> <li>--One bottle of Cognium tablets (originally containing 60 tablets) with approximately 30 tablets remaining in the bottle;</li> <li>--One bottle of Alpha CRS+ capsules (originally containing 120 capsules) with 5 capsules remaining in the bottle;</li> <li>--One bottle of 5000 micrograms (mcg) biotin capsules (originally containing 120 capsules with approximately 30 capsules remaining in the bottle;</li> <li>--One unopened bottle of TerraZyme capsules containing 90 capsules and one opened bottle with 5 capsules remaining in the bottle;</li> <li>--One unopened bottle of PB Assist+ Probiotic defense formula double layer capsule containing 30 capsules.</li> </ul> <p>Two additional bottles previously stored in the resident ' s room were provided by the DON for review on 6/20/19 at 9:25 AM and these included:</p> <ul style="list-style-type: none"> <li>--One bottle of an omega fatty acid dietary supplement which also contained Vitamin D and Vitamin E (originally containing 120 soft gel capsules) with 11 soft gel capsules left in the bottle; and,</li> </ul>	F 554			

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F 554	<p>Continued From page 6</p> <p>--One bottle of a dietary supplement tablet containing minerals such as calcium, magnesium, and zinc (originally containing 120 tablets).</p> <p>A comparison of the tablets and capsules stored in the resident ' s pill box with the labeled bottles of medications revealed pink-colored tablets from the pill box could not be identified; the tablets did not have a corresponding bottle with labeling to identify it. Also, there were no markings to assist with the identification of these tablets.</p> <p>An interview was conducted on 6/20/19 at 5:50 PM with a Nursing Assistant #1 (NA #1) who reported having worked with Resident #39 in the past. During the interview, the NA stated she did not recall seeing pill bottles in the resident ' s room. However, the NA reported she had seen a pill box "sectioned by time" placed on the resident's bedside table in her room in the past. Upon further inquiry, the NA stated she estimated seeing this pill box in the resident ' s room "over a month ago."</p> <p>An interview was conducted on 6/21/19 at 8:40 AM with NA #2. Upon inquiry, NA #2 stated she recalled seeing bottles of vitamins or supplements in Resident #39 ' s room a couple of times "in the last few weeks." She did not recall seeing a compartmented pill box in the resident ' s room.</p> <p>An interview was conducted on 6/20/19 at 9:52 AM with the DON. During the interview, the DON reported she would expect any medications (such as vitamins) brought in from the outside to be reviewed by the resident ' s NP or Medical Doctor and an order written for them.</p>	F 554			

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F 578 F 578 SS=D	Continued From page 7 Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he	F 578 F 578		7/19/19	

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F 578	<p>Continued From page 8</p> <p>or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interviews and record review, the facility failed to indicate code status in the medical record for 1 of 23 residents (Resident #66) reviewed for advance directives.</p> <p>Findings included:</p> <p>Resident #66 was admitted to the facility on 5/13/19 with diagnoses that included, in part, diabetes mellitus, hypertension and heart failure. Resident #66 discharged to the hospital on 6/6/19 and was re-admitted to the facility on 6/14/19.</p> <p>A review of the comprehensive Minimum Data Set (MDS) assessment dated 5/20/19 revealed Resident #66 was cognitively intact.</p> <p>A review of the medical record from the initial admission revealed an advance directive that included full code status (initiate cardio-pulmonary resuscitation should respirations and heartbeat stop).</p> <p>A review of the medical record when Resident #66 was re-admitted to the facility on 6/14/19 revealed no documented code status.</p> <p>On 6/20/19 at 11:05 AM an interview was completed with Unit Supervisor #1. She said typically, upon admission, the nurse entered code status in the electronic health record along with all the other orders. She stated the nurse obtained the code status from the hospital discharge</p>	F 578	<p>How Corrective Action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The facility failed to have code status in the medical record for resident #66. Resident #66 code status was entered into medical record on 6/20/2019. How the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>All other current residents had advanced directives audited for compliance on 06/21/2019 to ensure that all had code status entered into electronic medical records.</p> <p>Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>All licensed nurses will be in-serviced that upon admission and readmission residents will have their medical records reviewed for advanced directive documentation (code status), if no advanced directive (code status) is identified the admission nurse/licensed nurse will obtain the code status, and obtain an order and enter into electronic medical record. Any Licensed Nurse who has not received education by 07/19/2019 will not be allowed to work until received education</p> <p>All new hired licensed nurses will be</p>		

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F 578	Continued From page 9 paperwork. She further stated if a staff member needed to look for a resident's code status the staff member checked the electronic health record and if the code status wasn't indicated the staff member looked in a book at the nurse's desk. Unit Supervisor #1 said if there was no goldenrod form in the book at the nurse's desk then the nurse assumed the resident was a full code.  On 6/20/19 at 12:57 PM an interview was completed with Nurse #6. He was the admitting nurse on duty when Resident #66 re-admitted to the facility on 6/14/19. He stated code status information was located in the electronic health record. He said the admitting nurse typically entered the order for code status based on the paperwork that was sent from the hospital. Nurse #6 said when Resident #66 was re-admitted to the facility he thought the order for code status carried over from the previous admission and was already entered into the electronic health record. Nurse #6 reported he did not remember if he entered the order for code status in the electronic health record when Resident #66 re-admitted and said he thought all he needed to enter in were the prescription orders.  On 6/21/19 at 9:23 AM an interview was completed with the Director of Nursing (DON). She stated she expected code status information to be documented in the electronic health record upon a resident's admission to the facility.	F 578	educated in general orientation on obtaining a code status, advanced directive on admission or readmission. How facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing, Unit Managers, medical records coordinator and/or assigned designee will conduct audits on all new and readmit admissions daily Monday through Friday for compliance of a code status/advanced directive initiated. Results of audits will be reviewed at weekly Quality Assurance Risk meeting X 4 weeks, then monthly for 2 months. Results of all audits will be reviewed at Quarterly Quality Assurance and Improvement meeting X 1 to review for further problem resolution. F578: The Title of the person responsible for implementing the acceptable plan of correction: Director of Nursing		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)  §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		7/19/19	

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F 584	<p>Continued From page 10</p> <p>comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide-</p> <p>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 584			

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F 584	<p>Continued From page 11</p> <p>Based on observations and staff interviews, the facility failed to maintain the walls in the bathroom for 1 of 7 sampled resident rooms.</p> <p>The findings included:</p> <p>An observation on 6/18/19 at 11:18 AM revealed a softball sized hole extending through the sheetrock in the bathroom between resident rooms 209 and 211.</p> <p>Observations on 6/19/19, 6/20/19 and 6/21/19 revealed no repairs done to the hole in the wall of the bathroom between resident rooms 209 and 211.</p> <p>An interview was conducted with the Maintenance Director on 6/21/19 at 2:27 PM. The Maintenance Director stated he goes through the facility every day and checks everything, including the bathrooms included. He looks to make sure call lights are functioning properly, light bulbs are working, looks behind the beds for concerns with cords, and checks air filters. He stated he puts anything that needs repair down on paper and then enters it into a computer system when it is completed. He stated he knew about the hole in the bathroom wall between resident rooms 209 and 211 than stated he didn ' t know about it. An observation of the Maintenance Directors log book for the week of 6/18/19 and 6/21/19 revealed no documentation of the hole in the bathroom wall. He stated the hole was something that needed to be repaired as soon as possible, but he was the only maintenance person the facility had and he had recently been out sick.</p> <p>An interview with the Administrator on 6/21/19 at 4:50 PM revealed she knows about the hole in</p>	F 584	<p>How the corrective action will be accomplished for the residents found to have been affected by the deficient practice.</p> <p>Facility failed to maintain the walls in the bathroom between resident rooms 209 and 211. The wall was patched and repaired on 6/26/2019. The wall was repainted on 7/9/2019.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>Administrator and maintenance director will audit every patient room and note any and all problems that need to be fixed in the environment by 7/19/2019 and a work order placed on the TELS (Work order system)</p> <p>Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: CNAs, nurses, and Department heads were educated on the checklist of specific things to look for in their rounds and when providing care. Any problems will be identified in morning stand up meetings or reported to Director of Nursing and Administrator. Compliance is expected by July 19, 2019. All new hired employees will be educated on the process for when reporting and entering the order into the TELS (Work order system) in general orientation.</p> <p>The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains correct and/or in compliance with the regulatory requirements.</p>		

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F 584	Continued From page 12 the wall and the resident does it with his wheelchair. When the Administrator was shown the hole in the wall in between rooms 209 and 211, she stated it was another resident ' s room and this needed to be repaired.	F 584	Department heads will do visualization of each patient's room in their assigned rooms daily Monday-Friday for a period of 3 months, observing for holes in walls and report findings in morning stand-up meeting. Maintenance director will address and fix any holes observed in the walls reported in morning stand-up. These audits will be completed and provided to the Quarterly Quality Assurance and Improvement meeting x1 to review for further problem resolution. The title of the person responsible for implementing the acceptable plan of correction Administrator		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect the use of insulin for 1 of 6 residents reviewed for unnecessary medications (Resident #42).  The findings included:  Resident #42 was admitted to the facility on 6/20/18 from a hospital. Her cumulative diagnoses included Type 2 diabetes.  A review of Resident #42 ' s current physician medication orders included an order for Humalog	F 641	F641 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #42 Annual MDS ARD 5/9/19 was incorrectly coded as Zero for Questions N0300 Injections and N0350 Insulin in Section N. The MDS was modified on 6/21/19 to correctly code injections and insulin injections.  F641 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All current residents	7/19/19	

