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 04/17/2025

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/14/25 through 04/17/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #3IUK11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/14/25 through 04/17/25. Event ID# 3IUK11. The following intakes were investigated NC00227993, NC00226639, NC00226327, NC00225743, NC00223791, NC00222404, NC00222280, NC00217970, NC00217551, NC00215846, and NC00215571. 5 of the 24 complaint allegations resulted in deficiencies.	F 000	Past noncompliance: no plan of correction required.	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a	F 565		5/15/25

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

Electronically Signed | 05/12/2025

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 04/17/2025

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 565	Continued From page 1 resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews, the facility failed to act upon grievances that were reported by the Resident Council, resolve repeat grievances, and communicate the facility's efforts to address grievances voiced during Resident Council meetings for 7 of 7 consecutive months: September 2024, October 2024, November 2024, December 2024, January 2025, February 2025, and March 2025. The findings included: a. A review of the Resident Council minutes completed by the Activities Director dated 9/18/24 revealed the following grievance was expressed: banking hours 9-3pm. b. A review of the Resident Council minutes	F 565	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 facilitys allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F565- Resident/Family Group and Response " Address how the facility will identify other residents having the potential to be affected by the same deficient practice;	

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 04/17/2025

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 565	Continued From page 2 completed by the Activities Director dated 10/21/24 revealed the following grievances were expressed: would like monthly billing statements, larger size people want proper care and handle accordingly, portion size has gotten smaller, and they want to know why they can't get sandwiches and snacks, think rights have been violated with noise level at night. There was no documented resolution from the previous month's grievance related to banking hours. c. A review of the Resident Council minutes completed by the Activities Director dated 11/18/24 revealed the following grievances were expressed: call lights turned off but don't address the reason for being on, portion still small. The resolution addressed only one of the previous month's grievances related to monthly billing statements. d. A review of the Resident council minutes completed by the Activities Director dated 12/16/24 revealed the following grievances were expressed: staff not knocking on doors, still on phones and talking through ear buds, portions small and can't get seconds, still no snacks. There was no documented resolution from the previous month. e. A review of the Resident Council minutes completed by the Activities Director dated 1/13/25 revealed the following grievances were expressed: baseboards need cleaning. There was no documented resolution from the previous month. f. A review of the Resident council minutes completed by the Activities Director dated 2/20/25 revealed the following grievances were	F 565	All residents are at risk of being affected by this deficient practice. Resident council minutes for the last seven months were reviewed by the Facility Administrator to ensure response and resolution has been implemented for any concerns noted from the resident council. The Facility Administrator held an ad hoc council meeting on 5/15/25 to discuss resolution to all concerns voiced through the resident council meeting minutes. " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Facility Administrator provided education to facility leadership team on 5/09/25 regarding how to respond to concerns voiced in resident council meeting. The Activities Director was educated on Activities policies and procedures policy #601 which states that the Activities Director is to provide the administration with an original copy of the council minutes along with administrative response to the resident council for review and signature. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Facility Administrator will conduct regular meetings with the resident council	

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 04/17/2025

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 565	Continued From page 3 expressed: staff still wearing earbuds and on phones, want less pasta and more condiments. The stated resolution was the dietary manager spoke about what they are doing in the kitchen so it can get better. g. A review of the Resident Council minutes completed by the Activities Director dated 3/27/25 revealed the following grievances were expressed: ear buds, staff on the phone, loud noises, "why can't snacks not as plentiful", nursing assistants not assisting residents unless they are the assigned nursing assistant, too many sandwiches for dinner, snacks not as plentiful, food mediocre, noise on hall. There was no documented resolution from the previous month. A Resident Council meeting was held on 4/17/25 at 1:00 PM with Residents #17, #52, #84 and #32. During the meeting, Resident #17 , the resident council president, expressed frustrations that the Resident Council has made repeated grievances month after month which had not been addressed or resolved. Resident #52 stated the resident council's complaints did not seem to matter to corporate. The members present at the Resident Council meeting expressed their collective frustration in attempting to get their voices heard by corporate staff and the previous administrator. An interview with the Activities Director on 4/16/25 at 3:44 PM revealed that she did not fill out a grievance form for grievances or concerns brought up in Resident Council. She indicated she would try to tell the department heads about concerns but did not document the follow-up in the minutes for each concern.	F 565	president to discuss concerns and responses related to the council. This will occur weekly x4/weeks, twice a monthx2/months, then monthly until substantial compliance is achieved. The Administrator or designee will report the findings to the monthly Quality Assurance Improvement Committee for further recommendations as indicated. Date of Completion: 5/15/25	

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 04/17/2025

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 565	Continued From page 4 An interview with the Administrator on 4/16/25 at 4:05 PM revealed he just started in the position about four weeks ago and he was not aware that the Activities Director had not documented Resident Council grievances on a form and had not received follow-up to all grievances voiced during the meetings. He further indicated that all Resident Council grievances should be documented on a grievance form, provided to the appropriate department head and signed off by the Administrator each month.	F 565		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must	F 567		5/22/25

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 04/17/2025

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 567	Continued From page 5	F 567		

maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.
(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)
The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.
This REQUIREMENT is not met as evidenced by:
Based on staff and resident interviews, the facility failed to provide residents with access to their personal fund accounts for 2 of 2 residents reviewed for management of personal funds (Resident #17 and #52).

The findings included:

1. Resident #17 was admitted to the facility 9/27/23.

Review of #17's annual Minimum Data Set (MDS) dated1/6/25 revealed Resident #17 was cognitively intact.

An interview conducted with Resident #17 on 4/16/25 at 1:00 PM revealed he was a Medicaid recipient, and he was only allowed to withdraw $20 dollars a day and could not retrieve any money after hours or on the weekends. Resident #17 indicated this had been an issue for as long as he has been a resident at the facility.

F567

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
Residents #17 and #52 were instantly granted access to their funds and educated on the new process allowing for access to funds outside of normal operating hours.
Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
All residents who desire to access their funds outside of normal operating hours, including weekends, are at risk of being affected by this deficient practice.
Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
The Regional Business Office Manager

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 04/17/2025

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 567	Continued From page 6 An interview was conducted with the Business Office Manager (BOM) on 4/16/25 at 2:49PM. The Business Office Manager indicated that corporate staff only allows residents to receive $20 a day and if they request funds over that amount the money would be provided in a check form by the following business day. The BOM further revealed that residents can only withdraw funds Monday-Friday between the hours of 9:00 AM and 3:00 PM. An interview conducted with the Administrator on 4/16/25 at 3:37 PM revealed he had only been in this position for four weeks and he was not aware residents were only able to withdraw $20 a day and did not have access to personal funds after hours on the weekends and weekdays. The Administrator further revealed he had expected all residents to always have access. 2. Resident #52 was admitted to the facility 9/23/22. Resident # 52's 3/28/25 quarterly Minimum Data Set assessment revealed Resident #52 was cognitively intact. An interview was conducted with Resident #52 on 4/16/25 at 1:05 PM. Resident #52 indicated she had not been able to buy the things she wants because the facility will allow residents to withdraw $20 a day and the banking hours are only during the week from 9:00 AM- 3:00 PM and the facility offered no options to residents to access any of their funds during the weekends. An interview was conducted with the Business Office Manager (BOM) on 4/16/25 at 2:49PM. The Business Office Manager indicated that	F 567	updated the Resident Funds Management Policy to reflect the CMS requirement that resident personal funds from $20-$50. If the amount is greater than $50 the facility will have 3 days to complete this request. The facility will ensure that personal funds of $50 or less are maintained in the facility petty cash fund, as appropriate at all times. Establish procedures to provide residents with reasonable access to their funds daily during normal business hours, specifically from 8:00 AM to 4:00 PM, in compliance with CMS regulations and coordination of weekend access to funds, ensuring all residents can withdraw money as needed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The business office manager will audit residents utilizing the services weekly x 2weeks, 2x/month x 2 weeks, then monthly. Date of Compliance: 5/22/25	

