| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345460 | A. BUILDING _____ B. WING _____ | C 10/22/2015 |

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

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| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and physician and staff interviews, the facility failed to identify and address a discrepancy between the current dose ordered for an antihypertensive medication and a recommended dose increase for this medication based on a cardiology consultation for 1 of 5 residents (Resident #210) reviewed for unnecessary medications.<br><br>The findings included:<br><br>Resident #210 was admitted to the facility on 8/7/15. A review of the resident ' s medical record revealed his admission medication orders included 5 milligrams (mg) lisinopril (an antihypertensive medication) given as 1 tablet by mouth once daily for high blood pressure.<br><br>A review of Resident #210 ' s medical record included a Report of Consultation from a cardiologist dated 8/26/15. The consultation recommendations included the following notation which read, in part: " Increase lisinopril 10 mg daily. " The consultation report was signed and dated by the consulting provider. No other initials or facility staff notations were written on the consultation report.<br><br>A review of the resident ' s Physician Orders and Medication Administration Records (MARs) for August, September, and October 2015 revealed | F 281 | 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.<br><br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Medication Error report completed, MD notified with new orders received, and no adverse complications noted on resident # 210 10/21/15.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All current nurses will receive education on Policy number 2302 "Report of Consultation". All current residents were audited to ensure all consultation reports have been followed | 11/19/15 |

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

Electronically Signed | 11/09/2015

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| F 281 | Continued From page 1<br>the resident continued to receive 5 mg lisinopril given once daily.<br><br>Resident #210 was sent out to the hospital Emergency Department for evaluation of chest pain on 10/18/15 and returned to the facility later that same day. A review of the resident ' s current medication list from the hospital included 10 mg lisinopril taken once daily. Review of the resident ' s Physician Orders and October 2015 MAR revealed Resident #210 continued to receive 5 mg lisinopril upon return from the hospital.<br><br>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 stated Resident #210 should be on the increased dose of lisinopril recommended by the | F 281 | up on. Completion date: November 19, 2015<br><br>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 2302 “Report of Consultation”. DON and/or designee for each unit will conduct audit of consultations for 2 residents weekly for 4 weeks; 1 resident weekly for 4 weeks and monthly X 1. Completion date: November 19, 2015<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Risk Quality Assurance Meeting and Quarterly Quality Assurance meeting X 1 for further resolution if needed. Completion date November 19, 2015 | |

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| F 281 | Continued From page 2 | F 281 | | |

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 hospital. The Unit Manager reported if a resident 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 consultation report usually meant no one saw it.

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| F 281 | Continued From page 3<br>She acknowledged the recommendation made on the 8/26/15 cardiology consultation report for Resident #210 did not appear to have been reviewed by either the NP or MD. The DON confirmed the MD wrote an order on 10/22/15 to initiate a trial of 10 mg lisinopril given once daily for this resident. | F 281 | | |
| F 356 SS=C | 483.30(e) POSTED NURSE STAFFING INFORMATION<br><br>The facility must post the following information on a daily basis:<br>o Facility name.<br>o The current date.<br>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>- Registered nurses.<br>- Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>- Certified nurse aides.<br>o Resident census.<br><br>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:<br>o Clear and readable format.<br>o In a prominent place readily accessible to residents and visitors.<br><br>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as | F 356 | | 11/19/15 |