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F 641	<p>Continued From page 13</p> <p>insulin to be given on a sliding scale basis (ordered on 10/24/18) and Levemir insulin to be administered as 34 units injected subcutaneously twice daily (ordered on 4/3/19).</p> <p>A review of the resident ' s May 2019 Medication Administration Record (MAR) was conducted. Documentation on the MAR revealed Resident #42 received injections of both Humalog insulin and Levemir insulin each day from 5/3/19 through 5/9/19.</p> <p>A review of Resident #42 ' s annual Minimum Data Set (MDS) assessment dated 5/9/19 was completed. Section I (Diagnoses) of the MDS reported the resident had active diagnoses which included diabetes and the long term use of insulin. Section N (Medications) of the MDS assessment indicated the resident received zero (0) injections during the 7-day look back period. The number of days an insulin injection was received during the 7-day look back period was left blank. Section Z of the MDS was signed on 5/14/19 to indicate the assessment was completed.</p> <p>An interview was conducted on 6/21/19 at 12:30 PM with MDS Nurse #1. During the interview, the nurse reviewed Resident #42's annual MDS assessment dated 5/9/19. Upon inquiry, the nurse confirmed Section N of the MDS indicated no injections and no insulin was reported to have been given during the 7-day look back period. The look back period was determined to be 5/3/19 to 5/9/19. Upon review of the Resident #42's electronic medical record, MDS Nurse #1 reported the MDS assessment was incorrectly coded and should have indicated the resident received injections on 7 out of 7 days and</p>	F 641	<p>MDS who receive insulin injections will be reviewed to ensure Questions N0300 Injections and N0350 Insulin in Section N are correctly coded according to the documentation from the residents' medical records. Any issues identified as being coded incorrectly, will be modified by the MDSC. This audit was completed by the MDS Consultant on July 12, 2019.</p> <p>F641 Measures to be put in place or systemic changes made to ensure practice will not re-occur: Education was provided to MDSC on 7/3/19 by the MDSC Regional Consultant on the RAI requirements for coding Questions N0300 Injections and N0350 Insulin in Section N. All new MDSC employees will be educated during orientation on proper coding of Questions N0300 Injections and N0350 Insulin in Section N. The MDS Consultant or designee will audit 5 residents' MDS's who receive insulin injections and will be reviewed to ensure Questions N0300 Injections and N0350 Insulin in Section N is correctly coded according to the documentation from the residents' medical records once weekly for 4 weeks, twice a month for one month, and monthly x 1 month. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDSC. Any MDS's that are found to be improperly coded will result in additional education, if the coding continues to be an issue then it will result in a written counselling if education is not successful in ensuring accurate coding and the</p>		

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F 641	Continued From page 14 received insulin on 7 out of 7 days during the look back period.  An interview was conducted on 6/21/19 at 11:55 AM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for a resident ' s MDS to be coded correctly.	F 641	Administrator notified.  F641 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed. Title of person responsible for implementing the acceptable plan of correction: MDS Consultant		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)  §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, and interviews with the facility ' s Speech Language Pathologists and staff, the facility failed to provide staff supervision and/or assistance with eating for a resident diagnosed with dysphagia (difficulty with swallowing). This occurred for 1 of 12 residents (Resident #249) reviewed for Activities of Daily Living.  The findings included:  Resident #249 was admitted to the facility on 5/25/19 from the hospital. The resident ' s cumulative diagnoses included spinal stenosis of the cervical (neck) region, dysphagia (difficulty swallowing) and a history of a stroke.	F 677	How Corrective Action will be accomplished for those residents found to have been affected by the deficient practice: The Facility failed to provide supervise/assistance with eating for resident diagnosed with dysphagia (difficulty swallowing) for resident #249. Speech Therapy provided treatment until 7/05/2019. Recommendations to provide supervision with all meals served in room communicated to staff by Speech Therapist. 07/05/2019.  How the facility will identify other residents having the potential to be affected by the same deficient practice: All other current residents reviewed for diagnosis of	7/19/19	

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F 677	<p>Continued From page 15</p> <p>A review of Resident #249 ' s rehabilitation notes included a Speech Language Pathology (SLP) Evaluation and Plan of Treatment dated 5/29/19 and authored by SLP #2. SLP recommendations made on 5/29/19 included the following:</p> <p>--Intake: Diet recommendations for solids = puree consistencies; Diet recommendations for liquid = thin liquids.</p> <p>--Supervision: Supervision for oral intake = close supervision.</p> <p>--Strategies: Swallow Strategies/Positions: To facilitate safety and efficiency, it is recommended the patient use the following strategies and/or maneuvers during oral intake: alternation of liquid/solids, general swallow techniques/precautions, bolus size modifications and rate modification.</p> <p>The SLP Plan of Treatment included the following Short-Term Goal (in part): "Patient will safely swallow mechanical soft and thin liquids, successive swallows using general swallow techniques/precautions with 90% of attempts and with 25% Verbal Cues in order to decrease s/s (signs/symptoms) of oral and/or pharyngeal dysphagia. (Target: 6/5/2019)"</p> <p>A review of Resident #249 ' s admission Minimum Data Set (MDS) dated 6/1/19 revealed the resident had severely impaired cognitive skills for daily decision making. The MDS assessment indicated Resident #249 required extensive assistance from staff for all of her Activities of Daily Living (ADLs), including eating. Section K of the MDS reported the resident received a therapeutic and mechanically altered diet. Section O reported Resident #249 received rehabilitation services with 146 minutes of Speech Language Pathology (SLP) services initiated on 5/29/19 and received on 3 out of 7</p>	F 677	<p>Dysphagia (difficulty swallowing) as of 07/09/2019 and whether the patient has a need for supervision with meals served in room by Rehab Director.</p> <p>Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Any new admission or readmission that comes with a diagnosis of Dysphagia (difficulty swallowing) will have supervision provided for all meals served in room until Speech therapy evaluation completed. This process will be in place by July 19, 2019. Nurses and CNA's were educated on the this change in process and education will be completed by July 19, 2019, if education is not received the staff will be removed from the schedule until they receive the education. All new hired nurses and CNA's will be educated on this change in process during general orientation.</p> <p>How facility plans to monitor its performance to make sure that solutions are sustained: All new or readmissions that come with diagnosis of Dysphagia (difficulty swallowing) will be audited for supervision provided when meal served in room until Speech Therapy evaluation completed for 4 weeks, biweekly X 2, and monthly X 1. These audits will be completed and provided to the Quarterly Quality Assurance and Improvement meeting X 1 to review for further problem resolution.</p> <p>The title of the person responsible for implementing the acceptable plan of</p>		

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F 677	<p>Continued From page 16 days during the assessment look back period.</p> <p>A review of the resident ' s current Care Plan was completed. The Care Plan included the following areas of focus, in part: "The resident has impaired cognitive function/dementia or impaired thought processes r/t (related to) Disease Process" (Created on 6/7/19 and Revised on 6/17/19); and, "Nutrition Risk at admission to center r/t multiple comorbidities, including GERD (gastroesophageal reflux disease), HTN (hypertension), stroke, pt (patient) continues to request a straw in the dining room despite SLP recs (recommendations) for no straws" (Created on 5/27/19 and Revised on 6/19/19).</p> <p>Resident #249 went out to the hospital on 6/12/19 for an anterior cervical discectomy and fusion. Anterior cervical discectomy and fusion is a surgical procedure to treat spinal cord compression by removing a herniated or degenerative disc in the neck and inserting a graft to fuse the bones together.</p> <p>A review of the resident ' s hospital records revealed a Speech and Language Pathologist (SLP) conducted a Modified Barium Swallow study on 6/16/19. The Clinical Impression from the study noted: " ...Recommend initiating dys (dysphagia) 1 (small bites-1/2 teaspoon or less), thin liquids by small cup sips, no straws. Full supervision due to need for cuing for compensations ..." The Swallow Evaluation Recommendations included the following, in part: " ...SLP Diet Recommendations: Dysphagia 1 (Puree) solids; Thin liquid. Liquid Administration via: Cup; No straw. Medication Administration: Crushed with puree. Supervision: Full supervision/cueing for</p>	F 677	<p>correction Director of Nursing</p>		

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F 677	<p>Continued From page 17 compensatory strategies. Compensations: Minimize environmental distractions; Slow rate; Small sips/bites; Clear throat after each swallow..."</p> <p>Further review of the hospital SLP treatment notes indicated Resident #249 was seen by the SLP on 6/17/19 at 10:20 AM. Recommendations in this treatment note included: "Diet Recommendations: Dysphagia 1 (Puree); Thin liquid. Liquids provided via: Cup. Medication Administration: Crushed with puree. Supervision: Staff to assist with self feeding."</p> <p>A review of Resident #249 ' s Physician Discharge Summary from the hospital (dated 6/17/19) included the following instructions typed in bold print: "Diet recommendation: Recommend initiating dysphagia 1 (pureed solids)...(small bites - 1/2 teaspoon or less), thin liquids by small cup sips, no straws."</p> <p>Resident #249 was discharged from the hospital and returned to the facility on 6/17/19. The resident ' s diet order on 6/17/19 was noted to be a Heart Healthy diet, level 4 pureed texture, regular liquids consistency.</p> <p>An observation was conducted on 6/18/19 at 11:16 AM of Resident #249 in her room. An attempt was made to interview the resident. The resident was verbal but appeared confused. A sign entitled ' Safe Swallow Precautions ' was observed posted on the wall over the head of her bed which read: "Diet: Dysphagia 1 (pureed) Liquids: thin-no straws Medications: crush in pureed (small amount, 1/2</p>	F 677		

