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 03/08/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conducted from 3/7/23-3/8/23. Event ID #Y7MQ11. Intake #NC00197688 4of 4 allegation resulted in no deficiency and Intake NC00199317 1 of 2 allegations resulted in a deficiency.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observations, interviews with residents and staff, the facility failed to protect a resident's right to be free from mistreatment for 1 of 1 resident investigated for staff to resident abuse. (Resident #4). The findings included: Resident #4 admitted to the facility on 1/31/23. The diagnoses congestive heart failure, diabetes, and chronic kidney disease. The admission Minimum Data Set (MDS) dated	F 600	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F600 1. NA #1 was removed from the	3/24/23

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

Electronically Signed | 03/24/2023

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F 600	Continued From page 1 2/16/23, indicated Resident #4's cognition was intact for daily decision making and she required total assistance with activities of daily living. Resident #4 interview was conducted on 3/7/23 at 4:40 PM, Residen#4 stated that an aide had spoken rudely and handle her roughly during care and threatened her to push her on the floor. Resident #4 did not want to disclose the staff name, but knew she no longer worked at the facility anymore. An interview was conducted on 3/7/23 at 4:55, the Nurse#6 stated a family member came to the facility around 1:00 PM on 2/8/23, reported that she overheard Nurse Aide#1 speaking rudely to Resident #4, the resident stated to the aide she was handling her roughly and speaking in a threating manner. The family member reported Nurse Aide #1 stated to Resident #4 "if you don't get your hands out of my face you will find yourself on the floor." Review of the staff assignment sheet on 2/7/23, Nurse Aide #1 was assigned to Resident #4 and 8 other residents. A telephone interview was conducted on 3/8/23at 7:06 AM, Nurse Aide #1 stated she had been frustrated working with other residents on her assignment when Resident #5's family requested assistance with her needs. The assigned aide was not around to assist the family when they requested assistance, the responsibilities for her assignment and Resident #5 was overwhelming. When she completed the other assignments, she began to work with Resident #4 who required complete incontinent care. Nurse Aide #1 stated as she was rolling Resident #4 over during care. Resident #4 had fecal matter on her hands due to	F 600	schedule and reported to the Healthcare Personnel Registry 2. Current Residents are at Risk. Current residents interviewed by social services to ensure no evidence of abuse or neglect. Interviews were completed on 3/08/2023. No concerns voiced during interviews. 3. Current staff are educated by Director of Nursing or designee beginning on 03/08/2023 Education included information regarding types of abuse and neglect as referenced in administrative policy 704. Any staff not receiving the education will not be allowed to work until education received. Any new staff will receive education by Staff Development Coordinator or designee during the orientation process. 4. Social Services department or designee will interview 10 residents weekly for abuse and neglect. Audits will be conducted weekly x 8 weeks, then monthly x 1. 5. Results of the audits will be presented by the Administrator at the monthly Quality Assurance Meeting. Any negative findings will result in amendments to audit frequencies as necessary and will be reviewed for 3 months for any further resolution if needed. The QAPI committee will evaluate the effectiveness of the plan above and will add additional interventions based on the identified trends/outcomes	

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F 600	Continued From page 2 scratching. Resident #4 stated to her, she did not know what her problem was with her, when she responded to the resident "excuse me" the resident put her hand in her face, out of frustration as she was leaving the resident's room, she spoke out loud, "she(resident) would be the exact person who would say I pushed her on the floor." Nurse Aide #1 further stated the family of Resident #4's roommate was present in the room when she left to get the nurse for assistance. Nurse Aide #1 further stated "I know I should not have stated out loud what I was thinking, but I would have never pushed or threaten to push a resident on the floor. The statement was not directed at the resident." Nurse Aide #1 confirmed she completed her shift. A follow-up interview was conducted on 3/8/23 at 11:18 AM, Resident #4 stated the aide spoke to her rudely and handled her roughly during care. She asked the aide if there was something wrong and she had an attitude. Resident #4 stated she raised her finger up in the air but did not point it directly in the aide's face. The aide told her "if she pointed her finger in her face one more time, she would find herself on the floor." The resident stated she told the aide she would find herself fired and looking for another job. It was very unexpected experience, and she was very upset. Resident #4 stated she did not know why the aide would say that to her. "I was not afraid because she was too old to be afraid of anything." She did not see the staff after that point and had no other issues since then.	F 600	to Resident ensure continued appliance. Date of Completion 03/24/2023	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	F 610		3/24/23