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 04/17/2025

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 567	Continued From page 7 corporate staff only allows residents to receive $20 a day and if they request funds over that amount the money would be provided in a check form by the following business day. The BOM further revealed that residents can only withdraw funds Monday-Friday between the hours of 9:00 AM and 3:00 PM. An interview conducted with the Administrator on 4/16/25 at 3:37 PM revealed he had only been in this position for four weeks and he was not aware residents were only able to withdraw $20 a day and did not have access to personal funds after hours on the weekends and weekdays. The Administrator further revealed he had expected all residents to always have access.	F 567		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		6/1/25

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 04/17/2025

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 578	Continued From page 8 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to maintain accurate advance directive information (code status) throughout both the electronic medical record and paper record kept at the Nursing Station for 1 of 32 residents reviewed for advance directives (Resident #5). The findings included: Resident #5 was admitted to the facility on 6/16/23 with cumulative diagnoses which included heart failure, renal insufficiency, and a history of respiratory failure. A 3-ring binder containing paper copies of the residents' advance directives was observed at the	F 578	F578 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Do Not Resuscitate form was removed from the advanced directive binder and the current code status and order were confirmed for resident #5. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 4/25/25 the Discharge Planner	

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 04/17/2025

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 578	Continued From page 9 nursing station. A review of Resident #5's record kept in this binder revealed it included a signed "Do Not Resuscitate" (DNR) form printed on bright yellow/orange-colored paper, which indicated the resident had a DNR status. The DNR form was dated 6/19/23 and indicated by a checked box that this DNR directive had "No Expiration Date." A review of Resident #5's electronic medical record (EMR) revealed the banner at the top of Resident #5's EMR page documented that her advance directive was, "Full Code." A review of the resident's physician orders in the EMR revealed an order was received on 9/19/24 for Resident #5 to have a code status of "Full" code. The resident's care plan included an area of focus last revised on 9/23/24 which read, "The resident has an advance directive of full code." Resident #5's most recent Minimum Data Set (MDS) was a quarterly assessment dated 12/27/24. A review of the MDS assessment revealed Resident #5 had moderately impaired cognition. An interview was conducted on 4/15/25 at 9:17 AM with the facility's Admission Director. During the interview, the Admission Director stated that the initial information on Advance Directives was addressed in the resident's contract upon admission. When asked, she reported nursing staff was responsible for inputting the resident's code status after admission into the resident's EMR. An interview was conducted on 4/15/25 at 10:30 AM with Nurse #1. Nurse #1 identified herself as	F 578	completed a 100% audit of codes status for each resident in the facility. On 4/25/25 the Unit Mangers confirmed the orders for all residents within the facility and updated the advance directive book to accurately reflect the DNR code status for residents that are DNR. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Staff Development Coordinator began an education for all licensed nurses on the use of the Advanced Directive Binder. The education also included that the resident's electronic record is the primary source for determining the resident's advanced directives. The advanced directive binder should only be used to access DNR paperwork for transport to physician appointments or the hospital. The Staff Development Coordinator will be responsible for the education of all new nurses on this process during the new hire orientation. This education will be completed by 6/1/25. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The facility discharge planner and medical records will complete an audit of all resident advance directive orders and compare them the advanced directive	

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 04/17/2025

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 578	Continued From page 10 the hall nurse assigned to care for Resident #5. Upon inquiry, Nurse #1 was asked where she would locate a resident's advance directive to identify his/her code status in the event this was needed. The nurse reported she could access this information from the resident's EMR. She also stated there was a binder kept at the nursing station where she could check a resident's code status. At that time, Nurse #1 reviewed Resident #5's advance directive in her EMR. The EMR indicated the resident had a Full Code status. Next, Nurse #1 reviewed the resident's paper record kept in the Advance Directives binder. The paper record was observed to include a signed DNR form which indicated Resident #5 had a DNR status. When asked, the nurse stated both the EMR and the paper record in the Advance Directives binder should contain the same information. Nurse #1 reported if the resident coded, she would need to initiate a full code for her but then added, "There would be some confusion." An interview was conducted on 4/15/25 at 3:26 PM with the facility's Unit 2 Manager. During the interview, the Unit Manager was asked where the nursing staff could find a resident's code status. She stated it was on the "MAR [Medication Administration Record]" in the resident's EMR. Additionally, the Unit Manager reported the residents' code status was kept in a binder at the nursing station. She stated the provider was typically responsible to put any change in code status into a resident's EMR. If a resident returned from the hospital, then nursing needed to add it into the EMR as part of his/her admission orders. When the Unit Manager was informed of the discrepancy between Resident #5's two sources of information for code status,	F 578	binder. This audit will be continuing weekly for 4 weeks, then monthly for 2 months. All audit findings will be reported to the Director of Nursing, who will report these findings to the facility's monthly Quality Assurance Performance Improvement committee. Date of Completion 6/1/25	

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 04/17/2025

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 578	Continued From page 11 she reviewed the resident's EMR and confirmed it indicated she was a "Full Code." The Unit Manager stated, "I'm going to take it [the DNR form] out [of the binder]." An interview was conducted on 4/16/25 at 3:19 PM with the facility's Director of Nursing (DON). During the interview, the DON reported there needed to be only one source of information for a resident's code status. She stated, "I'm going to remove the binder."	F 578		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review, and interim Guardian and staff interviews, the facility failed to provide a safe and orderly discharge. The facility failed to make a referral to law enforcement and adult protective services on the day of discharge which caused a delay in Resident #203 receiving support in the home. This was for 1 of 2 residents reviewed for discharge (Resident #203). Findings included: Resident #203 was admitted to the facility on 5/15/24 which included metabolic encephalopathy, mood disorder, anxiety disorder	F 624	Past noncompliance: no plan of correction required.	

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 04/17/2025

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 624	Continued From page 12	F 624		

and hallucinations.

Resident #203's admission Minimum Data Set (MDS) assessment dated 5/15/24 revealed the resident was cognitively intact.

Resident #203's care plan revised on 5/9/24 revealed a focus area for assistance with activities of daily living due to chronic health conditions, muscle weakness and recent hospitalization related to acute metabolic encephalopathy. Interventions included one person assisting with transfers.

Resident #203's medical record revealed an interim guardianship document that was uploaded into the system on 5/17/24.

Resident #203's demographic sheet indicated guardian on the face sheet.

Physical therapy discharge summary note dated 5/23/24 indicated Resident #203 was able to sit up on the side of the bed, roll left and right independently and required supervision/touching assistance while standing up, transferring from bed to chair and transferring to and from the toilet.

An attempt was made to interview Resident #203, but the attempt was unsuccessful.

A progress note dated 5/25/24 written by Nurse #7 indicated Resident #203 left the facility Against Medical Advice (AMA) the morning of 5/25/25 with a unidentified individual in a private vehicle. The progress note indicated that Nurse #7 notified the family member and the Nurse Practitioner. The progress note also indicated that

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 04/17/2025

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 624	Continued From page 13	F 624		

"Resident is own Power of Attorney (POA)".