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F 677	<p>Continued From page 18</p> <p>tsp or less) Sit upright (underlined) *(Starred and underlined) Small bites and sips Supervision: Full (circled) Intermittent (not circled) Special Instruction (underlined): Must take very small bites and sips "1/2 tsp or less" (underlined) No straws Clear throat, re-swallow intermittently"</p> <p>A second attempt to interview the resident was made on 6/18/19 at 12:40 PM as she was sitting in her wheelchair in the hall. The resident was confused and unable to provide reliable information.</p> <p>An observation was made on 6/18/19 at 12:48 PM as Resident #249 was observed to be sitting in a wheelchair in her room with a lunch meal tray on a bedside table in front of her. The meal tray consisted of pureed foods. A diet slip on the tray identified the pureed solids as pureed chicken, mashed potatoes, pureed green beans, pureed bread, and vanilla pudding. The meal tray also included two glasses of liquids; one glass contained a clear liquid and the second glass contained a light brown liquid. No straws were on the tray. The resident was observed as she fed herself the pudding with full spoonfuls of food at a time. No staff member was in the room. A continuous observation was conducted from the hallway outside of the resident's room. At 12:53 PM, the resident was noted to have eaten all of her pudding and mashed potatoes; she was feeding herself the pureed chicken (with full spoonfuls of food at a time). No beverages had been consumed. At 12:54 PM, a female staff member was observed as she walked down the</p>	F 677			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345460</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>06/21/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2041 WILLOW ROAD</b> <b>GREENSBORO, NC 27406</b>		
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F 677	<p>Continued From page 19</p> <p>hallway past Resident #249 ' s room; the staff member did not turn her head or appear to look into the resident ' s room. At 12:55 PM, the resident was noted to have eaten all of her pureed chicken and was feeding herself the pureed green beans (with full spoonfuls of food at a time). No beverages had been consumed. At 1:00 PM, Resident #249 had finished all of the pureed chicken and 75% of the pureed green beans. She was observed to be feeding herself the pureed bread (again, with full spoonfuls of food at a time). No beverages had been consumed. At 1:05 PM, Resident #249 was observed to have eaten all of the pureed food from her tray, with the exception of 25% of her pureed green beans. No beverages had been consumed. At 1:06 PM, the resident was heard coughing several times from the hallway. The resident was directly observed and checked to ensure she had stopped coughing and was not in distress; no staff members came to check on the resident. At that time, Resident #249 was observed to have consumed approximately 1/2 ounce (equivalent to 3 teaspoons) of the light brown liquid from her meal tray. No staff member was in the room for supervision while Resident #249 fed herself the meal or drank the liquids during this continuous observation. The sign entitled ' Safe Swallow Precautions ' was observed to be posted on the wall over the head of her bed.</p> <p>An interview was conducted on 6/20/19 at 12:55 PM with an SLP (SLP #1) who worked at the facility on an ' as needed ' (PRN) basis. During the interview, SLP #1 reported she had completed an evaluation for Resident #249 on this date and the consistency of the liquids prescribed for her diet was changed from a thin</p>	F 677			

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F 677	<p>Continued From page 20</p> <p>consistency to nectar-thick liquids. The swallowing precautions observed to be posted on the wall at the resident ' s head of her bed were discussed. The SLP reported these precautions still applied, including taking 1/2 teaspoon pureed food per bite and alternating with small sips of liquids. When asked how much supervision Resident #249 required at mealtime if the she ate in her room, SLP #1 stated, "She needs to have someone in there." Upon further inquiry, the SLP reported the resident would need to be supervised at all times while eating in her room. The continuous observation of Resident #249 feeding herself the noon meal on 6/18/19 in her room without staff supervision was discussed. SLP #1 reported the resident needed a staff member in the room to provide supervision and cueing for her to eat slowly. The interview also included a discussion of the resident ' s coughing towards the end of the meal observation on 6/18/19. The SLP stated Resident #249 tended to cough more as she got tired. In addition, the resident was assessed as having some difficulty with thin liquids (which had been provided as ordered on 6/18/19 for the meal observed) and the orders were changed accordingly.</p> <p>A review of Resident #249 ' s SLP Evaluation and Plan of Treatment dated 6/20/19 was conducted. SLP recommendations made on 6/20/19 and authored by SLP #1 included the following: --Intake: Diet recommendations for solids = mechanical soft textures, puree consistencies; Diet recommendations for liquids = nectar thick liquids. --Supervision: Supervision for oral intake = close supervision. --Strategies: Swallow Strategies/Positions: To facilitate safety and efficiency, it is recommended</p>	F 677			

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F 677	<p>Continued From page 21</p> <p>the patient use the following strategies and/or maneuvers during oral intake: guided bolus/utensil placement, alternation of liquid/solids, rate modification, bolus size modifications, no straws and general swallow techniques/precautions upright posture during meals and upright posture for &gt;30 minutes after meals.</p> <p>The Assessment Summary of the SLP Evaluation and Plan of Treatment dated 6/20/19 read, in part: "Risk Factors: Due to the documented physical impairments and associated functional deficits, the patient is at risk for: aspiration, depression, dehydration, further decline in function and social isolation."</p> <p>A review of Resident #249 ' s medical record revealed the resident ' s diet orders were changed on 6/20/19 to a Regular diet, Level 4 (pureed texture for solid foods) with Level 2 mildly thick consistency for liquids.</p> <p>Upon request, the DON provided a copy of the resident ' s Kardex Report (not dated) on 6/20/19 at 1:50 PM. Resident #249 ' s admission date was noted as 6/17/19. Interventions for eating were listed under the category of "Eating/Nutrition." The interventions read, in part: "Eating: The resident is maximum assist."</p> <p>An observation was made on 6/20/19 at 6:05 PM as Resident #249 was lying in her bed with her head of the bed raised. Nursing Assistant (NA) #3 was observed to be feeding the resident. The ' Swallowing Precaution ' sign previously placed on the wall at the head of her bed was no longer in place. A review of the resident's diet slip placed on her meal tray indicated the resident received a pureed diet with mildly thickened</p>	F 677			

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F 677	<p>Continued From page 22</p> <p>liquids (as ordered). Upon inquiry, the NA reported this was not her usual hall. When asked how she knew which residents required meal assistance and/or supervision, NA #3 stated she could check the resident ' s Kardex or ask another NA who may be more familiar with the residents on the hall.</p> <p>An interview was conducted on 6/21/19 at 8:40 AM with the SLP who typically worked at the facility (SLP #2). During the interview, the SLP reported she had worked with Resident #249 at breakfast time that morning. She reported being familiar with this resident from her previous admission. However, the SLP stated this was the first time she had seen the resident since her readmission (as she had not been working until this date). The SLP stated the resident was on nectar-thick liquids (also termed mildly thickened liquids) prior to going to the hospital for neck surgery. The hospital discharged the resident on thin liquids, which was changed by the PRN SLP yesterday back to nectar-thick liquids. The SLP noted the resident seemed to be more confused now compared to when she went out to the hospital. When asked, the SLP discussed the recommendations for this resident and reported she should only eat 1/2 teaspoon of pureed foods at a time and very small sips of liquids, alternating solids and liquids. The SLP reported the sign observed to have been placed above the resident's bed were the hospital recommendations. However upon further inquiry, the SLP acknowledged the recommendations at the facility were the same as the hospital ' s, with exception of the thin liquids having been changed to nectar-thick liquids on 6/20/19. The continuous observation made at lunchtime on 6/18/19 while the resident fed herself in her room without</p>	F 677			

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F 677	Continued From page 23 supervision was shared with the SLP. In response, the SLP stated that based on today's evaluation (6/21/19), the resident required more supervision. When specifically asked if the resident needed to be supervised if she fed herself in her room, the SLP stated, "She will--will need full supervision."  An interview was conducted on 6/21/19 at 11:55 AM with the facility ' s Director of Nursing (DON). During the interview, the DON was asked how staff determined the need for a resident ' s supervision at mealtime. The DON stated this would be based on the SLP recommendations.  A follow-up interview was conducted on 6/21/19 at 2:00 PM with the DON. During the interview, the DON was asked what assistance or supervision she would have expected nursing staff to have provided at mealtime for Resident #249 upon re-admission to the facility. The DON stated, "We would follow the dietary orders upon admission and refer to speech." When asked about the resident ' s need for supervision at mealtime, the DON stated they did not have orders for supervision when the resident was first re-admitted to the facility. The DON was then asked if staff should have observed the instructions posted on the resident ' s wall for swallowing precautions (including full supervision). The DON responded by stating she did not know where those instructions came from and reported they should not have been posted.	F 677			
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii)  §483.25(b)(2) Foot care. To ensure that residents receive proper treatment	F 687		7/19/19	

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F 687	<p>Continued From page 24</p> <p>and care to maintain mobility and good foot health, the facility must:</p> <p>(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and</p> <p>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interviews and medical record review, the facility failed to obtain podiatry services as ordered by the nurse practitioner (NP) for 1 of 4 residents (Resident #66) reviewed for podiatry services.</p> <p>Findings included:</p> <p>Resident #66 was admitted to the facility on 5/13/19 with diagnoses that included, in part, diabetes mellitus and ingrowing nails. Resident #66 discharged to the hospital on 6/6/19 and was re-admitted to the facility on 6/14/19.</p> <p>A review of the comprehensive Minimum Data Set (MDS) assessment dated 5/20/19 revealed Resident #66 was cognitively intact. She required extensive assistance with her personal hygiene.</p> <p>A review of a NP note dated 5/21/19 revealed, "...She would also like podiatry consult because her toenails are thick and unable to be cut here. She feels like she is getting an ingrown toenail as well ..." Further review of the NP note revealed her assessment of Resident #66's feet as, "long, thick toenails bilaterally. Plan: Podiatry referral for thick toenails, ingrown toenail."</p>	F 687	<p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Facility failed to obtain podiatry services as ordered by the Nurse Practitioner for resident #66. Podiatry appointment made on 6/20/2019 for 07/12/2019.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>Current patients in-house were reviewed for orders for podiatry. The audit checked to ensure that an appointment has been scheduled or the patient has been seen since the order was placed by the physician. This audit was completed on 7/15/19.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>All Podiatry appointment orders will be processed by staff scheduler instead of the previous transition to a staff member, who was on leave at the time of the survey.</p>		