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| F 356 | Continued From page 4<br>required by State law, whichever is greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interviews, the facility failed to indicate the resident census on the daily nursing services staff posting for various dates for 7 months, which included April 2015 through October 22, 2015.<br>The findings included:<br>During the initial tour of the facility on 10/19/15 at 9:00am, the Health and Rehabilitation Center daily nurse staffing summary / posting was observed located in a frame on the desk in the main lobby. The Resident census was noted to be 92.<br>Surveyor reviewed documentation for daily nursing staff posting for seven months which included April 2015 through October 22, 2015. This review revealed the resident census data were not indicated each day on the daily staff posting as follows:<br>· April 2015 had missing census data 28 of 30 days.<br>· May 2015 had missing census data 31 of 31 days.<br>· June 2015 had missing census data 30 of 30 days.<br>· July 2015 had missing census data 31 of 31 days.<br>· August 2015 had missing data 29 of 31 days<br>· September 2015 had missing data 30 of 30 days and<br>· October 2015 had missing data 21 of 22 days.<br>An interview was conducted with the Director of Nursing (DON) on 10/22/15 at 3:50 pm, she | F 356 | 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.<br><br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice: No residents affected by deficient practice.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All daily staff postings from April 2015 to October 2015 will be updated to reflect daily census. DON and designees are to be educated by regional nurse consultant on posted nurse staffing and census. Completion date: November 19, 2015<br><br>Measures to be put in place or systemic changes made to ensure practice will not | |

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| F 356 | Continued From page 5<br>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 356 | re-occur: Administrator and/or DON will conduct audit of daily nurse staffing summary for completeness weekly for 4 weeks; every other week for 4 weeks and monthly X 1. Completion date: November 19, 2015<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the audits will be reviewed at Weekly Risk Quality Assurance Meeting and Quarterly Quality Assurance meeting X 1 for further resolution if needed. Completion date November 19, 2015 | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must | F 441 | | 11/19/15 |

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| F 441 | Continued From page 6<br>isolate the resident.<br>(2) The facility 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.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to follow infection control procedures by not wearing gloves while performing blood glucose monitoring for one of three residents (Resident #148) observed to have his/her blood glucose checked by nursing staff.<br><br>The findings included:<br><br>A review of the facility ' s Infection Control Policies and Procedures included a policy entitled, Handwashing Requirements (dated 2/1/2015). This policy addressed the use of gloves in Section D and read, in part:<br>"1. Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin could occur."<br><br>On 10/19/15 at 11:25 AM, Nurse #4 was observed as she performed a blood glucose | F 441 | 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.<br><br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Nurse #4 received immediate education on 10/19/15 for deficient | |

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| F 441 | Continued From page 7<br>check for Resident #148. The nurse did not put on gloves at any point in time during the procedure.<br><br>An interview was conducted on 10/19/15 at 11:42 AM with Nurse #4. During the interview, inquiry was made as to why gloves were not used while performing a blood glucose check on the resident. Nurse #4 reported she had recently completed a 3-week training period at the facility. During the training, she stated that none of the nurses (with the exception of one) wore gloves when performing blood glucose monitoring. When asked what the facility ' s policy was for the use of gloves while performing blood glucose monitoring checks, Nurse #4 indicated she was not sure.<br><br>An interview was conducted on 10/21/15 at 1:01 PM with Nurse #5. Nurse #5 assumed responsibility as the facility ' s Staff Development Coordinator and Infection Control Nurse. During the interview, Nurse #5 indicated he would expect nursing staff to use gloves when performing any task that potentially dealt with blood or body fluids, including blood glucose monitoring.<br><br>An interview was conducted on 10/21/15 at 2:15 PM with the facility ' s Director of Nursing (DON). During the interview, the DON indicated she felt the observation made of blood glucose monitoring without the use of gloves was an isolated incident. The DON stated the facility practice was to wear gloves every time when performing blood glucose monitoring. | F 441 | practice and disciplinary action on 10/30/15.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All current nurses will receive education on Policy number 401 “Handwashing Requirements”. Completion date: November 19, 2015<br><br>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 401 “Handwashing Requirements”. DON and/or designee for each unit will conduct random audit of blood glucose monitoring for 2 residents weekly for 4 weeks; 1 resident weekly for 4 weeks and monthly X 1. Completion date: November 19, 2015<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Risk Quality Assurance Meeting and Quarterly Quality Assurance meeting X 1 for further resolution if needed. Completion date November 19, 2015 | |