An interview was conducted Nurse #7 on 4/17/25 at 12:39 PM. Nurse #7 indicated that at the time of Resident #203's discharge on 5/25/24 she was not aware that the family member she notified had also been appointed the interim Guardian for Resident #203 on 5/17/24.

A telephone interview was conducted with the interim Guardian on 4/17/25 at 11:34 AM. She indicated that she was notified on 5/25/24 that Resident #203 was discharged from the facility AMA. She further revealed she felt the discharge was unsafe and the facility should have notified adult protective services and law enforcement at the time of discharge. The interim Guardian indicated that she eventually had to contact law enforcement for well checks because Resident #203 was hallucinating and would not allow anyone in her home. The department of social services was also made aware of the situation by law enforcement, and they provided Resident #203 with services to remain in the home under their oversight.

A telephone interview was conducted with the former Administrator on 4/17/25 at 12:39 PM. He indicated that he first became aware of the discharge on Monday 5/27/24 and was informed that Resident #203 had discharged AMA, and that adult protective services nor law enforcement had been notified on the day of discharge. The former Administrator indicated that he felt the discharge was not handled properly because the facility could not confirm if Resident #203 was safe and adult protective services and law enforcement was not contacted on the day of discharge. He further revealed that he contacted adult protective

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 04/17/2025

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 624	Continued From page 14	F 624		

services and law enforcement on 5/27/24 to make a referral and contacted the interim Guardian on 5/27/24 and offered Resident #203 to return to facility, but the offer was declined.

The facility implemented the following Corrective Action Plan with a compliance date of 5/28/24.

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident #203 no longer resides in the facility. The resident was offered to return to the facility but refused offer from facility.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
All residents are at risk for this deficient practice. The Regional Director of Clinical Services completed an audit of current residents and created a list of current residents as of 5/27/2024. The Regional Director of Discharge planning completed an audit of the last 30 days of discharges to home or lower level of care to ensure guardian notification has been completed. Audit was completed on May 28, 2024.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

Beginning May 27th, 2024, the administrator and assistant administrator provided in-person education for all licensed nurses, admissions team, and service ambassadors. Education included:

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 04/17/2025

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 624	Continued From page 15	F 624		

- How to conduct a proper discharge, including confirming with the responsible party, power of attorney, and guardianship process.

- Education for service ambassadors included not allowing residents to exit the center without verifying the appropriateness of their leaving with the assigned nurse.

- Verifying the process before letting any resident depart the facility.

- If permission is denied, Immediate action will be taken to notify the law enforcement and staff will keep the residents inside until law enforcement arrives.

All new licensed nurses, service ambassadors, and admissions staff will receive this training as part of their onboarding process before starting on the floor.

The admission team will be responsible for updating PCC if the resident has under the profile tab if the resident has a guardian. This also must be communicated on an admission alert. Admissions will communicate during the daily morning meeting if a resident with a guardian is admitted. Education was validated by verbal recall and just in time teaching reinforcement and re-education if needed.

After May 28, 2024, before residents depart the facility, service ambassadors will check with the resident's assigned nurse for the shift to verify the responsible party/guardianship/power of attorney status before granting access to open the doors. This information will be passed to the customer service ambassador/receptionist for door access.

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 04/17/2025

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 624	Continued From page 16 Licensed nurses will make sure to review the face sheet/profile before allowing any patient to be discharged or leave the facility. If the profile indicates guardian, then the guardian must approve all discharges, transfers, or leaving the facility. Licensed nurses were also educated on action steps regarding if a resident has a guardian and insisted on leaving the facility, if they do not have the guardian's permission, the local law enforcement will be immediately notified. 4. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained. The facility Administrator or the designee will audit all discharges weekly x 12 weeks. Audits will include AMA and planned discharges to lower-level care. Audits will consist of proper notification of the party/guardians responsible. These audits will include proper notification of the responsible party/guardian. These audits will be reported to the monthly QAPI committee for review of compliance. Date of Compliance May 28, 2024 The Corrective Action plan was validated on 4/17/15 by reviewing the completed audit of all residents discharged in the last 30 days, the education provided to the staff regarding safe discharged and reviewing the monthly Quality Monitoring documentation. The correction date of 5/28/24 was validated.	F 624		
F 636 SS=D	Comprehensive Assessments & Timing	F 636		5/15/25

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 04/17/2025

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 636	Continued From page 17 CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must	F 636		

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 04/17/2025

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 636	Continued From page 18 include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete the comprehensive Minimum Data Set (MDS) assessment within the regulatory timeframe as specified in the Resident Assessment Instrument (RAI) Manual for 1 of 1 resident reviewed for completion of a comprehensive MDS assessment (Resident #204). The findings included: Resident #204 was admitted to the facility on 3/30/25. Review of the admission Comprehensive Minimum Data Set (MDS) assessment on 4/16/25	F 636	F636-Comprehensive assessments and timing Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #204 admission assessment with ARD 4/6/25 was completed, signed, and transmitted 4/16/25 " Address how the facility will identify other residents having the potential to be affected by the same deficient practice;	

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 04/17/2025

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 636	Continued From page 19 revealed the assessment had not been completed and was still in progress. An interview was conducted with MDS Nurse #1 on 4/17/25 at 5:15 PM. MDS Nurse #1 stated that they had 14 days from the assessment reference date (ARD) to complete the MDS assessment and indicated that this assessment was late due to the influx of new admissions that had recently occurred. An interview was conducted with the Director of Nursing (DON) on 4/17/25 at 5:25 PM. The DON stated she had no idea why the MDS assessment for Resident #204 was not completed within 14 days of admission but stated she would expect that it would be completed within 14 days of admission.	F 636	On 5/8/25, the Regional Director of Clinical Reimbursement conducted a 100% audit to ensure that all residents admitted within the last 30 days have had an admission assessment completed, signed, and locked timely according to RAI manual guidelines. " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; ¿ On 5/8/25, MDS coordinators were educated by Regional Director of Clinical Reimbursement regarding timely completion of assessments according to RAI manual guidelines, focusing on timely completion timeline of admission assessments. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Regional Director of Clinical Reimbursement will audit 5 Residents for timely completion of admission assessments weekly for 4 weeks, biweekly for 2 weeks, and then monthly until substantial compliance is achieved. The Administrator or designee will report the findings to the Quality Assurance Improvement Committee for further recommendations as indicated. " Compliance Date: 5/15/25	

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 04/17/2025

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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of discharge location for 1 of 4 residents (Resident #100) and in the area of feeding tubes for 1 of 3 residents (Resident #36) whose MDS assessment was reviewed. The findings included: 1. Resident #100 was admitted to the facility on 2/07/25. Review of the discharge planning note dated 3/14/25 at 2:36 pm by the Discharge Planner revealed Resident #100 was noted to have been ready for discharge on 3/15/25 to another facility. The Discharge Planner further noted that transportation arrangements were made, and the admission paperwork was signed and returned to the accepting facility. The Nursing progress note dated 3/15/25 at 2:02 pm revealed Resident #100 was discharged to another facility with transport team. The Minimum Data Set (MDS) return not anticipated assessment dated 3/15/25 and completed by the Discharge Planner revealed Resident #100 was noted to have a discharge status of short-term general hospital.	F 641	F641-Accuracy of Assessments " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #100 3/15/25 discharge tracker was modified and transmitted 4/17/25, resident #36 1/20/25 was modified and transmitted 5/7/25 " Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 5/9/25,Regional Director of Clinical Reimbursement conducted a 100% audit of residents discharged to another skilled facility since 1/1/25 to ensure coding accuracy in section A2105 of the MDS and on 4/25/25, a 100% audit of current residents with a feeding tube was completed to ensure coding accuracy in section K0520 of the MDS " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 5/8/25, MDS coordinators and social	5/15/25

