STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G162	A. BUILDING _____ B. WING _____	C 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD #2	1800 STRATHMORE DRIVE GREENSBORO, NC 27410

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W 000	INITIAL COMMENTS A complaint survey was completed on April 23, 2024 for intake #NC00215160. The allegations were unsubstantiated, however, deficiencies were cited relative to the complaint.	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on observations, documentation review and interviews, the facility failed to ensure allegations relative to the unwitnessed injury of a client (#6) were reported to the administrator in a timely manner. The finding is: Review of facility documentation on 4/22/24 revealed an IRIS report dated 3/20/24 relative to bruising and scratches on client (#6). Continued review of the IRIS report revealed allegations that staff were not sure where the bruising came from and did not witness the client fall. Further review of the IRIS report revealed nursing assessed the bruising and scratches and determined that medical treatment was not necessary. Review of a handwritten nurse's note dated 3/22/24 revealed nursing was notified by staff and the home manager (HM) that client #6 had a bruise and scratch marks on his back. The nursing note also revealed nursing visited the facility and assessed the bruising and scratches on client #6's body. Additional review of facility documentation revealed an in-service dated	W 153		

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

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W 153	Continued From page 1	W 153		

3/18/24 relative to "incident reporting and follow up" to all staff in the facility.

Subsequent review of facility documentation revealed an abuse, neglect and exploitation policy (102.05) review indicated that "all staff are required to immediately report acts of abuse, neglect, or exploitation to the QIDP or Administrator. If this person is not available, the Administrator or Administrator-on-call should be contacted. Injuries of unknown origin may be the result of abuse and must be reported immediately". Continued review of facility documentation revealed a third shift staff received disciplinary action on 3/20/24 as a result of client #6's bed and chair alarms being disconnected on 3/19/24 during the third shift.

Review of a QIDP note dated 3/26/24 revealed "staff did not report anything about a bruise to the QIDP or HM". Continued review of the 3/26/24 QIDP note revealed she trained staff on incident reporting and monitoring clients during bathing. Further review of the QIDP note revealed that an audio monitor would be implemented in the client's room as a result of the unwitnessed injury on 3/19/24.

Additional review of facility documentation did not reveal written body checks for client #6 as a result of the unwitnessed incident. Continued review did not reveal written staff statements or a formal internal investigation to address concerns relative to an unwitnessed injury which resulted in bruising and scratches on client (#6)'s body. Review of nurse's notes did not reveal documentation relative to follow up, care instructions or interventions since client #6's alleged fall incident on 3/19/24.

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W 153	Continued From page 2 Interview with the facility administrator on 4/23/24 revealed an informal inquiry was completed with staff interviews and staff in-service training was completed for client #6 after the 3/19/24 incident. Interview with the administrator also revealed clinical monitoring was increased at the facility and an extra staff was placed on third shift. Interview with the administrator also revealed that a staff member expressed concerns relative to client #6's bruising and scratches and increasing concerns relative to a staff member in the facility. The administrator also revealed that the staff provided this information during the informal inquiry and did not provide specific examples that would escalate the inquiry to a formal investigation. Subsequent interview with the administrator revealed that the informal inquiry completed determined that client #6 had fallen per the client's interview, however, it could not be determined where and when the client had fallen and who assisted the client after the fall. Additional interview with the administrator revealed a formal investigation relative to unwitnessed injury resulting in bruising and scratches on client #6's body was not deemed necessary. Interview with the qualified intellectual disabilities professional (QIDP) on 4/23/24 revealed she received the allegations on 3/20/24 and initiated interviews with the staff. Continued interview with the QIDP revealed she provided in-service training to staff on completing bed and chair alarms checks after each shift and how to reporting incidents in a timely manner. Interview with the QIDP also revealed she discovered that	W 153		

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W 153	Continued From page 3 the bed and chair alarms in client #6's room were disconnected on 3/20/24. Further interview with the QIDP revealed she completed the IRIS report, and reported the alleged incident via IRIS report. The QIDP also revealed staff did not provide specific details to nursing and facility administrator relative to unwitnessed injury resulting in bruising and scratches for client #6 so that appropriate, timely steps such as a formal internal investigation could have been completed according to the facility policy.	W 153		
W 157	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on observations, interview and documentation review, the facility failed to show evidence of appropriate corrective action for an incident of unwitnessed injury for 1 of 6 clients (#6). The finding is: Review of facility documentation on 4/22/24 revealed an IRIS report dated 3/20/24 relative to bruising and scratches on client (#6). Continued review of the IRIS report revealed allegations that staff were not sure where the bruising came from and did not witness the client fall. Further review of facility documentation revealed a third shift staff received disciplinary action as a result of client #6's bed and chair alarms being disconnected on 3/19/24 during the third shift. Review of facility documentation revealed a QIDP note dated 3/26/24 which indicated staff did not report anything about a bruise to the QIDP or HM. Continued review of the 3/26/24 QIDP note	W 157		

