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Medication Administration Records (MARs) forresidents were audited to ensure allAugust, September, and October 2015 revealedconsultation reports have been followed		Medication Administ	ration Records (MARs) for			"Report of Consultation". All current residents were audited to ensure all		

Electronically Signed

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.

11/09/2015

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	OMB NO. 0938-03		
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345460	B. WING		C 10/22/2015	
NAME OF P	ROVIDER OR SUPPLIER			10/22/2010		
GUILFOR	D HEALTH CARE CENTE	R				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETIO	
F 281	Continued From page	e 1	F 281			
	the resident continue given once daily.	d to receive 5 mg lisinopril		up on. Completion date: Novembe 2015	r 19,	
	Emergency Departme pain on 10/18/15 and that same day. A rev current medication lis 10 mg lisinopril taken resident 's Physician MAR revealed Reside	ent out to the hospital ent for evaluation of chest returned to the facility later iew of the resident ' s it from the hospital included once daily. Review of the Orders and October 2015 ent #210 continued to I upon return from the		Measures to be put in place or syste changes made to ensure practice w re-occur: All new Licensed Nurses receive education in orientation on F number 2302 "Report of Consultation DON and/or designee for each unit conduct audit of consultations for 2 residents weekly for 4 weeks; 1 resi weekly for 4 weeks and monthly X 1 Completion date: November 19, 201	ill not will Policy on". will dent	
	An interview was conducted on 10/22/2015 at 10:00 AM with the resident 's Medical Doctor (MD) at the facility. During the interview, the MD reviewed Resident #210 's medical record, including the cardiology consultation and hospital discharge medication list, along with the resident ' s blood pressure readings. Upon review, the MD stated, "It (the recommendation for an increase in lisinopril) was missed apparently." The MD noted the dose of lisinopril would be need to be increased, "right now." When asked about the process employed for communicating results/recommendations of outside referrals and consultations, the MD stated the consult reports were typically placed in the MD communication binder. The MD or his Nurse Practitioner (NP) would review the consultation, initial the consult report, and then pass it along to the nursing staff for new orders. The MD stated "no one signed that," indicating neither he nor the NP had reviewed the recommendations. The MD reported the nursing staff must have missed putting the consult into the MD book. The MD		How facility will monitor corrective action(s) to ensure deficient practice not re-occur: Results of the weekly a will be reviewed at Weekly Risk Qua Assurance Meeting and Quarterly Q Assurance meeting X 1 for further resolution if needed. Completion dat November 19, 2015	audits ality Quality		