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 04/17/2025

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 641	Continued From page 21 An interview was conducted with the Discharge Planner on 4/15/25 at 3:18 pm who revealed Resident #100 was discharged to another skilled nursing facility on 3/15/25 with the anticipation to transition to long-term care after therapy services were completed. The Discharge Planner confirmed she completed the MDS assessment in error and should have chosen discharge to skilled nursing facility instead of short-term general hospital for Resident #100. During an interview on 4/16/25 at 10:22 am with the MDS Nurse she revealed she did not review the sections of the assessment that were completed by the other departments for accuracy. She stated the person that completed their assigned sections was responsible to ensure the information was accurate. An interview was conducted with the Administrator on 4/16/25 at 10:26 am who revealed the Discharge Planner should have reviewed Resident #100's information to ensure the assessment was correct before completing it. 2. Resident #36 was admitted to the facility on 6/17/16 with diagnoses that included severe protein-calorie malnutrition, adult failure to thrive, and gastrostomy status. A physician order dated 11/15/24 read Resident #36 was to receive the prescribed tube feeding formula continuously at 65 milliters per hour from 2:00 PM to 9:00 AM for a total of 19 hours via gastrostomy tube. Resident #36's annual Minimum Data Set (MDS) dated 1/20/25 noted she had impaired cognition, did not have any behaviors or rejection of care.	F 641	workers/discharge planners were educated by Regional Director of Clinical Reimbursement regarding accurate coding of the MDS, focusing on section A2105 discharge status, and MDS coordinators were also educated on coding of the MDS, focusing on section K0520 tube feeding per RAI manual guidelines " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Regional Director of Clinical Reimbursement will audit 5 Residents discharge status coding on the discharge tracker and 5 residents for tube feeding coding for accuracy weekly for 4 weeks, biweekly for 2 weeks, and then monthly until substantial compliance is achieved. The Administrator or designee will report the findings to the Quality Assurance Improvement Committee for further recommendations as indicated. Compliance Date 5/15/25	

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 04/17/2025

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 641	Continued From page 22 The MDS did not code that Resident #36 took her nutrition and hydration through a feeding tube. A progress note dated 2/3/25 at 7:17 PM by the MDS Nurse documented a MDS Reconciliation Note for the assessment reference date 1/20/25 which indicated after observation of the resident, interview with staff, and per progress notes, it was determined that the resident did not eat or drink by mouth and was fed by tube feeding only.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §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- (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- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655		5/22/25

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 04/17/2025

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 655	Continued From page 23 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §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: (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. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interview, the facility failed to create a person-centered baseline care plan and provide a summary to the residents and/or responsible party within 48 hours of admission for 5 of 14 residents reviewed for new admission procedures (Resident #153, #159, Resident #94, Resident #26 and Resident #11). Findings included: 1. Resident # 153 admitted to the facility on 4/10/2025 with an diagnosis that included urinary retention. A Physician's Order dated 04/11/2025 indicated Resident #153 required an indwelling urinary catheter for urinary retention. A review of Resident #153's baseline care plan	F 655	F655-Baseline CarePlan Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Residents 153, 159, 94, 26, and 11 had a care plan review completed on 5/12/25 to ensure all problems, goals, and interventions are person centered and addresses all MD orders, dietary orders, therapy services, and psychosocial needs. A copy of the resident care plan was provided to each resident or their representative. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Director of Nursing/MDS will complete a 100% audit of all current residents who have been admitted to the	

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 04/17/2025

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 655	Continued From page 24 dated 04/10/2025 was conducted and there was no indication for urinary catheter use. An interview was conducted with Nurse #6 on 4/17/2025 at 11:18 AM and she indicated when a new resident admits to the facility, she completes a nursing admission assessment. She stated the information she identifies as a concern on the admission assessment triggers the baseline care plan to be developed. Attempts were made to contact the Nurse that admitted Resident #153 and were unsuccessful. An interview was conducted on 4/17/2025 at 11:39 AM with the DON and she stated, "the basics of care should be on the baseline care plan and the catheter should have been put on the baseline care plan. The DON indicated she would need to come up with a process to put the needed information on the baseline care plan. During an interview with the Administrator on 04/17/2025 at 4:43 PM he indicated the baseline care plan should be accurate with the needs of the residents to be identified. 2. Resident #159 was admitted to the facility on 4/11/2025 with diagnoses which included end stage renal disease, congestive heart failure, coronary artery disease, hypertension and type 2 diabetes. A review of Resident #159's physician orders dated 4/11/2025 revealed an order for a life vest (LifeVest is a wearable defibrillator that can detect and treat abnormal heart rhythms). A review of the baseline care plan dated	F 655	facility within the last 30 days to determine if the baseline care plan requirement was met for each of them. The audit will be completed by 5/20/25. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; All licensed nurses will receive education on requirements for completion of the baseline care plan. This training will be conducted by the Staff Development Coordinator. The education will include the CMS requirements for ensuring that the baseline care plan requirement is med for all newly admitted residents including the following: o Baseline Care Plan Requirement: 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. o The baseline care plan must: 1. Be developed within 48 hours of a resident s admission. 2. Include the minimum healthcare information necessary to properly care fora resident including but not limited to: ¿ 1. Initial goals based on admission orders. ¿ 2. Physician orders. ¿ 3. Dietary orders. ¿ 4. Therapy services. ¿ 5. Social services ¿ 6. PASARR recommendation, if applicable. ¿ Within 48 hours of admission to the	

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 04/17/2025

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 655	Continued From page 25 4/12/2025 revealed there was no mention of the life vest. An interview was conducted with Nurse #6 on 4/17/2025 at 11:18 AM and she indicated when a new resident admits to the facility, she completes a nursing admission assessment. She stated the information she identifies as a concern on the admission assessment triggers the baseline care plan to be developed. Attempts were made to contact the Nurse who admitted on Resident #159 and were unsuccessful. During an interview with the Director of Nursing (DON) on 4/17/2025 at 11:39 AM she indicated the life vest should have been on the baseline care plan. An interview was conducted on 4/17/2025 at 04:38 PM with the Administrator and he indicated the life vest should have been on the baseline care plan. 3. Resident #11 was admitted to the facility on 3/24/25. Review of the admission assessment dated 3/24/25 by Nurse #4 revealed no documentation that the baseline care plan or list of medications were reviewed or provided to Resident #11 or the Responsible Party (RP). Review of the Baseline Care Plan assessment initiated on 3/27/25 by Unit Manager #1 revealed the following: the baseline care plan was marked as initiated and completed. The baseline care plan was not marked as being reviewed with	F 655	facility, the facility must develop and implement a Baseline Care Plan for the resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of care. All nurses will receive education on the baseline care plan process by 5/20/25. Any new licensed nurses will receive education on the baseline care plan process by the staff development coordinator during the orientation process. DON or designee will audit the baseline care plan for all new admits/readmits within 48 hours of admission to ensure the baseline care plan addresses MD orders, dietary needs, therapy needs, and psychosocial needs of the resident; as well as ensuring the care plan is person centered and addresses any devices ordered such as catheters and life vests etc. During the 48-hour audit the DON/designee will ensure that a baseline care plan assessment is completed, and a copy of the resident's medication list and care plan is provided to the resident or responsible party. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or designee will review the new admissions during the morning clinical meeting to ensure that baseline care plans have been initiated. This audit will be completed using the Quality Assurance audit tool entitled	