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F 610	Continued From page 3 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews and family interview, the facility failed to complete a thorough investigation and report within the required timeframe of 2 hours an allegation of resident abuse when a family reported staff was speaking rudely, handled the resident roughly, and communicated a verbal threat towards the resident for 1 of 1 resident reviewed for abuse (Resident #4). Additionally, the facility failed to protect all residents from abuse by allowing staff to continue working their scheduled shift after the abuse allegation was communicated to facility staff. The findings included: Th Review of the abuse policy updated 1/19/2022 revealed, in part, under procedure immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or	F 610	F610 1. For Resident #4, the facility reportable incident was reported by the Director of Nursing (DON) but was outside of the regulatory allowable timeframe. The incident was investigated, and a follow up summary sent to the regulatory agency of the findings. The DON and Administrator have been educated on the abuse policy and allowable timeframes of reporting allegations. 2. Current residents are at risk. On 3/08/2023 current residents were interviewed by social services department to ensure no concerns of abuse or neglect. No concerns voiced during interviews. 3. Current staff are educated by Director of Nursing or designee beginning on 03/08/2023 Education included	

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F 610	Continued From page 4 mistreatment, including injuries of unknown sources and misappropriation of resident property, the Administrator will immediately report to the State Agency, but no later than 2 hours after the allegation is made, if the events that caused the allegations involves abuse or results in serious bodily injury, or not later than 24 hour if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. The Administrator and Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrences. The investigative protocol will include, but not limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations. The Administrator must thoroughly investigate and file a complete written report of the investigation of the submitted Facility Reported Investigation (FRI) to the state agency within five working days of the incident. Upon completion of the internal investigation and prior to submitting any written follow-up investigation report to the State, copies of the completed investigation report must be submitted to the Regional Director of Clinical Services for review and consultation and to the Chief Nursing Officer for approval. Resident #4 admitted to the facility on 1/31/23. The diagnoses congestive heart failure, diabetes, and chronic kidney disease. The admission Minimum Data Set (MDS) dated 2/16/23, indicated Resident #4's cognition was intact for daily decision making and she required total assistance with activities of daily living. The 24-hour report to the State Agency dated	F 610	information regarding types of abuse and neglect as referenced in administrative policy 704. Any staff not receiving the education will not be allowed to work until education received. Any new staff will receive education by Staff Development Coordinator or designee during the orientation process. Administrator and DON were educated on regulatory allowable timeframe by Regional VP on 03/08/2023. 4. All grievances, service concerns, change of condition reports and the daily clinical reviews to include progress notes will be reviewed daily x4 weeks, weekly x4 weeks then monthly thereafter or until significant compliance has been achieved. 5. Results of the audits will be presented by the Administrator at the monthly Quality Assurance Meeting. Any negative findings will result in amendments to audit frequencies as necessary and will be reviewed for 3 months for any further resolution if needed. The QAPI committee will evaluate the effectiveness of the plan above and will add additional interventions based on the identified trends/outcomes to Resident ensure continued appliance. Date of Completion 03/24/2023	

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2/9/23 documented under allegation description, on 2/7/23 at 9:00 PM, Family member visiting overheard staff saying to Resident #4 "I'm telling you now if you point your finger at me one more time you will find yourself on the floor." The 5 -day report was submitted for abuse on 2/14/23.

Review of the facility investigation summary dated 2/14/23, identified the allegation as verbal abuse. The investigation did not provide evidence of protection for all residents, resident interviews on abuse, or staff training on abuse during the investigation.

An interview was conducted on 3/7/23 at 4:10 PM, the Director of Nursing stated she was not in the facility on 2/8/23 when the allegation of verbal abuse was reported to Nurse #6 and the Administrator. She began her investigation on 2/9/23. The Director of Nursing further stated the allegation should have been reported to the state agency within the required two-hour timeframe by the nurse receiving the report and/or Administrator. The Director of Nursing confirmed the alleged staff should have been sent home pending investigation when the family member reported to Nurse #7 that Resident #4 had been spoken to rudely, rough handled and a verbal threat was made by staff on 2/7/23. The Director of Nursing acknowledged, the protection of all residents was not provided when Nurse Aide #1 was allow to complete the shift. The resident interviews on abuse and abuse training for staff had not been done during the investigation process.

An interview was conducted on 3/7/23 at 4:33 PM, the Social Worker Assistant stated the unit manager asked her to come with her to speak

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with the family member and the residents on 3/8/23 at 1:00 PM. The Family Member stated on 2/7/23, she overheard an aide speaking rudely to the resident, the resident telling the aide she was handling her roughly and the staff tell Resident #4 "if she did not get her fingers out of her face you would find yourself on the floor." The Family Member reported they feared the aide would do this to their mother and other residents. Nurse #6 also asked both residents if this happen and both confirmed the aide had spoken to Resident #4 in this manner. Resident #4 stated she was very upset and did not want the aide to return.