Facility ID: 943221

If continuation sheet Page 2 of 8

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0930-03 STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIER/CLIA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SUPVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345460 B. WING C GUILFORD HEALTH CARE CENTER STREET ADDRESS, CITY, STATE ZIP CODE 2041 WILLOW ROAD GREENSBORO, NC 27406 (Y4) JD TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OERICENCY MUST EE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVA ACTION SHOULD BE CROSS-REFERENCE DT OT HE APPROPRIATE COMPLETED DEFICIENCY (EACH CORRECTIVA STATE REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETX TAG PRETX CORDINATES PLAN OF CORRECTION (EACH CORRECTIVA ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETED DEFICIENCY F 281 Continued From page 2 cardiologist. At the conclusion of the interview, the MD was observed as he put an order into the computer to increase the resident 's dose of lisinopril to 10 mg once daily. F 281 An interview was conducted on 10/22/2015 at clicussed. The Unit Manager reported when a resident returned to the facility from a consultation, the paper work would be given to the hall nurse for review. If a recommendation was made, the consult report would ug into the physician communication book for either the NP or MD to review when he/she came in . Upon review, the NP or MD would normality initial off on it. The Unit Manager was also asked to describe the process of checking orders when a resident returned from an ED visit or short staty at the hospital. The Unit Manager reported if a reside								FORM	D: 11/13/2015 A APPROVED
345460 B. WING 10/22/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2041 WILLOW ROAD GUILFORD HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE DVALOW ROAD COMMENT STATEMENT OF DEFICIENCIES PREFIX CEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE cardiologist. At the conclusion of the interview, the MD was observed as he put an order into the computer to increase the resident's dose of lisinopril to 10 mg once daily. F 281 An interview was conducted on 10/22/2015 at 2:51 PM with the facility 's Unit Manager. During the interview, the process of following up on recommendations made by outside providers was discussed. The Unit Manager reported when a resident returned to the facility from a consultation, the paper work would be given to the hall nurse for review. If a recommendation was made, the consult report would go into the physician communication book for either the NP or MD to review when he/she came in. Upon review, the NP or MD would normaliy initial off on it. The Unit Manager was also asked to describe the process of checking orders when a resident returned from an ED visit or short stay at the SUBMARY STATE PROFINE 10/22/2015 at	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SL COMPLE	
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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH OERFICENCY AND FORMATION) (%5) (EACH OERFICENCY AND FORMATION) F 281 Continued From page 2 cardiologist. At the conclusion of the interview, the MD was observed as he put an order into the computer to increase the resident 's dose of lisinopril to 10 mg once daily. F 281 F 281 An interview was conducted on 10/22/2015 at 2:51 PM with the facility 's Unit Manager. During the interview, the process of following up on recommendations made by outside providers was discussed. The Unit Manager reported when a resident returned to the facility from a consultation, the paper work would be given to the hall nurse for review. If a recommendation was made, the consult report would go into the physician communication book for either the NP or MD to review when he/she came in. Upon review, the NP or MD would normally initial off on it. The Unit Manager was also asked to describe the process of checking orders when a resident returned from an ED visit or short stay at the					2	2041 WILLOW ROAD			
PREFX TAG (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENTION DATE F 281 Continued From page 2 cardiologist. At the conclusion of the interview, the MD was observed as he put an order into the computer to increase the resident 's dose of lisinopril to 10 mg once daily. F 281 F 281 An interview was conducted on 10/22/2015 at 2:51 PM with the facility 's Unit Manager. During the interview, the process of following up on recommendations made by outside providers was discussed. The Unit Manager reported when a resident returned to the facility from a consultation, the paper work would be given to the hall nurse for review. If a recommendation was made, the consult report would go into the physician communication book for either the NP or MD to review when he/she came in. Upon review, the NP or MD would normally initial off on it. The Unit Manager was also asked to describe the process of checking orders when a resident returned from an ED visit or short stay at the	GUILFOR	D HEALTH CARE CENTE	:R		Ģ	GREENSBORO, NC 27406			
cardiologist. At the conclusion of the interview, the MD was observed as he put an order into the computer to increase the resident ' s dose of lisinopril to 10 mg once daily. An interview was conducted on 10/22/2015 at 2:51 PM with the facility ' s Unit Manager. During the interview, the process of following up on recommendations made by outside providers was discussed. The Unit Manager reported when a resident returned to the facility from a consultation, the paper work would be given to the hall nurse for review. If a recommendation was made, the consult report would go into the physician communication book for either the NP or MD to review when he/she came in. Upon review, the NP or MD would normally initial off on it. The Unit Manager was also asked to describe the process of checking orders when a resident returned from an ED visit or short stay at the	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	FION SHOULD B		COMPLETION
returned from the hospital, the hall nurse would be expected to review any paperwork sent back from the hospital and to verify any new orders. An interview was conducted on 10/22/2015 at 3:18 PM with the facility 's Director of Nursing (DON). The DON reported paperwork from consultations typically would not be filed or scanned into the computer without being initialed by the NP or MD. She noted if the consult recommendation had been declined, it should have been initialed with "decline" written in; and, if the recommendation was accepted, it should have been initialed either by the provider (NP or MD) or both the provider and the nurse (if nurse put the order into the computer system). The DON indicated that no initials written on the	F 281	cardiologist. At the co the MD was observed computer to increase lisinopril to 10 mg ond An interview was com 2:51 PM with the facil the interview, the proor recommendations ma discussed. The Unit II resident returned to th consultation, the pape the hall nurse for revie was made, the consu physician communicat or MD to review when review, the NP or MD it. The Unit Manager the process of checkin returned from an ED hospital. The Unit Ma returned from the hosp be expected to review from the hospital and An interview was com 3:18 PM with the facil (DON). The DON rep consultations typically scanned into the com by the NP or MD. Sh recommendation had have been initialed wit the recommendation the mD) or both the provi-	onclusion of the interview, d as he put an order into the the resident 's dose of ce daily. ducted on 10/22/2015 at lity 's Unit Manager. During cess of following up on ade by outside providers was Manager reported when a he facility from a er work would be given to ew. If a recommendation at report would go into the ation book for either the NP in he/she came in. Upon 0 would normally initial off on twas also asked to describe ing orders when a resident visit or short stay at the anager reported if a resident spital, the hall nurse would w any paperwork sent back to verify any new orders. ducted on 10/22/2015 at lity 's Director of Nursing ported paperwork from y would not be filed or to puter without being initialed the noted if the consult been declined, it should ith "decline" written in; and, if was accepted, it should ither by the provider (NP or ider and the nurse (if nurse computer system). The	F	281				