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 04/17/2025

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 655	Continued From page 26 Resident #11 and/or the RP and was not marked that a copy of the baseline care plan and copy of the medications were provided to the resident and/or RP. Review of the progress notes revealed no documentation that Resident #11's baseline care plan was reviewed with the Resident or the RP. The progress notes further revealed no documentation that Resident #11 or the RP received a copy of the baseline care plan or list of medications. The Minimum Data Set (MDS) admission assessment dated 3/31/25 revealed Resident #11 had moderate cognitive impairment. An interview was conducted with the MDS Nurse on 4/16/25 at 9:22 AM and she indicated that the baseline care plan was initiated on the day of admission by the admitting nurse and nursing staff were responsible to review and provide a copy to Resident #11 and/or the RP. An interview was conducted on 4/16/25 at 2:41 pm with Unit Manager #1 who revealed she opened and completed the baseline care plan assessment at the time of the admission but she did not review it with Resident #11 or provide the Resident with a copy of the care plan or medications. Unit Manager #1 stated the nurse that completed the admission assessment for Resident #11 was responsible to review and provide a copy of the baseline care plan and the current medications to Resident #11 and the RP. A telephone interview was conducted on 4/16/25 at 3:13 pm with Nurse #4 who revealed she was not responsible for completing the baseline care	F 655	Baseline Care Plan Completion Audit. This will be done 5x weekly for 4 weeks then 3x weekly x 4 weeks then monthly x 1. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The Administrator and Director of Nursing are responsible for the implementation of this plan of correction. The DON will report the findings of the 48-hour baseline care plan audits to the monthly Quality assurance/Performance Improvement committee for further recommendations as indicated. Compliance Date: 5/22/25	

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 04/17/2025

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 655	Continued From page 27	F 655		

plan or reviewing the information with Resident #11 or his RP. Nurse #4 stated she was an agency nurse and she believed that the facility staff were responsible to review the baseline care plan and medications with Resident #11.

An interview was conducted with the Director of Nursing (DON) on 04/16/25 at 11:28 AM. The DON indicated that she had determined that nurses were not completing all sections of the baseline care plan and should have been reviewing the care plan and providing a copy of the summary to the resident and responsible party as appropriate with 48 hours of admission.

4. Resident #94 was admitted to the facility on 2/5/25. Diagnosis included, in part, nontraumatic intracerebral hemorrhage.

The medical record was reviewed and revealed a baseline care plan was completed on 2/6/25. There was no documented evidence that a summary of the baseline care plan was offered or given to Resident #94 or to the responsible party.

The quarterly Minimum Data Set (MDS) assessment dated 2/12/25 revealed Resident #94 was severely cognitively impaired.

An interview was conducted with Resident #94's responsible party on 4/16/25 at 9:14 AM and he indicated he was not provided with the opportunity to review or get a copy of the summary of the baseline care plan.

An interview was conducted with the MDS Nurse #1 on 4/16/25 at 9:22 AM and she indicated that the baseline care plan was initiated on the day of admission by the admitting nurse and nursing

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 04/17/2025

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 655	Continued From page 28	F 655		

staff are responsible for reviewing and providing a copy to the resident and/or the responsible party.

An interview was conducted with the Director of Nursing (DON) on 04/16/25 at 11:28 AM. The DON indicated that she had determined that nurses were not completing all sections of the baseline care plan and should have been reviewing the care plan and providing a copy of the summary to the resident and responsible party as appropriate with 48 hours of admission.

5. Resient #26 was admitted to the facility on 3/22/25. Diagnosis included in part, Nondisplaced fracture of fifth metatarsal bone in left foot.

The medical record was reviewed and revealed a baseline care plan was completed on 3/26/25. There was no documented evidence that a summary of the baseline care plan was offered or given to Resident #26.

The Admission Minimum Data Set dated 3/29/25 indicated Resident #26 was cognitively intact.

An interview was conducted with Resident #26 on 4/15/25 at 4/11/25 and she indicated she was not offered or provided a copy of the summary of the baseline care plan.

An interview was conducted with the MDS Nurse #1 on 4/16/25 at 9:22 AM and she indicated that the baseline care plan was initiated on the day of admission by the admitting nurse and nursing staff are responsible for reviewing and providing a copy to the resident and/or the responsible party.

An interview was conducted with the Director of Nursing (DON) on 04/16/25 at 11:28 AM. The

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 04/17/2025

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 655	Continued From page 29 DON indicated that she had determined that nurses were not completing all sections of the baseline care plan and should have been reviewing the care plan and providing a copy of the summary to the resident and responsible party as appropriate with 48 hours of admission.	F 655		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and Responsible Party and staff interviews, the facility failed to complete a smoking assessment for 1 of 1 resident reviewed for smoking (Resident # 94). Findings included: Resident #94 was admitted to the facility on 2/5/25 which included nontraumatic intracerebral hemorrhage. A review of the smoking safety screen completed on 2/5/25 indicated Resident #94 was not a smoker. Review of Resident #94's admission Minimum Data Set (MDS) assessment dated 2/12/25 revealed the resident was severely cognitively impaired and was not coded for tobacco use.	F 689	F689-Free of Accident Hazards/Supervision/Devices " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #94 smoking assessment was updated on 4/15/25. The results of the assessment deemed the resident safe to smoke without supervision. Residents care plan was updated on 4/15/25 to include his smoking status. " Address how the facility will identify other residents having the potential to be	5/15/25

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 04/17/2025

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 689	Continued From page 30 Review of Resident #94's care plan revised on 2/18/25 revealed no care plan related to smoking. Review of Resident #94's medical record revealed the resident had not been assessed for safe smoking. An observation of Resident #94 was made on 04/15/25 2:21 PM. Resident #94 was observed smoking a cigarette in the facility's designated smoking area without staff present. There was no safety concern observed. An interview was conducted with the Responsible Party on 04/15/25 01:34 PM and he indicated that Resident #94 did not smoke upon admission but after he improved, he started to smoke again about three weeks after his admission. The Responsible Party had no concerns with Resident #94 smoking independently. An interview was conducted with Nurse #6 on 4/15/25 1:45 PM. Nurse #6 indicated that Resident # 94 was a smoker, and he was safe to smoke independently. Nurse #6 was not sure why there was not a smoking assessment on file. An interview was conducted with Unit Manager #1 on 4/15/25 1:50 PM. She indicated Resident #94 was an independent smoker and a smoking assessment was supposed to be completed by the admitting nurse. An interview was conducted with the Director of Nursing (DON) on 4/15/25 at 3:32 PM. She indicated that the admitting nurse was responsible for completing resident smoking assessments on admission and the charge nurse	F 689	affected by the same deficient practice; All residents who wish to smoke have the potential to be affected by this deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; All nurses will receive education related to smoking assessment and care plan process by 5/15/25. All new hired nurses will receive education during the orientation process. DON or designee will audit all current smokers to ensure a smoking assessment has been completed and their care plan includes smoking status. The audit will be completed by 5/12/25. All new admits will be questioned related to smoking preferences on the day of admission. If residents prefer to smoke, a smoking assessment will be completed on the day of admission and baseline care plan will reflect smoking status. DON or designee will audit all new admissions within 48 hours of admission to ensure that residents who prefer to smoke have a completed smoking assessment, and the baseline care plan reflects the smoking status. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and	