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F 687	<p>Continued From page 25</p> <p>A review of NP order dated 5/21/19 revealed, "Podiatry consult."</p> <p>On 6/20/19 at 10:05 AM an observation of Resident #66's feet revealed long, thick and discolored toenails on both feet. An interview with Resident #66 revealed she told different staff members that she needed her toenails cut but was told by different staff the facility only referred residents to the podiatrist if there was a problem. Resident #66 stated she couldn't remember whom she told about her feet or how long ago she told staff she needed her toenails cut.</p> <p>On 6/20/19 at 9:40 AM an interview was completed with the Discharge Planning Assistant. She stated she maintained the podiatry list in her office and typically if a resident needed to be seen by the podiatrist she would be notified by the nurse and the resident's name was then added to the list. The Discharge Planning Assistant said she had not been notified by any nurse that Resident #66 needed to be seen by the podiatrist. She further stated the podiatrist who provided services in the facility came on 5/14/19 and 6/17/19.</p> <p>On 6/20/19 at 2:00 PM an interview was completed with the Nursing Secretary. She said that typically the process for scheduling appointments was once the NP wrote the order, either the NP notified the nurse of the order for the consult or the order was printed off and placed in the appointment book. The Nursing Secretary then pulled the order from the book and scheduled the appointment. The Nursing Secretary stated she was unsure if she scheduled appointments when the order was initially</p>	F 687	<p>All Licensed Nurses, will be educated on the process for when receiving a podiatry order to enter the order into the computer and then place a copy of the order in the appointment book where the scheduler will check the book and make the appointment. Any Licensed nurse who is not educated by 07/19/2019, will not be allowed to work until education received. All new hired licensed nurses will be educated on the process for when receiving a podiatry order to enter the order into the computer and then place a copy of the order in the appointment book where the scheduler will check the book and make the appointment in general orientation.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing or designee will audit all podiatry consult orders for scheduled appointment weekly X 4 weeks, Biweekly X 2, monthly X 1. These audits will be completed and provided to the Quarterly Quality Assurance and Improvement meeting X 1 to review for further problem resolution.</p> <p>The Title of the person responsible for implementing the acceptable plan of correction: Director of nursing</p>		

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F 687	Continued From page 26 received for Resident #66 or if the payroll clerk was responsible for appointments.  On 6/21/19 at 3:31 PM an interview was completed with Nurse #8. She said she was the nurse on duty when the podiatry consult was ordered. She said when a provider wrote an order for a consult she entered the order into the computer and then placed a copy of the order in the appointment book. She said once the order was placed in the appointment book the scheduler checked the book and made the appointment. Nurse #8 said she remembered that she entered the order for the podiatry consult into the computer, printed the order off and placed it in the appointment book.  On 6/21/19 at 10:03 AM an interview was completed with the Interim Administrator. She stated during the time the podiatry consult was ordered, the facility had transitioned to a different staff member who scheduled appointments and said that staff member was currently on leave. The Interim Administrator said Resident #66 needed to be seen by a podiatrist outside of the facility and she thought the staff member had worked on scheduling a podiatry appointment but said there was no "paper trail" that it had been completed. She further stated her expectation was that once an order was written for an outside referral that the facility immediately began scheduling the appointment.	F 687			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)  § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		7/19/19	

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F 695	<p>Continued From page 27</p> <p>needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident interview, staff interviews, and physician interview the facility failed to (1a) follow physicians' orders for oxygen therapy and (1b) assess a trach dependent resident for complications. This was evident for 1 of 1 resident reviewed for tracheostomy care (Resident #16).</p> <p>Findings included:</p> <p>Resident #16 was initially admitted on 11-1-13 and readmitted to the facility on 6-18-19 with multiple diagnoses that included sepsis, acute respiratory failure and diabetes.</p> <p>The quarterly Minimum Data Set (MDS) dated 4-4-19 revealed Resident #16 was moderately cognitively impaired and needed total assistance with 2 people for bed mobility and total assistance with one person for dressing, eating, toileting and personal hygiene. Resident #16 was coded for oxygen use, suctioning and tracheostomy.</p> <p>Resident #16's care plan dated 4-17-19 revealed a goal that the resident would have clear and equal breath sounds bilaterally. The interventions for that goal were as follows; ensure the trach ties are always secure, observe for and document restlessness, agitation, confusion and increased heart rate, observe for and document level of consciousness, mental status and lethargy as</p>	F 695	<p>F695</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The facility failed (1a) to follow physician orders for oxygen therapy for resident #16. 06/20/19 after 430pm Oxygen Compressor was changed out to a new one, and oxygen was set at 3L per trach collar by Central Supply; (1b) assess a trach dependent resident for complications. Director of Nursing provided verbal discussion on assessing for complication's to Nurse #5 06/20/2019. How the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>All other residents with tracheostomy oxygen orders were audited on 6/21/2019 to ensure following physicians orders for oxygen therapy by Regional Nurse Consultant.</p> <p>All other residents with tracheostomies were assessed for any signs or symptoms of complications on 6/21/2019 by Regional Nurse Consultant. No complications found.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not</p>		

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F 695	<p>Continued From page 28</p> <p>needed, oxygen setting through the trach at 3 liters per minute, provide oxygen as ordered, suction as necessary and tracheostomy care as ordered.</p> <p>A review of staff training revealed the nurses had received tracheostomy care and suctioning training within the last year.</p> <p>A review of the physician's orders dated 6-18-19 revealed orders for oxygen to be administered at 3 liters per minute</p> <p>1a. During an observation and interview with Resident #16 on 6-18-19 at 4:03pm, the resident was noted to be returning from the hospital. Resident #16 was noted to be a little confused as she stated she had not been at the hospital. The resident's oxygen mask was noted to be placed over her trach opening and the oxygen setting was at 4.5 liters per minute.</p> <p>Resident #16's oxygen was observed again on 6-19-19 at 8:30am and was noted to remain on 4.5 liters per minute.</p> <p>The oxygen rate was observed on 6-20-19 at 4:00pm and revealed Resident #16's oxygen was set at 4.5 liters per minute.</p> <p>Resident #16's oxygen rate was observed on 6-21-19 at 10:15am to be set at 4.5 liters per minute.</p> <p>Nurse #1 was interviewed on 6-21-19 at 10:20am. The nurse stated Resident #16's oxygen rate should be 3 liters per minute.</p> <p>The physician was interviewed on 6-21-19 at</p>	F 695	<p>recur:</p> <p>All licensed nurses will be in-serviced on "Care of the Patient with a Tracheostomy": which includes administering oxygen as prescribed by the physician and assessing trach dependent resident for complications by Staff Development Coordinator beginning 07/12/2019 and completion by 07/19/2019. Any nurse who is not educated by 07/19/2019, will not be allowed to work until education received. All new hired licensed nurses will be educated on "Care of the Patient with a Tracheostomy" by Staff Development Coordinator, which includes administering oxygen therapy as prescribed by the physician and assessing trach dependent resident for complications in general orientation.</p> <p>Indicate how facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing, Unit Manager, Staff Development Coordinator, Central Supply and or assigned designee will conduct audits on all residents with tracheostomy and oxygen orders to ensure following physician orders for oxygen therapy and observation of Licensed Nurse assessing a trach dependent resident for complications daily Monday through Friday for 4 weeks, Biweekly X 2, and Monthly X 1.</p> <p>Results of all audits will be reviewed at Quarterly Quality Assurance and Improvement meeting X 1 to review for further problem resolution.</p> <p>F695: The Title of the person responsible</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2041 WILLOW ROAD</b> <b>GREENSBORO, NC 27406</b>		
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F 695	<p>Continued From page 29</p> <p>4:08pm. The physician stated that he expected the nursing staff to follow the orders provided by him and/or the Nurse Practitioner and that if something changed that he be informed.</p> <p>During an interview with the DON and the Administrator on 6-21-19 at 6:15pm, The DON stated she would expect the nursing staff to follow physicians' orders.</p> <p>A review of the physician's orders dated 6-18-19 revealed orders for suctioning every shift and as needed and to provide trach care every shift and as needed.</p> <p>1b. During an observation of Resident #16 on 6-20-19 at 3:50pm, the resident was noted to be diaphoretic (sweating to an unusual degree), eyes were wide open, and the resident was unable to speak when asked if she was ok. The oxygen mask was laying on the side of the resident's head on her pillow and the opening to the trach was blocked with gauze. The resident was noted to be making gurgling sounds.</p> <p>The 3:00pm to 11:00pm nurse (nurse #5) for Resident #16 was interviewed on 6-20-19 at 4:45pm. Nurse #5 stated he had not been informed by nurse #6 of Resident #16 needing to be suctioned around 3:55pm. He also stated he had done resident rounds upon coming on shift and had entered Resident #16's room "around 3:50pm". The nurse denied seeing the oxygen mask off the resident and the opening of her trach blocked with gauze or hearing the resident gurgling "I usually just look around the room and make sure the residents' chest is rising and falling and that is about it." Nurse #5 also stated he did not assess his residents with tracheostomy's any</p>	F 695	<p>for implementing the acceptable plan of correction:</p> <p>Director of nursing Completion date 07/19/2019</p>		