Facility ID: 943221

If continuation sheet Page 3 of 8

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	D: 11/13/2015 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345460	B. WING		_		C 22/2015
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GUILFORI	D HEALTH CARE CENTE	R		041 WILLOW ROAD	406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281 F 356 SS=C	the 8/26/15 cardiology Resident #210 did nor reviewed by either the confirmed the MD wro initiate a trial of 10 mg for this resident. 483.30(e) POSTED N INFORMATION The facility must post a daily basis: o Facility name. o The current date. o The current date. o The total number ar by the following categ unlicensed nursing sta resident care per shift - Registered nurse - Licensed practic vocational nurses (as - Certified nurse a o Resident census. The facility must post specified above on a of each shift. Data m o Clear and readable o In a prominent place residents and visitors. The facility must, upo make nurse staffing d for review at a cost no standard. The facility must main	e recommendation made on y consultation report for t appear to have been e NP or MD. The DON ote an order on 10/22/15 to g lisinopril given once daily URSE STAFFING the following information on ad the actual hours worked ories of licensed and aff directly responsible for : es. al nurses or licensed defined under State law). ides. the nurse staffing data daily basis at the beginning ust be posted as follows: format. e readily accessible to in oral or written request, ata available to the public ot to exceed the community tain the posted daily nurse	F 281				11/19/15
		imum of 18 months, or as					

If continuation sheet Page 4 of 8

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 11/13/2018 RM APPROVEE IO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION		TE SURVEY IPLETED
		345460	B. WING		1	C 0/22/2015
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
GUILFOR	D HEALTH CARE CENTE	R		2041 WILLOW ROAD GREENSBORO, NC 27406		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 356	Continued From page 4 required by State law, whichever is greater.		F 35	56		
	by: Based on observation facility failed to indicat the daily nursing served dates for 7 months, we through October 22, 2 The findings included During the initial tour 9:00am, the Health a daily nurse staffing su observed located in a main lobby. The Resi be 92. Surveyor reviewed do nursing staff posting fi included April 2015 th This review revealed were not indicated ea posting as follows: - April 2015 h 30 days. - June 2015 h 31 days. - July 2015 h 31 days. - August 2015 days - September 2 30 days and - October 201 days.			The statements included are n admission and do not constitute agreement with the alleged def herein. The plan of correction completed in the compliance of federal regulations as outlined. in compliance with all federal a regulations the center has take take the actions set forth in the plan of correction. The followin correction constitutes the center allegation of compliance. All all deficiencies cited have been or completed by the dates indicate How corrective action will be accomplished for each residen have been affected by the defic practice: No residents affected deficient practice. How corrective action will be accomplished for those residen the potential to be affected by th deficient practice: All daily staf from April 2015 to October 201 updated to reflect daily census designees are to be educated I nurse consultant on posted nur and census. Completion date: 19, 2015 Measures to be put in place or changes made to ensure practi	e iiciencies is f state and To remain nd state of or will following ng plan of er's lleged will be ed. t found to cient d by ts having he same ff postings 5 will be . DON and by regional rse staffing November systemic	

Facility ID: 943221

		MEDICAID SERVICES	(X2) MULTIPI	OMB NO. 0938-0 (X3) DATE SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED C 10/22/2015	
		345460	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			10/22	2010	
GUILFOR	D HEALTH CARE CENTE	ER				
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 356	56 Continued From page 5 stated that she usually never writes the census on the posting, she looked at the direct care schedule and assigned staff based on the number of residents.		F 35	 re-occur: Administrator and/or DON conduct audit of daily nurse staffing summary for completeness weekly tweeks; every other week for 4 week monthly X 1. Completion date: Nov 19, 2015 How facility will monitor corrective action(s) to ensure deficient practice not re-occur: Results of the audits w reviewed at Weekly Risk Quality Assurance Meeting and Quarterly C Assurance meeting X 1 for further resolution if needed. Completion data November 19, 2015 	affing ekly for 4 weeks and November tive actice will dits will be ty erly Quality her	
F 441 SS=D	SPREAD, LINENS The facility must esta Infection Control Prog safe, sanitary and co to help prevent the do of disease and infecti (a) Infection Control I The facility must esta Program under which (1) Investigates, cont in the facility; (2) Decides what pro should be applied to (3) Maintains a record actions related to infe (b) Preventing Sprea (1) When the Infection determines that a res	Program ablish an Infection Control n it - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ections. d of Infection	F 44			/19/15

