STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite complaint survey was conducted on 11/9/2023. Event ID HI3H11. The following intake was investigated, NC00209586. 1 of 1 allegation did not result in deficiency.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance	F 842		11/24/23

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

Electronically Signed | 11/27/2023

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F 842	Continued From page 1 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and interviews with the Nurse Practitioner, the facility failed to maintain complete and accurate medical	F 842	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility	

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F 842	Continued From page 2 records when Nurse #1 failed to document a change in a resident's status for 1 of 1 resident (Resident #1) reviewed for respiratory care. The findings included: Resident #1 was admitted to the facility on 3/7/2023 with diagnoses that included Chronic obstructive pulmonary disease (COPD), right sided heart failure, chronic hypoxic respiratory failure, with a history of cerebral vascular accident (stroke) and pulmonary emboli (clot in lungs) on long term anticoagulant therapy. A record review of Resident #1's nurse progress notes conducted on 11/9/2023 for the date of 10/23/23 for the period of 7:00 AM to 7:00 PM revealed no entries regarding the resident's condition. On 11/9/2023 at 10:45AM an interview was conducted with Nurse #1 who was assigned to Resident #1 during the 7:00AM-7:00PM shift on 10/23/2023. Nurse #1 stated she had worked with Resident #1 for a long time, and she was very familiar with her. She stated she assessed Resident #1 several times during the day shift on 10/23/2023. The resident reported she "was fine". Nurse #1 stated she noticed the resident was not keeping her nasal cannula in place. That was not uncommon for the resident, but it was occurring more frequently on that day. Nurse #1 stated she checked Resident #1 during the morning of 10/23/2023 and found her oxygen saturation to be 80-90% on supplemental oxygen at 5LPM. Resident #1 reported she did not feel short of breath and reported "feeling fine". Nurse #1 stated she called the NP on two occasions that day and received verbal orders for labs,	F 842	has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F842 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #1 (LP) experienced an acute episode, No documentation regarding the episode was documented at the time of the episode. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Licensed Nurse who was in charge of care of resident at time of acute episode was educated on importance of documentation at time of acute episode. Education was given to nurse on 11/09 by Director of Nursing. Current residents are at risk Measures to be put in place or systemic changes made to ensure practice will not re-occur: All licensed nurses will be educated on documentation of acute episode at the time of the episode by DON or designee by 11/14/23 DON or designee will audit all hospital transfers for complete documentation on the morning after the transfer 5x weekly x 4 weeks, then three times weekly x 4	

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F 842	Continued From page 3 antibiotics, and steroids. Nurse #1 stated she entered the verbal orders. She further stated the NP recommended the resident go out to the Emergency Department, but the resident refused on both occasions. This was not uncommon for Resident#1. She had refused transport to the Emergency Department in the past. Nurse #1 stated she did not document the resident's change in condition or her assessments in the resident's medical record. Nurse #1 stated she did not document her calls to the NP or the resident's refusals to transport to the Emergency Department. Nurse #1 stated she was busy on that day and meant to go back and document the change in condition, but never did. An interview was completed with the NP on 11/9/2023 at 11:00AM. She stated she was not at the facility on 10/23/23. She explained she was called by Nurse #1 on two occasions 10/23/2023 regarding Resident #1. She did suggest the resident be transported to the Emergency Department on both occasions, but Nurse #1 informed her the resident refused transfer. The NP stated she gave Nurse #1 verbal orders for nebulizers, antibiotics, steroids, labs, and a chest x-ray. She was concerned the resident had pneumonia. A record review of Resident #1's nursing progress notes for 10/23/2023 during the 7:00 PM - 7:00 AM shift revealed Resident #1 was assessed by Nurse #2 shortly after shift change and again around 9:30PM. Nurse #2 found Resident #1 to have thick mucus coming from her nose, with dry cyanotic (blue in color) lips. The resident's oxygen saturation was found to be 79% on supplemental oxygen at 5 liters per minute (LPM). Other vital	F 842	weeks, then weekly x 4 weeks. Any Licensed Nurse who is not educated will not be allowed to work until education received. Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation process 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 X 2 for further resolution if needed. Completion 11/24/2023	

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F 842	Continued From page 4	F 842		

signs documented at that time included blood pressure of 139/83, heart rate 111 beats per minute (BPM), and respiratory rate of 16 breaths per minute. The resident's temperature was documented as 98.7degrees Fahrenheit.

A phone interview was conducted with Nurse #2 on 11/9/2023 at 10:20AM. Nurse #2 stated she was an agency nurse and not very familiar with Resident #1. She stated she got shift report at 7:00PM from Nurse #1. Nurse #1 reported Resident #1 had experienced hypoxia throughout day shift with oxygenation between 85-90% on 5LPM of supplemental oxygen. Nurse #1 stated she made the Nurse Practitioner (NP) aware. The NP recommended sending Resident #1 out to the Emergency Department (ED) but the resident refused. Nurse #1 reported the NP ordered labs, antibiotics, steroids, and a chest x-ray on Resident #1 and she had entered and completed those orders. Nurse #2 stated after shift report ended, she assessed the resident and stated the resident did not look good. The resident was found with thick mucus coming out of her nose and her oxygen saturation only 90% on 5LPM. The resident could answer yes and no questions but was drowsy. Nurse #2 stated when she reviewed the day shift documentation, she found there was no documentation of the resident's oxygen saturation, calls to the NP, or the resident's refusal to be transported to the Emergency Department. Nurse #2 stated when she reassessed the resident an hour later, her oxygen saturation had declined to 79% on 5LPM of supplemental oxygen. Nurse #2 called the NP, and the NP told her to transfer the resident out to the Emergency Department. Nurse #2 stated she called Emergency Medical Services (EMS) and Residents Responsible Party (RP). She then

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F 842	Continued From page 5 printed discharge paperwork and discharged the resident to the hospital. On 11/9/2023 at 11:57AM an interview was conducted with the Director of Nursing. She stated it was her expectation that nurses document a resident's change in condition in the resident's medical record. Nurse #1 should have documented the resident's change in condition, her calls to the NP, and the resident's refusal to be transported to the Emergency Department in the medical record.	F 842		