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F 695	Continued From page 30 more thoroughly than any other resident.  During an interview with the physician on 6-21-19 at 4:08pm, the physician stated he expected staff to assess a tracheostomy resident thoroughly to make sure they were receiving oxygen and for any symptoms that the resident may need to be suctioned.  The Administrator and the Director of Nursing (DON) were interviewed on 6-21-19 at 6:15pm. The DON stated she was not made aware of the situation but would have expected the nurse to assess the resident and provide the care as needed.	F 695			
F 698 SS=D	Dialysis CFR(s): 483.25(l)  §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff and dialysis staff interviews, the facility failed to ensure on-time transportation to dialysis center, resulting in shortened and missed treatments for 1 of 1 residents reviewed for dialysis (Resident #9).  Findings included:  Record review revealed Resident #9 was admitted to the facility on 1/12/16 with diagnoses which included End Stage Renal Disease with	F 698	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to ensure on-time transportation to dialysis center, resulting in shortened and missed treatments for resident #9. 06/21/2019 transportation changed from pubic Scat transportation to CJ Transportation to ensure on-time transportation. How corrective action will be	7/19/19	

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F 698	<p>Continued From page 31</p> <p>Hemodialysis three times a week.</p> <p>Review of the most recent quarterly Minimum Data Set (MDS) dated 4/2/19 revealed Resident #9 had moderate cognition impairment and required one to two-person extensive assistance with activities of daily living. The MDS indicated the resident required hemodialysis for End Stage Renal Disease.</p> <p>Review of Monthly "Tracking My Numbers" documents from Resident #9's dialysis center to the facility from January 2019 through May 2019 revealed that the resident had missed one dialysis treatment and had thirteen shortened treatments.</p> <p>During an interview with Resident #9's dialysis center's Social Worker on 6/21/19 at 2:42 PM the social worker stated the missed appointment on 2/2/19 dialysis documentation revealed that it was due to transportation issues. Dialysis treatments had to be shortened due to Resident #9 being late to his appointments on 3/16/19, 3/21/19, 3/23/19, 3/28/19, 4/13/19, 4/20/19, 4/27/19, 5/1/19, 5/2/19, 5/18/19, 5/28/19, 6/4/19, and 6/11/19.</p> <p>Review of nursing notes and facility records revealed no documentation about missed appointments or Resident #9 being late to appointments.</p> <p>During an interview with the facility Nursing Secretary on 6/21/19 at 3:03 PM she stated that she was not aware of Resident #9 missing or being late for appointments, but that he used public transportation for disabled residents to get to his weekly dialysis appointments on Tuesday,</p>	F 698	<p>accomplished for those residents with the potential to be affected by the same practice:</p> <p>Medical Records requested from Dialysis center to receive weekly treatment logs of all residents who receive dialysis from 07/09/2019 forward to ensure on-time transportation, no missed appointments or shortened appointments. If appointments were missed or shortened this information was shared with the Director of Nursing and determination made as to the cause. If the appointment was missed then re-education will be provided to the scheduler, if the appointment was cut short because of late arrival, then the Nurse and CNA will be re-educated on keeping appointment times. If the issue continues to be a staff related issue then formal counseling will begin after the re-education is completed. If the late arrival or shortened dialysis run, the nurse will notify the physician and document in the medical record as to the cause. The care plan will be updated to reflect patient's non-compliance with schedule and family notified of the non-compliance. This will be implemented and in place by July 19, 2019.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>Medical Records will ensure receive weekly treatment logs of all residents who receive dialysis and give to Director of Nursing to review for missed or shortened appointments and analyze reason for/and problem solve occurrence if noted to</p>		

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F 698	<p>Continued From page 32 Thursday, and Saturday.</p> <p>During an interview with the Unit Coordinator on 6/21/19 at 3:10 PM she stated that nursing staff sends medication sheets with the residents to their dialysis appointments but will only get communication back from the dialysis center when there is an issue, abnormal labs, or new orders placed for Resident #9. She stated that no one from dialysis or from the facility staff had communicated to her that the resident was late to or missing appointments.</p> <p>During an interview with the Director of Nursing on 6/21/19 at 4:35 PM she stated that she was not aware of any missed appointments and that the dialysis center had not informed the facility of the resident having shortened treatments due to being late. When asked who reviews the monthly "Tracking My Numbers" sheets sent from dialysis, she stated that they were reviewed by the Registered Dietician (RD), but that she did not expect that particular document to be the only way that dialysis would communicate these types of issues. She stated that she expected the dialysis center to communicate with facility nursing staff or to her directly if Resident #9 wasn't having transportation issues.</p> <p>During an interview with the Medical Director on 6/21/19 at 4:52 PM he stated that it was his expectation that residents have dependable transportation to and from their dialysis appointments, so that they did not miss treatments or have them shortened. He stated he was not notified by the facility staff or by the nephrology team from the dialysis center about the resident missing appointments or having shortened treatments due to being late.</p>	F 698	<p>prevent further missed or shortened appointments if able. If the appointment was missed then re-education will be provided to the scheduler, if the appointment was cut short because of late arrival, then the Nurse and CNA will be re-educated on keeping appointment times. If the issue continues to be a staff related issue then formal counseling will begin after the re-education is completed. If the late arrival or shortened dialysis run, the nurse will notify the physician and document in the medical record as to the cause. The care plan will be updated to reflect patient's non-compliance with schedule and family notified of the non-compliance. This will be implemented and in place by July 19, 2019. New hire nurses and CNA's will be educated on this process during general nursing orientation and will not be placed on the floor until the education is completed.</p> <p>Indicate how facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing or designee will review all treatment logs of all residents who receive dialysis to review for missed or shortened appointments and analyze reason/problem solve for occurrence if noted weekly. Results of all review of treatment logs for all residents who receive dialysis will be reviewed at weekly Quality Assurance Risk meeting. Results of all reviews will be reviewed at Quarterly Quality Assurance and Improvement meeting X 1 for further problem resolution.</p>		

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F 698	Continued From page 33	F 698			
F 756 SS=D	<p>Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)</p> <p>§483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>§483.45(c)(2) This review must include a review of the resident's medical chart.</p> <p>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.</p> <p>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.</p> <p>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</p> <p>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p>	F 756	<p>The Title of the person responsible for implementing the acceptable plan of correction: Director of nursing Completion date 07/19/2019</p>	7/19/19	

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F 756	<p>Continued From page 34</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews, and staff, consultant pharmacist, and Nurse Practitioner interviews, the pharmacist failed to identify and address an excessive dose of a medication administered to 1 of 6 sampled residents (Resident #42) reviewed for unnecessary drugs.</p> <p>The findings included:</p> <p>Resident #42 was admitted to the facility on 6/20/18 from a hospital. Her cumulative diagnoses included Type 2 diabetes, hypothyroidism, anemia, and history of a fall.</p> <p>A review of Resident #42 's current physician medication orders included the following order dated 9/19/18: "Vitamin D3 tablet (cholecalciferol) Give 1 tablet by mouth one time a day related to anemia, unspecified (D64.9) Vitamin D3 50,000 units one tablet monthly." D64.9 is a medical code for the diagnosis of unspecified anemia.</p> <p>According to Lexi-Comp, a comprehensive medication database used by medical professionals, the strategies for treatment of Vitamin D insufficiency/deficiency may vary depending on the desired target serum Vitamin D levels as well as the clinical status of the patient. Therapeutic dosing of Vitamin D3 may be as high</p>	F 756	<p>How the corrective action will be accomplished for the resident(s) affected. Pharmacist failed to identify and address an excessive dose of a medication administered to resident #42. Resident #42 Medication order changed on 6/21/2019 and scheduled for every 30 days to start 7/21/2019. Responsible party and MD/NP notified on 6/21/2019.</p> <p>How corrective action will be accomplished for those residents with the potential to be affected by the same practice. 06/28/2019 all current residents receiving Vitamin D3 orders were reviewed to ensure that doses were scheduled as ordered. No other issues found.</p> <p>Measures in place to ensure practices will not re-occur. The Pharmacy Consultant to be educated by the Director of Nursing on during Pharmacy Consultant Reviews how to pull up the Medication Administration Record to be able to view the entire order and that the facilities expectation is that the Pharmacist will utilize this method during monthly chart reviews. The education to be completed July 18, 2019. Reviews by the</p>		

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F 756	<p>Continued From page 35</p> <p>as 50,000 units given once weekly for 6 to 8 weeks, followed by decreased maintenance dosing as needed to maintain target serum Vitamin D levels.</p> <p>A review of Resident #42 ' s Medication Administration Records (MARs) from September 2018 through January 2019 revealed the resident received 50,000 units of Vitamin D3 once daily each day (beginning on 9/20/18).</p> <p>Review of the resident ' s lab results dated 1/4/19 included Vitamin D, 1, 25 (OH)2 (Total) with a value of 26 picograms (pg) per milliliter (ml). The normal laboratory range was reported to be 18-72 pg/ml.</p> <p>Resident #42 ' s medical record included a progress note authored by the Nurse Practitioner (NP) on 2/11/19. The note indicated 50,000 units of Vitamin D3 "q (every) month" was initiated for the resident ' s bone health.</p> <p>A review of the resident ' s February, March, April and May 2019 MARs was conducted. Documentation on the MARs revealed Resident #42 continued to receive 50,000 units of Vitamin D3 once daily each day.</p> <p>A review of Resident #42 ' s annual Minimum Data Set (MDS) assessment dated 5/9/19 was completed. The resident was assessed to have intact cognitive skills for daily decision making. She was independent with bed mobility and eating and required supervision for transfers, dressing and toileting. Other Activities of Daily Living were only performed once or twice during the 7-day look back period.</p>	F 756	<p>Pharmacist will be scanned into the appropriate medical record by Medical Records once completed and reviewed by the Unit Managers or Director of Nursing which will be an on-going process. If during the review of Medication Reviews it is found that the Pharmacist overlooks a medication error, the Director of Nursing will address with the Consultant and this communication will be documented and notification of the Pharmacy Manager of continued missed errors, this process will be on-going.</p> <p>How the facility plans to monitor and ensure correction is achieved and sustained. Director of Nursing or designee will audit all Vitamin D3 orders to ensure dose is not excessive weekly X 4 weeks, Biweekly X 2, and monthly X 1. Results of all audits will be completed and provided to the Quarterly Quality Assurance and Improvement meeting X 1.</p> <p>The Title of the person responsible for implementing the acceptable plan of correction: Director of Nursing</p>		

