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 01/09/2015

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

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 1/9/15. Event ID# K9ZI11.	F 000		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and a staff interview, the facility failed to administer medications separately via gastric tube and flush between individual medication administrations for 1 of 2 residents with a percutaneous endoscopic gastrostomy tube (PEG tube) (Resident #65). Findings included:	F 322	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	2/6/15

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

Electronically Signed | 01/30/2015

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F 322	Continued From page 1 Resident #65 was admitted on 4/25/13 with relevant diagnoses that included quadriplegia and multiple sclerosis. The most recent quarterly Minimal Data Set dated 9/17/14 described Resident #65 as being unresponsive, total dependence for all care, and requiring a permanent PEG tube. Medication administration was observed on 01/06/15 at 8:00 AM. Nurse #1 was observed to retrieve all ordered medications for Resident # 65. She crushed all of Resident #65's tablet medications together and emptied the contents into a cup. These crushed medications included one Cranberry 425 milligram (mg) tablet, one multivitamin with minerals tablet, one Garlic 500 mg tablet, and one Loratidine 10 mg tablet. She then pierced and emptied the content of a Vitamin C 500 mg capsule into the same cup with the cocktail of crushed tablet powder. She then proceeded to add and mix 7.5 milliliters (ml) of Keppra liquid (total of 750 mg) into the cup and then finally measured and added 30 ml of UTI Stat liquid into it as well. She then mixed the cocktail and drew up the entire mixture of medications into a syringe for administration via PEG tube. Nurse #1 was observed checking for placement of the PEG tube, flushing the tube site with 30 ml of water, and then administered the entire content of the medication mixture into the PEG tube via gravity force. She then flushed the PEG tube for the final time with 120 ml of water. The Nurse Consultant commented on 1/06/15 at 9:00 AM that the facility was aware that Nurse #1 administered the medications incorrectly as a	F 322	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 to have been affected by the deficient practice: Medication Error report completed, MD notified, and no adverse complications noted for resident #65 on 01/06/15. How corrective action will be accomplished for those residents with the potential to be affected by the same deficient practice: All current nurses have received education on Policy number 1401 Care of the Resident with a Feeding Tube-Medication Administration Nurse #1 is no longer employed at facility. Measures to be put in place or systemic changes made to ensure practice will not re-occur: All new Licensed Nurses will receive education in orientation on Policy number 1401 Care of the Resident with a Feeding Tube-Medication Administration . Don and/or designee for each unit will conduct Feeding Tube Medication Administration observation for 2 residents weekly for 4 weeks; 1 resident weekly for 4 weeks and monthly X 1. How the facility plans to monitor and ensure corrections are achieved and	

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F 322	Continued From page 2 "cocktail" and stated that the facility has had concerns about Nurse #1's ability to administer medications safely. She provided documentation showing that Nurse #1 had been re-trained on all types of medication administration, including PEG tube administration, on 12/31/14. She also provided documentation of an email sent out to facility staff on 02/15/13 that emphasized strict prohibition of cocktailing medications per federal regulations. The Nurse Consultant then stated that Nurse #1 had just been dismissed from work with plans to be officially terminated. Nurse #1 was not available for an interview.	F 322	sustained: Results of the weekly audits will be reviewed at Weekly Quality Assurance Meeting and Quarterly Quality Assurance meeting X 1 for further resolution if needed.	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to 1) failed to air dry serving pans, 2) failed to clean serving trays 3) failed to ensure plates and bowls were clean, 4) failed to remove and discard chipped/ broken failed plates from the serving line, 5) failed to clean dry storage containers and 6) failed to clean and repair the hot plate warmer.	F 371	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	2/6/15