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 04/17/2025

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 689	Continued From page 31 was responsible for completing the smoking assessment when a resident started smoking after they were admitted. The DON further explained that she was not aware that Resident #94 did not have a smoking assessment, and it should have been completed by the charge nurse when he started smoking. An interview was conducted with the Administrator on 4/15/25 at 3:40 PM. He indicated that any residents who smoked should be assessed for safety and have a smoking care plan created.	F 689	The DON will report the finding of the 48-hour audits to the monthly Quality assurance/Performance Improvement committee for further recommendations as indicated. During the monthly QA meeting the committee will review the list of all residents who smoke. Compliance Date: 5/15/25	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		5/15/25

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 04/17/2025

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 690	Continued From page 32 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to secure an indwelling catheter tubing to prevent tension and/or trauma and to keep a urinary catheter bag and its tubing from touching the floor to reduce the risk of infection for 1 of 1 resident (Resident #153) reviewed. Findings included: Resident #153 was admitted to the facility on 04/10/25 and had diagnoses that included urinary retention. A Physician's Order dated 04/11/25 indicated Resident #153 required an indwelling urinary catheter for urinary retention. An admission nursing assessment dated 04/10/25 indicated Resident #153 was cognitively intact. A review of the Nurse Practitioner admission note dated 04/11/25 revealed Resident #153 had an indwelling urinary catheter in place for urinary	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #153 had catheter securement device placed and bag was properly positioned so that the foley bag did not touch the ground. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents with foley catheters are at risk for this deficient practice " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

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 04/17/2025

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 690	Continued From page 33 retention. During an observation of Resident #153 on 04/14/25 at 10:04 AM she was found to be in bed and her urinary catheter drainage bag was lying on the floor beside her bed. An observation was conducted on 04/17/25 at 10:08 AM of Nursing Assistant (NA) #2 performing catheter care on Resident #153. The indwelling catheter tubing was not secured to the resident's leg, and the tubing was noted on the floor bedside the bed. NA #2 attempted to secure the indwelling urinary tubing to the bed with clips, however she was unable to do so, and the tubing remained on the floor. During an interview at the end of the observation, NA #2 indicated she had informed Nurse #5, Resident #153 needed catheter to be secured on 04/16/25 and would inform Nurse 5 again. An interview was conducted on 04/17/25 at 10:48 AM with Nurse #5 and she indicated NA #2 had informed her on 04/16/25 about Resident #153 not having a secure strap. She stated, "I got busy and forgot." She indicated the drainage tubing should not be on the floor. The Director of Nursing was interviewed on 04/17/25 at11:39 AM, and she stated Resident #153's indwelling catheter drainage bag or the tubing should not have been on the floor and it should have had a device to keep the indwelling catheter tubing in place. During an interview with the Administrator on 04/17/25 at 04:43 PM he stated he expected staff to follow proper procedures to keep the indwelling catheter secured and the tubing off the floor. He	F 690	recur; By 5/20/25 the DON or designee educated all licensed nursing staff on placement of securement device for each resident with an indwelling foley catheter to ensure that the catheter is secured. Education also included documentation requirements and proper monitoring every shift of the securement device placement. All nursing staff were educated on infection control practices related to foley catheters and prevention of urinary tract infections. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Director of Nursing/designee will complete an audit of five resident□s catheters to ensure placement of the securement device and proper positioning of the foley bag off of the floor. This will be done 5x/week for 4 weeks then 3x/week for four weeks, then weekly x4 weeks. Results of the monitoring will be presented to the Quality Assurance Improvement Committee for review and recommendations. Once the QAPI committee determines there is substantial compliance the monitoring can be conducted randomly. Date of compliance: 5/15/25	

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 04/17/2025

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 690	Continued From page 34 further stated Resident #153's urinary catheter bag should not have been on the floor.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and Registered Dietitian interviews, the facility failed to administer tube feedings via a gastrostomy tube as ordered by the physician for 1 of 3 residents reviewed for tube feeding (Resident #36). The findings included:	F 693	F693 Tube Feeding Management/Restore Eating Skills " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The medical provider for resident number	5/15/25

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 04/17/2025

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 693	Continued From page 35 Resident #36 was admitted to the facility on 6/17/16 with diagnoses that included severe protein-calorie malnutrition, adult failure to thrive, and gastrostomy status. Resident #36's annual Minimum Data Set (MDS) dated 1/20/25 noted she had impaired cognition and did not have any behaviors or rejection of care. The MDS did not include she had a feeding tube and received all of her nutrition and hydration through the tube feedings. Resident #36's comprehensive care plan dated 11/17/22 noted she was dependent on tube feedings to meet her estimated nutrition and hydration needs with interventions including to provide tube feedings per order. A physician order dated 11/15/24 read Resident #36 was to receive the prescribed tube feeding formula continuously at 65 ml (milliters) per hour from 2:00 PM to 9:00 AM for a total of 19 hours via gastrostomy tube. An observation was made of Resident #36 on 4/16/25 at 4:06 PM. Resident #36 was asleep in bed. There was a feeding tube pump mounted to a pole beside Resident #36's bed. The pump was not turned on and the tubing connected to the pump was not connected to the resident's gastrostomy tube. There was a bottle of the prescribed tube feeding formula hanging from the pole which was dated 4/16/25 and timed 6:00 AM. According to the graduated lines on the tube feeding bag there were 900 ml of formula remaining in the bag. Resident #36's private attendant was not observed to be in the resident's room.	F 693	#93 was informed of the issue with the resident tube feeding. The enteral feeding was corrected and new bottle hung per order and policy. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents that receive their nutrition by enteral means are at risk to be affected by this deficient practice. On 5/9/25 the Director of Nursing completed a review of all enteral orders for residents with enteral feedings to assure that the orders were entered correctly and there is supplemental documentation added for recording of amount of feeding consumed at the end of each shift. " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Staff Development Coordinator educated all licensed nurses on F693 and its contents with the emphasis on the importance of ensuring that residents who receive their nutrition by enteral mean receive appropriate treatment as ordered by the physician. This education will be completed by 5/15/25. Education also included proper way to enter enteral orders to include the supplemental documentation to record amount of enteral feeding received in cc□s.	