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W 157	Continued From page 4	W 157		

revealed she trained staff on incident reporting and monitoring skin integrity during client bathing. Further review of the QIDP note revealed that an audio monitor will be implemented in the client's room as a result of the unwitnessed injury. Additional review of facility documentation did not reveal written body checks for client #6 as a result of the unwitnessed incident. Further review of facility documentation did not reveal evidence of increased clinical monitoring and bed and chair alarm checklists since the 3/19/24 alleged incident.

Interview with the facility administrator on 4/23/24 revealed an informal inquiry was completed with staff interviews and staff in-service training was completed for client #6 after the 3/19/24 incident. Interview with the administrator also revealed clinical monitoring was increased at the facility and an extra staff was placed on third shift. Interview with the administrator also revealed that a staff member expressed concerns relative to client #6's bruising and scratches and increasing concerns relative to a staff member in the facility. Additional interview with the administrator revealed that the informal inquiry completed determined that client #6 had fallen per the client's interview, however, it could not be determined where and when the client had fallen and who assisted the client after the fall.

Interview with the qualified intellectual disabilities professional (QIDP) on 4/23/24 revealed she received the allegations on 3/20/24 and initiated interviews with the staff. Continued interview with the QIDP revealed she discovered that the bed and chair alarms in client #6's room were disconnected on 3/20/24. Further interview with the QIDP revealed that increased clinical

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W 157	Continued From page 5 monitoring was completed however evidence of interaction assessments were not provided during the survey.	W 157		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record verification, the facility failed to provide nursing services in accordance with clients needs relative to bruises or injuries of unknown origin for 2 of 6 clients (#5 and #6) and medication monitoring. The findings are: During a complaint investigation completed on 4/23/24, review of the facility's incident reports from 11/23 - 4/24 revealed two incidents of bruises discovered on clients #5 and #6 of unknown origin. A. Review of the facility informal investigation completed did not reveal a nursing assessment or nursing note was completed following the discovery of bruises in the middle of client #5's back, the right side of the torso, left wrist and hand. Request of nursing notes from 1/24 - 4/24 did not reveal notes or assessments completed by the facility nurse. B. Review of the facility inquiry summary did not reveal documentation relative to follow up, care instructions or interventions following client #6's incident.	W 331		

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W 331	Continued From page 6	W 331		

Review of a handwritten nurse's note dated 3/22/24 revealed nursing was notified by staff and the home manager (HM) that client #6 had a bruise and scratch marks on his back. The handwritten note also revealed nursing visited the facility and assessed the bruising and scratches on client #6's body. Continued review did not reveal documentation relative to follow up, care instructions or interventions since client #6's alleged fall incident on 3/19/24.

Interview with the facility nurse on 4/22/24 and 4/23/24 revealed per the agency's policy, staff is required to call nursing and their supervisor of any bruises of unknown origin. Continued interview revealed nursing will complete an assessment to make a determination if additional medical services are needed. Further interview revealed nursing notes are completed and kept in the nurse's personal folder and nursing on call logs. Subsequent interview revealed copies of her notes are stored for a year and later shredded. Additional interview revealed notes provided to surveyors were handwritten on sticky notes, copy paper and a page from a ringed binder.

Further interview with the facility nurse relative to medication monitoring revealed there was an incident back in 2/24 where concerns were brought to her attention of possible missing medications and clients' receiving other clients' medications in the group home. Continued interview revealed a medication check was completed and no medications were missing. Subsequent interview revealed there were no notes or documentation available to review relative to the nurse's findings, recommendations, or follow up if needed.

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W 331	Continued From page 7 Interview with the facility administrator (FA) on 4/23/24 revealed all nursing notes and assessments should be completed in the Therap system. Continued interview with the FA revealed any significant event, communication with guardians, etc should be documented in Therap.	W 331		