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F 371	Continued From page 3 The findings included 1.During an kitchen observation on 1/5/15 at 6:50PM, the following items included 6 silver pans were stacked wet with dripping water located in the dry storage area. During an interview on 1/8/15 at 1:10PM, the dietary manager indicated that the pans should not have been stacked wet. The pans should have been stacked individually to air dry. 2. During an observation on 1/5/15 at 6:50PM, there were 3 silver serving pans with grease dripping from each of them stored on the serving cart located in the dry storage area. During an interview on 1/18/15 at 1:10PM, the dietary manager indicated that the serving pans should have been thoroughly cleaned and grease free before storage. 3. During an observation on 1/8/15 at 11:43AM, there was 38 wet/dirty plates and 10 serving bowls that had dried food and debris on the surfaces that was being used on the serving line. During an interview on 1/8/15 at 1:10PM, the dietary manager indicated that all staff was responsible for checking the dishes before serving to ensure they were cleaned and free of chips/broken pieces before placing on the serving line. 4. During an observation 1/8/15 at 11:43AM, there was 18 chipped/broken plates being used on the serving line. During an interview on 1/8/15 at 1:10PM, the	F 371	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 to have been affected by the deficient practice: On 1/5/15, the silver serving plans found stacked wet were removed immediately and taken to be cleaned and sanitized and restored with the ability to air dry at the time of observation. On 1/5/15, the soiled silver serving pans with grease were removed immediately and taken to be cleaned and sanitized and restored with ability to air dry at the time of observation. On 1/8/15, all wet and soiled plates and bowls were removed immediately and taken to be cleaned and sanitized and allowed to air dry before storage at the time of observation. On 1/8/15, all china found to be chipped and broken were immediately removed and discarded at time of observation. On 1/8/15, all dry storage bins found to be dirty were emptied of contents, detail cleaned and sanitized and allowed to air dry before being refilled with appropriate contents. On 1/8/15, the hot plate warmer found soiled was immediately cleaned and sanitized at the time of observation. The hot plate warmer was also immediately repaired and working efficiently after the time of observation.	

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F 371	Continued From page 4 dietary manager indicated that all staff was responsible for checking the dishes before serving to ensure they were cleaned and free of chips/broken pieces before placing on the serving line. 5. During an observation on 1/8/15 at 11:43AM, 3 dry storage containers for flour, sugar and corn meal was dirty on the inside and outside with dried liquids and food debris. During an interview on 1/8/15 at 1:10PM, the dietary manager indicated that staff were expected to follow the checklist to ensure that all the kitchen equipment and storage containers were clean after each shift. 6. During an observation on 1/8/14 at 11:43AM, the hot plate warmer had large volume of dried liquids/food debris. The hot plate warmer was not operational due to broken element and power cord. During an interview on 1/8/15 at 1:10PM, the dietary manager indicated the kitchen equipment should be cleaned after each shift in accordance to the checklist by the cook. She added she was aware the hot plate warmer was not working properly and should have been repaired sooner. During an interview on 1/8/15 at 1:10PM, the cook indicated that the hot plate warmer had been broken for 6 months or more and reported to the administrator and maintenance department for repair. He added that he was responsible for checking and cleaning the kitchen equipment for cleanliness and repairs. During an interview on 1/8/14 at 1:28PM, the	F 371	How corrective action will be accomplished for those residents with the potential to be affected by the same deficient practice: The department equipment cleaning schedule was updated to include more frequent cleaning of the dry storage bins and plate warmer. Completion 2/6/15 All current Dining Services employees were in-serviced regarding proper procedures for discarding broken/chipped china, air-drying, cleaning schedule and cleaning procedures, and proper storage of equipment. Position job responsibilities regarding sanitation standards were reviewed with each current Dining Services employee. Measures to be put in place or systemic changes made to ensure practice will not re-occur: A sanitation inspection will be conducted weekly x 4 weeks, twice monthly x 4 weeks, and at least monthly thereafter to ensure compliance with corrective actions and sanitation standards. All new hires will receive in-service education on proper procedures for air-drying, cleaning schedule and procedures, and proper storage of equipment. Any deficient practice identified through the sanitation inspections will result in reeducation or disciplinary action as indicated. How the facility plans to monitor and ensure corrections are achieved and	

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F 371	Continued From page 5 administrator indicated the dietary manager was responsible for ensuring the kitchen conditions were sanitary and orderly. The administrator acknowledged the plate warmer should have been fixed properly and three months was a long time to wait for repairs for a necessary item in the kitchen.	F 371	sustained: Findings will be reviewed at the Quarterly Quality Assurance meeting x1 for tracking and trending and further problem resolution if indicated.	