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F 756	<p>Continued From page 36</p> <p>A review of the resident ' s June 2019 MAR revealed Resident #42 continued to receive 50,000 units of Vitamin D3 once daily each day up until the date of the review (on 6/21/19).</p> <p>Further review of Resident #42 ' s electronic medical record included the pharmacist ' s notes and consultation reports from September 2018 to the date of the review. No documentation was found to indicate the consultant pharmacist identified the excessive dose of Vitamin D administered on a daily basis since 9/20/18. There was no documentation to show the excessive dose was addressed with Resident #42 ' s provider.</p> <p>An interview was conducted on 6/21/19 at 11:05 AM with the facility ' s Nurse Practitioner (NP) providing care for Resident #42. During the interview, concern regarding the high dose and frequency of Vitamin D3 for Resident #42 was discussed. The NP stated the order was intended to be 50,000 units of Vitamin D3 to be given once a month (not once a day). Upon further inquiry, the NP stated a dosage of 50,000 units of Vitamin D3 was always ordered once a month and she believed the order must have been put into the electronic system incorrectly. The NP reiterated she did not intend for the resident to get a daily dose of Vitamin D and reported the resident was due for lab work next week with a follow-up Vitamin D3 level. When asked if she would consider this medication dosing error to be significant, the NP stated, "Yes." The NP reported she would clarify the order on this date (6/21/19).</p> <p>A telephone interview was conducted on 6/21/19 at 3:45 PM with the facility ' s consultant</p>	F 756			

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F 756	Continued From page 37 pharmacist. Upon inquiry, the pharmacist reported he did have access to his consultant records at the time of the interview. During the interview, concern regarding the high dose and frequency of Vitamin D3 administration (since September 2018) for Resident #42 was discussed. The pharmacist stated he has never encountered such a high dosage/frequency of Vitamin D3. He acknowledged Vitamin D was a fat-soluble vitamin that could potentially accumulate in the body and reported that 50,000 units of Vitamin D3 given once a day was an excessive dosage. Upon inquiry, the pharmacist stated he would have wanted to identify the excessive dosing during his monthly Medication Regimen Review (MRR), but did not recall doing do. If he had identified this concern, the pharmacist reported he would have recommended the dose (or frequency) of the Vitamin D3 be decreased.	F 756			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-  §483.45(d)(1) In excessive dose (including duplicate drug therapy); or  §483.45(d)(2) For excessive duration; or  §483.45(d)(3) Without adequate monitoring; or  §483.45(d)(4) Without adequate indications for its use; or	F 757		7/19/19	

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F 757	<p>Continued From page 38</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, consultant pharmacist, Nurse Practitioner, and staff interviews, the facility failed to ensure a resident's drug regimen was free from an excessive dose of a medication for 1 of 6 residents (Resident #42) reviewed for unnecessary medications.</p> <p>The findings included:</p> <p>Resident #42 was admitted to the facility on 6/20/18 from a hospital. Her cumulative diagnoses included Type 2 diabetes, hypothyroidism, anemia, and history of a fall.</p> <p>A review of Resident #42 ' s current physician medication orders included the following order dated 9/19/18: "Vitamin D3 tablet (cholecalciferol) Give 1 tablet by mouth one time a day related to anemia, unspecified (D64.9) Vitamin D3 50,000 units one tablet monthly." D64.9 is a medical code for the diagnosis of unspecified anemia.</p> <p>According to Lexi-Comp, a comprehensive medication database used by medical professionals, the strategies for the treatment of Vitamin D insufficiency/deficiency may vary depending on the desired target serum Vitamin D levels as well as the clinical status of the patient.</p>	F 757	<p>How the corrective action will be accomplished for the resident(s) affected: Resident #42 medication order changed on 6/21/2019 and scheduled for every 30 days to start 7/21/2019. Responsible party and MD/NP notified on 6/21/2019.</p> <p>How corrective action will be accomplished for those residents with the potential to be affected by the same practice: 06/28/2019 all current residents receiving Vitamin D3 orders were reviewed to ensure that doses were scheduled as ordered. No other issues found.</p> <p>Measures in place to ensure practices will not re-occur: All licensed nurses will be educated on order transcription by Staff Development Coordinator. Any Licensed nurse unable to be educated by 07/19/2019 will not be allowed to work until education received. All new hire Licensed Nurses will be educated on order transcription during general orientation. During audits if a transcription error is found the nurse will be re-educated by the Staff Development Coordinator or Director of Nursing or Unit Manager on transcribing orders. If the</p>		

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F 757	<p>Continued From page 39</p> <p>Therapeutic dosing of Vitamin D3 may be as high as 50,000 units given once weekly for 6 to 8 weeks, followed by decreased maintenance dosing as needed to maintain target serum Vitamin D levels.</p> <p>A review of Resident #42 ' s Medication Administration Records (MARs) from September 2018 through January 2019 revealed the resident received 50,000 units of Vitamin D3 once daily each day (beginning on 9/20/18).</p> <p>Review of the resident ' s lab results dated 1/4/19 included Vitamin D, 1, 25 (OH)2 (Total) with a value of 26 picograms (pg) per milliliter (ml). The normal range was reported to be 18-72 pg/ml.</p> <p>Resident #42 ' s medical record included a progress note authored by the Nurse Practitioner (NP) on 2/11/19. The note indicated 50,000 units of Vitamin D3 "q (every) month" was initiated for the resident ' s bone health.</p> <p>A review of the resident ' s February, March, April and May 2019 MARs was conducted. Documentation on the MARs revealed Resident #42 continued to receive 50,000 units of Vitamin D3 once daily each day.</p> <p>A review of Resident #42 ' s annual Minimum Data Set (MDS) assessment dated 5/9/19 was completed. The resident was assessed to have intact cognitive skills for daily decision making. She was independent with bed mobility and eating and required supervision for transfers, dressing and toileting. Other Activities of Daily Living were only performed once or twice during the 7-day look back period.</p>	F 757	<p>nurse continues to have transcription errors then written counselling will be provided if re-education is not successful in correcting the behavior.</p> <p>The Pharmacy Consultant to be educated by the Director of Nursing on during Pharmacy Consultant Reviews how to pull up the Medication Administration Record to be able to view the entire order and that the facilities expectation is that the Pharmacist will utilize this method during monthly chart reviews. The education to be completed July 18, 2019.</p> <p>How the facility plans to monitor and ensure correction is achieved and sustained: Director of Nursing or designee will audit all Vitamin D3 orders to ensure dose is not excessive weekly X 4 weeks, Biweekly X 2, and monthly X 1. Results of all audits will be completed and provided to the Quarterly Quality Assurance and Improvement meeting X 1.</p> <p>Title of person responsible for implementing the acceptable plan of correction: Director of Nursing</p>		

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F 757	<p>Continued From page 40</p> <p>A review of the resident ' s June 2019 MAR revealed Resident #42 continued to receive 50,000 units of Vitamin D3 once daily each day up until the date of the review (on 6/21/19).</p> <p>An interview was conducted on 6/21/19 at 10:30 AM with Nurse #1. Nurse #1 was the hall nurse currently assigned to Resident #42's hall medication cart. At that time, the med cards dispensed from the pharmacy for this resident were reviewed. The pharmacy-dispensed medications for Resident #42 did not include Vitamin D3. Upon further inquiry, Nurse #1 reported there was a stock bottle containing 50,000 units of Vitamin D3 on the cart. The nurse reported she administered a capsule of 50,000 units Vitamin D3 to Resident #42 from this stock bottle during the morning ' s medication pass. The labeling on this stock bottle was reviewed with Nurse #1 and confirmed to contain 50,000 units of Vitamin D3.</p> <p>An interview was conducted on 6/21/19 at 11:05 AM with the facility ' s Nurse Practitioner (NP) providing care for Resident #42. During the interview, concern regarding the high dose and frequency of Vitamin D3 for Resident #42 was discussed. The NP stated the order was intended to be 50,000 units of Vitamin D3 to be given once a month (not once a day). Upon further inquiry, the NP stated a dosage of 50,000 units of Vitamin D3 was always ordered once a month and she believed the order must have been put into the electronic system incorrectly. The NP reiterated she did not intend for the resident to get a daily dose of Vitamin D and reported the resident was due for lab work next week with a follow-up Vitamin D3 level. When asked if she would consider this medication</p>	F 757			

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F 757	Continued From page 41 dosing error to be significant, the NP stated, "Yes." The NP reported she would clarify the order on this date (6/21/19).  An interview was conducted on 6/21/19 at 11:55 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated that if a medication was intended to be given once monthly that she would expect it to be given once a month. When asked about the order entry and checking of medication order, the DON reported the hall nurses typically put the orders into the computer system and the third shift nurse checked the new orders entered. Additionally, the nurses would review the medication orders monthly. Also, the DON noted the doctors reviewed the medication orders monthly when they signed the orders.  A telephone interview was conducted on 6/21/19 at 3:45 PM with the facility ' s consultant pharmacist. During the interview, concern regarding the high dose and frequency of Vitamin D3 administration (since September 2018) for Resident #42 was discussed. The pharmacist stated he has never encountered such a high dosage and acknowledged this was a fat-soluble vitamin that could accumulate in the body. The consultant pharmacist reported that 50,000 units of Vitamin D3 given once a day was an excessive dosage.	F 757			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		7/19/19	