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 04/17/2025

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 693	Continued From page 36 Nurse #2 was interviewed on 4/16/25 at 4:10 PM. She stated when she came to the facility that morning at approximately 7:30 AM, Resident #36's tube feeding was not running. She explained she hooked up the tube feeding to administer the prescribed tube feeding formula at 65 ml per hour at approximately 8:15 AM and disconnected it at 9:30 AM when the resident requested. She stated in the mid-afternoon (she was unable to remember the time), she hooked up Resident #36's prescribed tube feeding formula at 65 ml per hour until Resident #36 wanted to be taken outside by her private attendant. The nurse explained it was at that time she disconnected the tube feeding. Nurse #2 stated she was not sure when Resident #36 had returned from being outside. She said the resident had not been reconnected to the tube feeding since the resident came in from outside. She stated she had not observed that Resident #36 had any complications such as gastric reflux or too much residual (formula which remained undigested in the stomach) that would have necessitated holding the resident's tube feeding. She stated she was an agency nurse and that was her first time in the facility, and she was not aware of Resident #36's tube feeding orders. The Registered Dietitian (RD) was interviewed on 4/17/25 at 12:28 PM. She explained Resident #36's tube feeding order hours were set for the evening so Resident #36 was able to visit with her private attendant outside of her room throughout the day. The RD indicated Resident #36's private attendant had a history of turning off the resident's tube feeding when she felt Resident #36 had too much formula or when the resident wanted it off. She stated Resident #36 had been gaining weight over the last few months but not	F 693	" Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Director of Nursing or designee will observe the enteral feeding for all residents in the facility that receive enteral feedings. This will be done daily x 2/weeks, then 3x/week for 2 weeks, then weekly x4. Findings will be documented and reported to the monthly Quality Assurance Performance Improvement. Once the QAPI committee determines there is substantial compliance, the monitoring can be conducted randomly. Compliance Date: 05/15/25	

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 04/17/2025

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 693	Continued From page 37 significantly. The Registered Dietitian indicated Resident #36 needed her tube feeding to be administered as ordered to ensure the resident received the daily caloric intake she needed. She stated if there was 900 milliliters remaining in the formula bottle which was scheduled to start at 6:00 AM, it meant Resident #36 only received 100 ml of the 1,000 ml bag. The RD explained 100 ml of formula would have been 150 calories. The RD further stated Resident #36 should have received 325 ml since 6:00 AM (65 ml/hour from 6:00 AM through 9:00 AM and 65 ml/hour from 2:00 PM to 4:00 PM, a total of 5 hours at 65 ml/hour which would equate to a total 325 ml) and the resident would have received a total of 487.5 calories for that 5 hour period. In an interview on 4/17/25 at 4:01 PM, the Director of Nursing (DON) stated Nurse #2 should have ensured the tube feeding was running as ordered. She said Resident #36's private attendant had a history of turning off the feeding pump, but Nurse #2 should have started it. Attempts made to interview the resident's physician were unsuccessful.	F 693		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 698		6/1/25

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 04/17/2025

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 698	Continued From page 38 Based on record review, observation, and interviews with residents and staff, the facility failed to provide fluids in accordance with the physician ordered fluid restriction and failed to provide a bagged meal/snack on dialysis days for 2 of 3 residents reviewed for dialysis (Resident #41 and Resident #159). The findings included: 1. Resident #41 admitted to the facility on 1/03/23 with diagnoses including end-stage renal disease and dependence on dialysis. Resident #41's physician orders dated 8/15/24 noted he was on a 1200 milliliter (ml) fluid restriction per day due to end-stage renal disease. The order did not indicate how much fluid should be given from dietary with his meals and how much was to be provided by the nursing staff throughout the day. Resident #41's Minimum Data Set dated 1/7/25 indicated he was cognitively intact, had no behaviors, and was receiving dialysis care. Resident #41's comprehensive care plan updated 11/13/24 indicated he attended dialysis care three times a week with an intervention of a fluid restriction. Resident #41's dialysis laboratory result summary for March 2025 indicated his fluid weight gain had increased from the month prior and he needed to focus on taking in less fluids during the day. Observation and interview with Resident #41 on 4/14/25 at 12:50 PM revealed him in his room with a cup of water on his table. He indicated he	F 698	F698 Dialysis " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident number 159 was provided a snack/meal bag for each dialysis day starting 4/15/25 before leaving the facility for dialysis. Resident 159 and 41 received an order review by the Center NP on 5/9/25 and orders for fluid restrictions were discontinued. Current residents receiving fluid restrictions were audited and the designated amount of fluids to be delivered by nursing and dietary were added to the orders of the fluid restrictions. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The facility Discharge Planner interviewed interviewable dialysis residents and responsible parties of non-interviewable dialysis residents on 5/12/25 to determine if they were receiving a snack/meal bag before leaving the facility for dialysis. The Director of Nursing or designee completed an audit on 5/12/25 of all residents on fluid restrictions to ensure that the orders designated the amount of fluids to be delivered by nursing and	

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 04/17/2025

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 698	Continued From page 39	F 698		

had just finished lunch and had the cup of water already in his room.

Resident #41's fluid intake record from 3/17/25 to 4/14/25 noted he drank more than 1200 ml per day on 3/28/25, 4/07/25, 4/11/25, and 4/13/25.

In an interview on 4/17/25 at 9:53 AM Nurse Aide #1 was passing out water to residents on the 200 hall. She said Resident #41 was on a fluid restriction but the amount of fluids he had per day varied. She said sometimes he would drink between 450-600 ml in the morning because he liked coffee, had milk in his cereal, and would have a glass of juice. She said the nurse would tell her how many fluids to give him throughout the day due to his fluid restriction.

In an interview on 4/17/25 at10:08 AM, Nurse #3 said Resident #41 would be given 120 ml when she passed medications, and he would not drink all of that amount. She said he would drink 120 ml at breakfast, but didn't drink much throughout the day. Nurse #2 said she thought the dietitian liberalized his diet and had allowed for more fluids during the day. She said the physician's orders would detail how much fluid Resident #41 should receive from dietary with meals and how much the nursing staff should provide. She looked at the orders during the interview and said the order did not specify the amount of fluids to be given by the different departments.

In an interview on 4/17/25 at 12:28 PM, the consultant Registered Dietitian (RD) said the dietary meal tracking system calculated how many fluids would be given by dietary with meals. She said he would get 840 ml per day with his meals, leaving 360 ml to be given by the nursing dietary etc.

" Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

The Facility Administrator educated 100% of the dietary staff that dietary must provide each dialysis resident with a snack/meal bag before the resident leaves the facility for dialysis. Place the meal bag in the refrigerator on the appropriate unit the night before scheduled dialysis. Dietary will inform the nursing staff that meal bags have been provided. Nursing is to provide a list of residents and their schedule for dialysis to dietary and must update the list with changes in schedule or new dialysis residents. Education was completed on 5/12/25.

Current licensed nurses received education regarding how to separate fluid restrictions between nursing and dietary staff and to include the designated amounts with the order for fluid restriction.

Staff will not be permitted to work until education is complete.
New hires will be educated on topic during education. The administrator will verify education completion.

The Director of nursing and/or the staff development coordinator educated the 100% nursing staff and center service ambassadors to ensure that each resident

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 04/17/2025

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 698	Continued From page 40 staff. She did not know if the nursing staff knew how many fluids to give him. In an interview on 4/17/25 at 4:01 PM, the Director of Nurses (DON) said she was not aware that the nursing staff did not know how the fluid restriction breakdowns were done for Resident #41. She said Resident #41 was noncompliant with his fluid restriction and would drink what he wanted throughout the day and would ask staff for fluids which they would give him because he was noncompliant. In an interview on 4/17/25 at 5:17 PM, the Administrator said the dietary department and the nursing department would need to coordinate how the fluid restriction amounts would be divided. 2. Resident #159 admitted to the facility on 4/11/25 with diagnoses including end-stage renal disease and dependence on dialysis. Review of physician orders dated 4/11/25 revealed Resident #159 was on a renal diet. A review of Resident #159's nursing admission assessment dated 4/11/25 indicated Resident was cognitively intact. Reviewed baseline care plan dated 4/12/25 and it revealed Resident #159 received dialysis three times a week. A review of Resident 159's physician orders revealed an order dated 4/13/25 for Dialysis three times weekly Monday, Wednesday and Friday. During an interview with Resident #159 on	F 698	receives a snack/meal bag before leaving for dialysis. Provide dietary with an updated list of dialysis residents. The weekend supervisor will ensure that a snack/meal bag is sent with each dialysis resident on the weekends. The licensed nurse will document that snack/meal bag was provided. Education will be completed by ___5/20/25. Staff will not be permitted to work until education is complete. New hires will be educated on topic during orientation. The Staff development coordinator will verify completion of education. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The unit manager will audit and ensure that each dialysis resident was provided a snack/meal bag before leaving the facility for dialysis. Audit will be completed 5xper week for 4 weeks; 3xper week for 4 weeks; 1xper week for 4 weeks. The Director of nursing or designee will audit all orders for fluid restrictions to ensure that the designated fluid amounts have been scheduled between disciplines. This will occur 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks. The Director of Nursing will report the	

