

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345460	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 9/27/2018
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NAME OF PROVIDER OR SUPPLIER GUILFORD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2041 WILLOW ROAD GREENSBORO, NC
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 655	<p>Baseline Care Plan CFR(s): 483.21(a)(1)-(3)</p> <p>§483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-</p> <ul style="list-style-type: none"> (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- <ul style="list-style-type: none"> (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <ul style="list-style-type: none"> (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <ul style="list-style-type: none"> (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to develop a baseline care plan within 48 hours of a resident's admission and failed to provide a copy of the baseline care plan to the resident for 1 of 11 (Resident #41) new admissions reviewed.</p> <p>Findings included:</p> <p>Resident #41 was admitted to the facility on 7/1/18 with diagnoses that included, in part, hypertension and diabetes mellitus.</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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F 655	<p>Continued From Page 1</p> <p>A review of the comprehensive Minimum Data Set (MDS) assessment dated 7/8/18 revealed Resident #41 was cognitively intact.</p> <p>A review of the medical record revealed a baseline care plan was completed 7/4/18.</p> <p>A review of the medical record revealed Resident #41 was her own responsible party.</p> <p>A review of the medical record revealed no documented evidence that a copy of the baseline care plan was given to the resident.</p> <p>On 9/27/18 at 2:32 PM an interview was completed with MDS Nurse #1. She stated that typically the unit manager developed the baseline care plan and gave a copy to the resident or resident representative within 24 hours. She further stated she thought the unit manager documented in the notes that a copy of the baseline care plan was given to the resident or resident representative.</p> <p>On 9/27/18 at 3:07 PM an interview was completed with the Director of Nursing (DON). She said the baseline care plan was able to be completed by any nurse. She stated that either the nurse or MDS staff gave a written summary of the baseline care plan to the resident or resident representative and documented in the notes that the summary was provided. Further interview with the DON revealed there was no documentation that a written summary of the baseline care plan was provided to the resident.</p> <p>On 9/27/18 at 3:45 PM a follow up interview was completed with the DON. She stated the baseline care plan was completed 7/4/18. She said she expected the baseline care plan be developed within 48 hours of admission and a copy provided to the resident or resident representative. The DON further stated she did not know why the baseline care plan was not completed within the 48 hour timeframe.</p> <p>On 9/27/18 at 3:47 PM an interview was completed with Resident #41. She stated the facility had not given her a copy of the written summary of the baseline care plan.</p> <p>On 9/27/18 at 5:37 PM an interview completed with Nurse #1 revealed she was the admission nurse on the day Resident #41 admitted to the facility. She stated she had not developed a baseline care plan for Resident #41 since she was not a Registered Nurse (RN) and said the baseline care plan had to be completed by a RN.</p>
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