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F 761	<p>Continued From page 42</p> <p>appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, resident interview, and staff interviews, the facility failed to safely and securely store medications observed to be kept at bedside for 2 of 25 sampled residents (Resident #39 and Resident #61) reviewed.</p> <p>The findings included:</p> <p>Resident #39 was admitted to the facility on 3/15/19. Her cumulative diagnoses included unspecified psychosis and age-related nuclear cataract (unspecified eye).</p> <p>On 6/18/19 at 3:15 PM, Resident #39 was observed to be asleep in her bed. At the time of this observation, a 28-compartment (7-day) pill</p>	F 761	<p>How Corrective Action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The facility failed to safely and securely store medications observed to be kept at bedside for resident #39 and #61. 06/19/2019 medications removed from bedside for resident # 39 and # 61 placed in cart for safe keeping.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice: All patient rooms were checked for medications (prescription or over-the-counter), to ensure that no other medications were</p>		

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F 761	<p>Continued From page 43</p> <p>box was visible on the resident ' s nightstand. Multiple tablets and capsules were observed to be stored in the pill box.</p> <p>An interview was conducted on 6/19/19 at 4:10 PM with Resident #39. During the interview, the pill box was not within view. When asked where the pill box was, the resident reported "a nurse" came in that morning (6/19/19) and told her she could not have it in her room. The resident stated she had the pill box containing supplements and vitamins in her room ever since she was admitted to the facility, and she did not understand, "why it was a problem all of a sudden."</p> <p>A review of the resident ' s electronic medical record included a Nursing Note dated 6/19/19 at 2:32 PM. The notation included the brand names and number of pills/capsules found in the resident ' s bottles of the vitamins and supplements. After being counted, the medications were reported to have been labeled and placed in the med cart.</p> <p>An interview was conducted on 6/20/19 at 8:57 AM with the facility ' s Director of Nursing (DON) in the presence of the facility ' s corporate consultant. During the interview, the DON was asked about the pill box containing tablets and capsules observed in Resident #39 ' s room. The DON stated on 6/19/19, the nurses reported Resident #39 had a pill cup and pill box containing vitamins and minerals in her room. She was not aware the resident had tablets or capsules in her room until 6/19/19. The DON stated she talked with the resident and told her that she could not self-medicate without a physician ' s order for the vitamins. The DON reported she removed the pill box and bottles of the vitamins/minerals from the resident ' s room.</p>	F 761	<p>found at bedside. When a medication during the initial audit was identified it was removed from the patients <input type="checkbox"/> room until determination by the Interdepartmental Team and could evaluate the abilities of the resident to safely administer medication. A patient with a BIMS score of 12 or less will not, be considered for self-administration due to patients <input type="checkbox"/> inconsistent cognitive function. Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Nurses, CNA <input type="checkbox"/> s and Department Heads were educated on Nursing Policy 1805, Self-Administration of Medication at bedside and making sure that attention is payed to in resident rooms when providing care and making rounds, by Regional Nurse Consultant and Staff Development Coordinator, and were educated to notify the Director of Nursing or Administrator of any medications seen at bedside. This education to be completed by July 19, 2019. All new hired employees will be educated on Nursing Policy 1805, Self-Administration of Medication at bedside and making sure that attention is payed to in resident rooms when providing care and making rounds to ensure no medications are at the patient <input type="checkbox"/> s bedside, during general orientation. Administrator or Director of nursing will review daily rounds during the morning meeting so that appropriate steps can be taken to properly determine the patient <input type="checkbox"/> s ability to safely administer medications and properly secure the medications in a lock box if determination is made by the IDT</p>		

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F 761	<p>Continued From page 44</p> <p>Upon request, the contents of Resident #39 ' s pill box were reviewed. The compartments labeled for morning administration contained 4-5 capsules with two tablets each (for 6 of the 7 days in the pill box); the compartments labeled for evening administration included 5 capsules and two tablets each (for 6 of the 7 days in the pill box).</p> <p>Accompanied by the DON, an observation and review was conducted on 6/20/19 at 9:15 AM of the hall medication cart. The pill bottles removed from Resident #39 ' s room (on 6/19/19) were currently stored on the locked med cart and included the following:</p> <ul style="list-style-type: none"> <li>--One bottle of Cognium tablets (originally containing 60 tablets) with approximately 30 tablets remaining in the bottle;</li> <li>--One bottle of Alpha CRS+ capsules (originally containing 120 capsules) with 5 capsules remaining in the bottle;</li> <li>--One bottle of 5000 micrograms (mcg) biotin capsules (originally containing 120 capsules with approximately 30 capsules remaining in the bottle);</li> <li>--One unopened bottle of TerraZyme capsules containing 90 capsules and one opened bottle with 5 capsules remaining in the bottle;</li> <li>--One unopened bottle of PB Assist+ Probiotic defense formula double layer capsule containing 30 capsules.</li> </ul> <p>Two additional bottles previously stored in the resident ' s room were provided by the DON for review on 6/20/19 at 9:25 AM. These included:</p> <ul style="list-style-type: none"> <li>--One bottle of an omega fatty acid dietary supplement which also contained Vitamin D and Vitamin E (originally containing 120 soft gel capsules) with 11 soft gel capsules left in the bottle; and,</li> </ul>	F 761	<p>during the morning meeting that the patient can safely administer the medications. A letter was drafted to families and patients outlining the necessity for patients and families to notify the facility of medications that are brought into the facility and mailed to the Responsible Party and given to patients residing in facility. Patients and families during the admission process will be given a letter explaining the self-administration process to begin July 19th, 2019. How facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>Department Heads will do visualization of each patient's room in their assigned rooms daily Monday through Friday for a period of 3 months, observing for medications (prescription or over-the-counter) at bedside and report findings in morning Stand up meeting. Administrator or Director of nursing will remove any medications (prescription or over the counter) so that appropriate steps can be taken to properly determine the patient's ability to safely administer medications and properly secured the medications in a lock box if determination is made by the IDT that the patient can safely administer the medications.</p> <p>These audits will be completed and provided to the Quarterly Quality Assurance and Improvement meeting X 1 to review for further problem resolution. The title of the person responsible for implementing the acceptable plan of correction Director of Nursing</p>		

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F 761	<p>Continued From page 45</p> <p>--One bottle of a dietary supplement tablet containing minerals such as calcium, magnesium, and zinc (originally containing 120 tablets).</p> <p>An interview was conducted on 6/20/19 at 5:50 PM with a Nursing Assistant #1 (NA #1) who reported having worked with Resident #39 in the past. During the interview, the NA stated she did not recall seeing pill bottles in the resident ' s room. However, the NA reported she had seen a pill box "sectioned by time" placed on the resident's bedside table in her room. Upon further inquiry, the NA stated she estimated seeing this pill box in the resident ' s room "over a month ago."</p> <p>An interview was conducted on 6/21/19 at 8:40 AM with NA #2. Upon inquiry, NA #2 stated she recalled seeing bottles of vitamins or supplements in Resident #39 ' s room a couple of times "in the last few weeks." She did not recall seeing a compartmented pill box in the resident ' s room.</p> <p>An interview was conducted on 6/20/19 at 9:52 AM with the DON. During the interview, the DON was asked what her expectation would have been in regards to the storage of Resident #39 ' s medications observed at her bedside. In response, the DON stated, "We wouldn't keep them in the room....had we known about it, we would have done what we did yesterday."</p> <p>2. Resident #61 was admitted to the facility on 5/17/19. A review of Resident #61 ' s quarterly Minimum Data Set assessment dated 5/27/19 revealed she had severely impaired cognition and required extensive assistance of 1-2 people for</p>	F 761	Completion date: 07/19/2019		

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F 761	Continued From page 46 her activities of daily living.  An observation on 6/18/19 at 10:30 AM revealed a 1 ounce medicine cup approximately three quarters full of a cream that appeared to be Nystatin cream on Resident #61 ' s bedside.  A record review revealed an order dated 12/5/18 for Nystatin cream 100,000 units/gram applied to back topically three times a day for rash.  An interview was conducted with Nurse #7 on 6/18/19 at 10:40 AM. Nurse #7 was taken to Resident #61 ' s bedside and asked if he knew what the substance in the medicine cup was. Nurse #7 stated he didn ' t know, it was already there when he got there this morning. Nurse #7 was asked to review Resident #61 ' s medications with the surveyor. Nurse #7 stated Resident #7 was receiving Nystatin cream to her back for a rash. Nurse #7 stated they are not supposed to leave medications at the bedside.  An interview was attempted with the off-going night nurse on 6/19/19 but was unsuccessful.  An interview conducted with the Director of Nursing on 6/20/19 at 9:52 AM revealed medications should not be in resident ' s rooms.	F 761			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		7/19/19	

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F 880	Continued From page 47 diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880			