Resident #4 interview was conducted on 3/7/23 at 4:40 PM, Residen#4t stated that an aide had spoken rudely and handle her roughly during care and threatened her to push her on the floor. Resident #4 did not want to disclose the staff name, but knew she no longer worked at the facility anymore.

An interview was conducted on 3/7/23 at 4:55, the Nurse#6 stated a family member came to the facility around 1:00 PM on 3/8/23, stated she overheard Nurse Aide#1 speaking to Resident #4 rudely, the resident stating to the aide she was handling her roughly and speaking in a threating manner. The family member reported Nurse Aide #1 stated to Resident #4 "if you don't get your hands out of my face you will find yourself on the floor. The family member was upset and agitated the aide would make such a statement to the resident. Nurse #6 stated she and the Social Work Assistant went to the resident's room and spoke with Resident #4 and roommate who both stated the incident happened on 2/7/23. The family stated they were fearful for Resident #4 and their loved one based on the manner in

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which Nurse Aide #1 spoke to the resident and were afraid she would do something to their loved one and other residents. Nurse#6 stated she reported the concern to the administrator who took over from that point. The employee was given the suspension notice on 2/8/23 but refused to sign and sent home. She stated she did not interview any other residents nor was an in-service done.

A telephone interview was conducted on 3/8/23at 7:06 AM, Nurse Aide #1 stated she had been frustrated working with other residents on her assignment when Resident #5's family requested assistance with her needs. The assigned aide was not around to assist the family when they requested assistance, the responsibilities for her assignment and Resident #5 was overwhelming. When she completed the other assignments she began to work with Resident #4 who required complete incontinent care. Nurse Aide #1 stated as she was rolling Resident #4 over, Resident #4 stated she did not know what her problem was with her, when she responded to the resident "excuse me" the resident put her hand in her face, out of frustration as she was leaving the resident's room she spoke out loud, "she(resident) would be the exact person who would say I pushed her on the floor." Nurse Aide #1 further stated the family of Resident #4's roommate was present in the room when she left to get the nurse for assistance. Nurse Aide #1 further stated "I know I should not have stated out loud what I was thinking, but I would have never pushed or threaten to push a resident on the floor. The statement was not directed at the resident."

A telephone interview was conducted on 3/8/23 at

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7:26 AM, the Family Member for Resident #5 was visiting on 2/7/23. The incident between Resident #4 and Nurse Aide #1 happened around 7:30 PM. The Family Member reported to Nurse #7 indirectly about the situation and what was said by Nurse Aide #1 as she was leaving the facility after 9:00 PM. She further stated did not provide the details about the residents putting her fingers in the resident's face and threatening to finding the resident on the floor, until 2/8/23. The Family Member stated she did report to Nurse #7 she overheard Nurse Aide #1 speak rudely to Resident #4. She stated she could not directly see what took place behind the curtain, but heard Resident #4 tell Nurse Aide #1 she was handling her roughly. The Family Member stated she heard Nurse Aide#1 tell Resident #4 "If you point your finger/ put your hand in my face again, I promise you, you will find yourself on the floor." She and Resident # 5 and Resident #4 was very upset about the statement and felt as though it was a threat. The Family member thought if she would speak that way to Resident #4, she would probably speak to other residents the same way. The Family Member was afraid for Resident #4 and Resident #5 and decided to she stayed beyond the visiting hours to make sure both residents were ok. She felt as though Nurse #7 did not see anything wrong. She spoke with Nurse #6 the following day and shared what transpired on 2/7/23. She told Nurse #6 that she overheard the aide speaking rudely and handling the resident roughly and made the statement to the resident if the resident to point her finger /hand in her face the resident would find herself on the floor.

A follow-up interview was conducted on 3/8/23 at 11:18 AM, Resident #4 stated the aide spoke to

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her rudely and handled her roughly during care. She asked the aide if there was something wrong and she had an attitude. She stated raised her finger up in the air but did not point it directly in the aide's face. The aide told her "If she pointed her finger in her face one more time, she would find herself on the floor." The resident stated she told the aide she would find herself fired and looking for another job. It was very unexpected experience, and she was very upset. Resident #4 stated she did not know why the aide would say that to her. "I was not afraid because she was to0 old to be afraid of anything." She did not see the staff after that point and had no other issues since then.

A follow-up interview was conducted on 3/8/23 at 1:30 PM, the Director of Nursing stated, the director of nursing and administrator should have been contacted immediately on 2/7/23 per policy, the employee should have been removed from the shift, resident interviews on abuse and staff in-service on abuse should have been done during the investigation process.