

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>345460</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: <b>6/25/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2041 WILLOW ROAD GREENSBORO, NC</b>
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<b>F 157</b>	<p>483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>(g)(14) Notification of Changes.</p> <p>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, family and resident interview the facility failed to notify an interested family member of an accident which required physician intervention for 1 of 1 residents (#1). Findings included:</p> <p>Review of the medical record revealed that Resident #1 was admitted to the facility on 1/8/14 with diagnosis including heart failure, hypertension and diabetes. Review of the medical record revealed a face sheet 6/14/14 which listed Resident #1 as a contact and her sister as the 2nd contact and Next of Kin.</p> <p>The minimum data set assessment 4/5/17 revealed the resident scored 14 on the brief interview of mental status indicating that the resident had good memory and cognition. The resident was assessed as being dependent on staff for care except for eating. The resident care plan included goals related to current level of</p>
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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

The above isolated deficiencies pose no actual harm to the residents

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<b>F 157</b>	<p>Continued From Page 1</p> <p>functioning, falls, nutrition and pain relief.</p> <p>Medical record review revealed nurses note 6/7/17 which stated, "Resident sustained a fall from the mechanical lift during staff transfer. Lift noted with safety mechanism failure. Lift pad loop placement not maintained due to safety mechanism failure. Due to this resident slipped from pad and sustained fall."</p> <p>Medical record review revealed doctor's orders for X-rays 6/7/17. Nurse Practitioner progress note 6/8/17 revealed, Resident is 95 years old. She is alert and oriented. X-rays were ordered. "All results of x-rays were negative. Neuro- checks were ordered per facility protocol. Currently the patient is laying in bed requesting transfer to hospital for a scan of her head. She reported that she is sore at this time but that increased pain is related to fall on 6/7/17." Per the NP note the resident 's x-rays were of her ankle, right forearm, foot, and right shoulder. No acute fracture, dislocation or osseous lesion.</p> <p>Nurses note 6/8/17 stated, "Chair bound, requires assistance to transfer. Resident complains of pain to her head. As need pain medication given effectiveness noted. Resident does have a scratch to her right ear and it continues behind her ear." Nurses note 6/8/17, stated resident request to be sent to hospital for further treatment.</p> <p>Hospital discharge summary 6/9/17 revealed that the resident had a scan of her cervical spine, a scan of her head, ribs and right chest. The hospital prescribed Tylenol and Oxycodone.</p> <p>Interview with Resident #1 at 2:35 PM on 6/25/17 revealed that staff were putting her in her chair and the pad they had under her slipped and she went down on the floor on her right side. She stated that the staff could not catch her and she can't walk. Resident #1 stated that staff used the lift and the pad wasn't right. Resident #1 reported that after she fell the staff did not think it was too bad. She stated that her niece told them to send her to the hospital. The resident stated, "I think they took from the hospital that I was alright. A couple days after the fall the condition started." Resident #1 stated she was not bleeding right then it started 2 days later. She stated that the pad needed to be crossed and it just wasn't right. She stated that she can't stand to have her hair braided anymore because her head and ear hurt. She also said that she can't hear well anymore after the fall. The resident was observed to have a scab on her right ear and behind her right ear.</p> <p>Interview with the Director of Nurses at 6:45 PM revealed that prior to the fall, the resident was her own responsible party. The staff updated her face sheet after contact from her family member stating that she was Resident #1's responsible party.</p> <p>Interview with Resident #1 at 7:00 PM revealed that her sister was mad because the facility staff did not inform her of the fall. the resident stated, "They call her for everything else."</p> <p>Interview on 6/25/17 at 7:26 PM with the nurse present during the incident revealed that she did not know about the resident's sister. She stated that she had been at the facility for a year and had never seen the family member visit. She stated she was just informed about the family member.</p>
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<b>F 157</b>	<p>Continued From Page 2</p> <p>Interview with Resident #1's family member on 6/25/17 at 6:31 PM revealed that the resident complained of a headache and she can no longer stand to get her hair braided. She stated the resident was not hard of hearing prior to the fall and that she could hear and see good. The resident's family member stated that she was not notified about the fall and found out from her daughter. She stated the facility called her about everything else.</p>
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