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NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2041 WILLOW ROAD</b> <b>GREENSBORO, NC 27406</b>		
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F 880	<p>Continued From page 48</p> <p>must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to 1) maintain a sterile field and perform proper hand hygiene when providing tracheostomy care for 1 of 1 resident (Resident #16) reviewed for tracheostomy care 2) perform hand hygiene after handling soiled linens and after resident contact for 1 of 15 residents (Resident #31) and 3) initiate contact precautions for 1 (Resident #200) of 2 residents reviewed for infection control with loose stools suspected of C. Diff. (clostridium difficile).</p> <p>Findings included:</p> <p>1.The facility's Infection Prevention and Control Program was reviewed and revealed policies and procedures that included the assessment of staff compliance with infection control and identifying</p>	F 880	<p>F880</p> <p>How Corrective Action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to 1) maintain a sterile field and perform proper hand hygiene when providing tracheostomy care for Resident #16; Nurse # 6 received one on one education on "Tracheostomy Care" 07/09/2019 2) perform hand hygiene after handling soiled linens and after resident contact for resident #31; Staff Member received one on one education "Handwashing Requirements" 07/10/2019 3) initiate contact precautions for resident #200 reviewed for infection control with loose stools suspected of C. Diff.</p>		

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F 880	<p>Continued From page 49</p> <p>any significant problems and the prevention of infection to include educating staff and ensuring that they adhere to proper techniques and procedures. The Infection Prevention and Control Program also revealed monitoring employee safety by requiring the staff who have direct contact with blood or bodily fluids to use appropriate precautions and personal protective equipment.</p> <p>A review of staff training revealed nursing staff had infection control training within the last year.</p> <p>Nurse #6 was noted to be walking down the hall on 6-20-19 at 3:52pm and stated he was not the nurse for Resident #16 but that he would assist the resident if she needed assistance. Nurse #6 was noted to put on a pair of gloves he obtained from his pocket and assessed the resident. The nurse stated he felt the resident needed to be suctioned and began obtaining supplies from Resident #16's night stand while wearing the same gloves he initially put on. He removed the dirty dressing around the tracheostomy and then was observed opening the sterile package for the suction tubing and taking the suction tube out of the sterile container, laying it on the bed, applying one end to the suction machine and began suctioning Resident #16 without changing his gloves or maintaining sterilization of the suction tubing. The nurse was noted to apply a new dressing around the tracheostomy without changing his gloves. Nurse #6 stated he was unaware that the tubing needed to remain sterile or that he should have cleaned his hands and applied the sterile gloves supplied in the packaging.</p> <p>During an interview with the Administrator and</p>	F 880	<p>Resident # 200 discharged 03/09/2019. How the facility will identify other residents having the potential to be affected by the same deficient practice: All current residents reviewed 07/10/2019 for loose stools and suspicion of C Diff and contact precautions if needed. None noted that weren't already on precautions. Staff Member received one on one education "Handwashing Requirements" 07/10/2019 by Staff Development Coordinator</p> <p>All other residents with Tracheostomies were assessed for any signs and symptoms of complications on 6/21/2019 by Regional Nurse Consultant. No complications found.</p> <p>Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All current Licensed Nurses will receive education by Staff Development Coordinator for 1) "Tracheostomy Care including sterile field", 2) "Handwashing Requirements" Policy # 401 Infection Control 3) "initiating contact precautions for any resident with loose stools suspected of C Difficile before culture done" Policy # 502 Enteric Pathogens starting 07/12/2019 and completion 07/19/2019. Any Nurse unable to be educated by 07/19/2019 will not be allowed to work until education received. New hire Licensed Nurses will received education by Staff Development Coordinator for 1) "Tracheostomy Care", 2) "Handwashing Requirements" Policy # 401 Infection Control 3) "initiating contact precautions for any resident with loose</p>		

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F 880	<p>Continued From page 50</p> <p>Director of Nursing (DON) on 6-21-19 at 6:15pm, the DON stated all the employees have been trained on infection control and that she expected the staff to perform hand hygiene when providing care to residents. She also stated Nurse #6 had received training on Tracheostomy care and should have known he needed to perform hand hygiene and maintain a sterile field.</p> <p>3. Review of the facility infection control policy and procedure dated 12/26/17, provided by the DON, revealed "the center followed established standards of practice and provided parameters for appropriate clinical management and education of patients known or suspected to have C. difficile associated diarrhea. The procedure for transmission prevention stated to: "A: use contact precautions special enteric sign with persons known or suspected to have C. difficile associated diarrhea and B: place in a room with another patient with C. difficile associated diarrhea if a private room was not available.</p> <p>Resident #200 was admitted to the facility on 12/15/18 and diagnoses included congestive heart failure, chronic kidney disease, glaucoma and chronic pain.</p> <p>Review of the facility infection control policy and procedure dated 12/26/17, provided by the DON, revealed "the center followed established standards of practice and provided parameters for appropriate clinical management and education of patients known or suspected to have</p>	F 880	<p>stools suspected of C Difficile before culture done" Policy # 502 in general orientation.</p> <p>All Certified Nursing Assistants will receive education by Staff Development Coordinator for "Handwashing Requirements" Policy #401. Any Certified Nursing Assistants unable to be educated by 07/19/2019 will not be allowed to work until education received.</p> <p>New hire Certified Nursing Assistants will receive education by Staff Development Coordinator for "Handwashing Requirements" Policy #401 in general orientation.</p> <p>How facility plans to monitor its performance to make sure that solutions are sustained: Staff Development Coordinator or Director of Nursing will complete 1) 3 observations of Tracheostomy Care to include sterile field per week, 3 different nurses each week until all nurses have been observed and then continue 3 observations weekly X 3months. 2) 3 observations of handwashing per week, different staff members, X 3 months. 3) Audit all patients with loose stools and suspicion of C-Difficile for contact precautions X 3 months.</p> <p>These audits will be completed and provided to the Quarterly Quality Assurance and Improvement meeting X 1 to review for further problem resolution. The title of the person responsible for implementing the acceptable plan of correction Director of Nursing Completion date: 07/19/2019</p>		

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F 880	<p>Continued From page 51</p> <p>C. difficile associated diarrhea. The procedure for transmission prevention stated to: "A: use contact precautions special enteric sign with persons known or suspected to have C. difficile associated diarrhea and B: place in a room with another patient with C. difficile associated diarrhea if a private room was not available.</p> <p>A significant change minimum data set (MDS) dated 1/12/19 for Resident #200 revealed he was incontinent of bowel, was totally dependent for toilet use, received an antibiotic during the 7-day look back period and had moderately impaired cognition.</p> <p>Review of the bowel elimination record for Resident #200, provided by the Director of Nursing (DON), identified the resident had loose / diarrhea stools twice on 3/2/19, 3/3/19, 3/4/19, 3/7/19 and 3/8/19. The resident had loose / diarrhea stools three times on 3/6/19 and 3/9/19.</p> <p>Review of a progress note dated 3/3/19 for Resident #200 revealed staff had reported the resident had loose stools and the Nurse Practitioner (NP) was notified.</p> <p>Review of a medical visit note dated 3/4/19 for Resident #200 revealed he was seen for loose stools. Per staff the resident had loose stools for about 2 days. He did not have any vomiting and his abdomen was soft with positive bowel sounds. Plan to collect stool for C. Diff, give Imodium 2 tabs x 1 dose and 1 tab after each loose stool, notify NP with any other changes or if loose stools don ' t get better and reassessment by NP after results are reported.</p> <p>Review of a progress note dated 3/5/19 for</p>	F 880			

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F 880	<p>Continued From page 52</p> <p>Resident #200 revealed a stool specimen was collected for C. Diff (clostridium difficile).</p> <p>Review of the lab report for Resident #200 revealed a stool specimen was obtained on 3/5/19 at 5:00 pm.</p> <p>Review of a change of condition SBAR (situation, background, assessment and recommendation) dated 3/9/19 for Resident #200 revealed a change of condition started on 3/8/19 that included low blood pressure, diarrhea and decline in food and fluid intake. Recommendation from the Nurse Practitioner to send the resident to the hospital.</p> <p>An interview on 6/20/19 at 10:37 am with Nursing Assistant (NA) #4 revealed she had provided care for Resident #200 while he was at the facility. She stated the resident did have some diarrhea. She added the resident had been on isolation precautions while he was a resident, but she didn't think it was during the time he had diarrhea. NA #4 stated usually residents that had C. diff were placed on contact isolation.</p> <p>A phone interview on 6/21/19 at 10:27 am with Nurse #2 revealed she had provided care for Resident #200 while he was at the facility. She stated she had assisted a NA change the resident and observed he was having loose stools with an "odor". Nurse #2 explained she notified the NP and received an order to check his stool for C. Diff. She stated she would not have initiated contact precautions until the stool culture confirmed that the resident had C. diff.</p> <p>An interview of 6/21/19 at 11:17 am with Nurse #3 revealed she was the Infection Control Nurse.</p>	F 880			

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F 880	<p>Continued From page 53</p> <p>She stated she recalled Resident #200 had loose stools and was checked for C. Diff. Nurse #3 explained typically if the staff nurses suspected a resident needed isolation precautions they would notify her, and she would initiate the process. She stated in this case she had been off for a few days, but a staff nurse could initiate isolation precautions on their own if needed. Nurse #3 added since the resident continued to have diarrhea contact precautions should have been initiated.</p> <p>An interview on 6/21/19 at 11:26 am with the DON revealed when a resident was having loose stools suspected of C. Diff the residents nurse would notify the physician and they would follow any orders given. She explained the facility policy was to initiate contact precautions for residents suspected or known to have C. Diff. The DON stated in the case of Resident #200 the facility should have initiated contact precautions even though the results of the stool culture weren ' t back yet because of the continued presence of loose stools and prior antibiotic use.</p> <p>An interview on 6/21/19 at 12:37 pm with NP #2 revealed she had cared for Resident #200 during his stay. She stated it was her expectation that residents with suspected C. Diff were placed on contact precautions even if the stool culture wasn ' t back to confirm a C. Diff diagnosis. She stated especially if the resident continued to be symptomatic with loose stools.</p>	F 880			