Facility ID: 943221

If continuation sheet Page 6 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVE COMPLETED	
		345460	B. WING			C 22/2015	
NAME OF F	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GUILFOR	R			2041 WILLOW ROAD GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441	 isolate the resident. (2) The facility must p communicable diseas from direct contact wid direct contact will tran (3) The facility must r hands after each dire hand washing is indic professional practice. (c) Linens Personnel must hand transport linens so as infection. This REQUIREMENT by: Based on observatio facility failed to follow by not wearing gloves glucose monitoring fo (Resident #148) obse glucose checked by r The findings included A review of the facility Policies and Procedu entitled, Handwashing 2/1/2015). This polici gloves in Section D a "1. Wear gloves r other potentially infect membranes, and non 	 arohibit employees with a se or infected skin lesions th residents or their food, if asmit the disease. equire staff to wash their ct resident contact for which eated by accepted le, store, process and to prevent the spread of ' is not met as evidenced ns and staff interviews the infection control procedures so while performing blood or one of three residents erved to have his/her blood hursing staff. : ' 's Infection Control res included a policy g Requirements (dated y addressed the use of nd read, in part: when contact with blood or tious materials, mucous -intact skin could occur." 	F	441	The statements included are not an admission and do not constitute agreement with the alleged deficiencie herein. The plan of correction is completed in the compliance of state a federal regulations as outlined. To rem 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 each resident found thave been affected by the deficient practice: Nurse #4 received immediate education on 10/19/15 for deficient	nd nain ng of	

Facility ID: 943221

If continuation sheet Page 7 of 8

PRINTED: 11/13/2015

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	· · /	TE SURVEY MPLETED		
		345460	B. WING		C 10/22/2015	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
GUILFOR	D HEALTH CARE CENTE	R		2041 WILLOW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	Continued From page	e 7	F 441			
	check for Resident # on gloves at any poin procedure.	148. The nurse did not put It in time during the		practice and disciplinary action o 10/30/15.	n	
	AM with Nurse #4. D was made as to why performing a blood gl resident. Nurse #4 re completed a 3-week During the training, si nurses (with the exce when performing blood When asked what the use of gloves while p monitoring checks, N not sure. An interview was com PM with Nurse #5. N responsibility as the f Coordinator and Infect the interview, Nurse # nursing staff to use g task that potentially d fluids, including blood An interview was com PM with the facility 's During the interview, the observation made monitoring without the isolated incident. The	eported she had recently training period at the facility. he stated that none of the eption of one) wore gloves od glucose monitoring. e facility 's policy was for the erforming blood glucose urse #4 indicated she was ducted on 10/21/15 at 1:01 Nurse #5 assumed facility 's Staff Development ction Control Nurse. During #5 indicated he would expect loves when performing any lealt with blood or body d glucose monitoring. ducted on 10/21/15 at 2:15 s Director of Nursing (DON). the DON indicated she felt e of blood glucose e use of gloves was an e DON stated the facility gloves every time when		How corrective action will be accomplished for those residents the potential to be affected by the deficient practice: All current nur receive education on Policy num "Handwashing Requirements". Completion date: November 19, Measures to be put in place or sy changes made to ensure practice re-occur: All new Licensed Nurs receive education in orientation of number 401 "Handwashing Requirements". DON and/or des each unit will conduct random au blood glucose monitoring for 2 re weekly for 4 weeks; 1 resident w 4 weeks and monthly X 1. Comp date: November 19, 2015 How facility will monitor correctiv action(s) to ensure deficient prac not re-occur: Results of the week will be reviewed at Weekly Risk of Assurance Meeting and Quarter Assurance meeting X 1 for further resolution if needed. Completion November 19, 2015	e same ses same ses swill ber 401 2015 ystemic e will not es will on Policy signee for rolit of sidents eekly for oletion e tice will kly audits Quality y Quality er	

If continuation sheet Page 8 of 8