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 04/17/2025

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 698	Continued From page 41 4/16/25 at 09:12 AM Resident indicated he did not receive any food or lunch when going to dialysis. The resident stated, he "be hungry a little, can't eat while on machine but can eat before getting on or when get off." Resident #159 indicated he would like to have something to eat when he went to dialysis. Resident #159 stated he had not reported the lack of a lunch meal on dialysis days to anyone at the facility. An interview was conducted 4/16/25 at 09:17 AM with the Dietary Manager and he indicated generic food bags were placed in the refrigerator and the receptionist would retrieve the food bags for dialysis residents prior to them leaving for dialysis. He indicated they had a list of dialysis residents and presented the list, however Resident #159's name was not on the list. On 4/16/25 at 09:20 AM an interview was conducted with Nurse # 7, and she indicated staff would take dialysis residents to the front lobby for pickup and they would get a bag of food to take with them from the receptionist. Nurse #7 indicated if the food bag was not at the reception desk staff would go to the kitchen and get one for the resident. She stated, "this is my first day working this week and I haven't met him (Resident #159) yet." An interview was conducted on 4/16/25 at 09:26 AM with the Assistant Business Office Manager, and she indicated the regular receptionist was on vacation this week. She indicated she was aware of the dialysis residents from the dialysis listed and she would get a bag of food from the kitchen to take with them to dialysis. She stated, "I'm not sure who he is (Resident #159), he is not on the list." Assistant Business Office Manager indicated	F 698	results of the audits to the monthly Quality Assurance Performance committee for suggestions and/or recommendations until substantial compliance is obtained and maintained. Compliance Date: ___6/01/2025_____	

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 04/17/2025

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 698	Continued From page 42 she did not recall giving Resident #159 a food bag before going to dialysis on Monday. On 4/16/24 at 09:27 AM, an observation of the dialysis list was presented by the Assistant Business office Manager, and Resident #159 was not on the list. During an interview on 4/16/25 at 09:28 AM with the Director of Nursing (DON) she indicated Resident #159 should have been given a snack to take with him to dialysis and she would make sure he had one now. The DON stated she was not sure what happened. An interview with the Administrator was conducted on 4/17/25 at 04:38 PM and he indicated there should be a procedure in place for any new residents that were admitted to the facility for reports to be updated and communicated to the kitchen that were on dialysis and for dietary to have accurate information about diets, and appropriate information needed to be documented for resident needs.	F 698		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 5 medication errors out of 25	F 759	F759 Free of Medication error rate 5% or More	6/1/25

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 04/17/2025

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 759	Continued From page 43 opportunities, resulting in a medication error rate of 20% for 1 of 5 residents (Resident #36) observed during the medication administration observation. The findings included: Resident #36 was admitted to the facility on 11/11/24. Her cumulative diagnoses included dysphagia (difficulty swallowing) and the presence of a percutaneous endoscopic gastrostomy (PEG) tube. A PEG tube is a feeding tube inserted through the skin and the stomach wall to provide nutrition and a route for medication administration. A review of Resident #36's current physician orders included the following, in part: ---Flush the PEG-tube with 20 - 30 milliliters (ml) of water before and after administration of medication pass (Order Date 11/11/24); ---Flush the PEG-tube with 30 ml of water before and after each medication (Order Date 11/11/24). On 4/16/25 at 8:15 AM, Nurse #2 was observed as she began to prepare medications for administration to Resident #36 via a PEG-tube. The medications included, in part: one - 100 micrograms (mcg) levothyroxine tablet (a thyroid medication); two - 8.6 milligrams (mg)/50 mg sennosides/docusate tablets (a combination stimulant laxative and stool softener); one - 100 mg lamotrigine tablet (an antiseizure medication); one - 10 mg midodrine tablet (a medication used to treat low blood pressure); and one - 5 mg metoclopramide tablet (a gastrointestinal or GI medication which may be used to treat nausea). All 5 medications (6 tablets) were placed into one small medication cup. On 4/16/25 at 8:21 AM,	F 759	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #36 orders were reviewed by the Director of Nursing and Nurse Practitioner on 5/9/25. The Nurse practitioner was made aware of the medications being administered together during medication pass to ensure there were no contraindications or negative effects to cause harm to resident #36. During order review a new order was obtained to administer medications together and flush with 30cc of water before and after medication administration. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The facility completed a 100% audit of all residents receiving medications via gastrostomy tube to ensure that any resident receiving multiple medications via enteral tube did not receive these medications administered together and that the orders reflected correctly the route of administration. " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Director of Nursing and Staff Development Coordinator provided education to all licensed nurses on administration of medications to residents	

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 04/17/2025

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 759	Continued From page 44 Nurse #2 was observed as she transferred all the tablets into a single plastic sleeve, crushed the tablets together, and then poured the contents of the plastic sleeve back into one medication cup. Nurse #2 was observed on 4/16/25 at 8:25 AM as she brought the medications for administration into Resident #36's room. After the nurse connected a syringe to the resident's PEG-tube, she flushed the tube with 20 - 30 milliliters (ml) of water prior to initiating the medication administration. The crushed tablets were observed to be mixed with approximately 30 ml of water in a cup and the solution was poured into the syringe connected to Resident #36's PEG-tube. The nurse added an additional 15 ml of water into the cup to dissolve the remaining solids from the crushed tablets, then poured this solution into the syringe and PEG-tubing. Nurse #2 completed the medication administration by flushing the resident's PEG-tube with 20 - 30 ml of water. An interview was conducted with Nurse #2 on 4/16/25 at 12:30 PM. Nurse #2 reported she was an agency nurse (a temporary employee) who was assigned to care for Resident #36. During the interview, concerns regarding the resident's medications (tablets) being crushed and administered together via the PEG-tube were discussed. Resident #36's physician orders instructing the PEG-tube to be flushed with water before and after each individual medication's administration were also discussed. At that time, Nurse #2 reviewed the resident's current physician orders. She acknowledged there were no physician orders that allowed Resident #36's tablets to be crushed and administered together via her PEG-tube. The nurse reported she was	F 759	with enteral tube. Education included: " Giving each medication individually via enteral tube " Flushing enteral tube before and after administering all medications. " Consultation of the Medication Crushing Guidelines regarding which medication should not be crushed. " Procedure for safe and effective administration of enteral formulas and medications. Any nurse that did not receive the initial education will receive the education prior to the next scheduled shift and this education will become a part of the new hire orientation for licenses nurses. All nurses will receive a skill competency review to assure that they are correctly administering medications via enteral tube. This education and skilled competency will be completed by 6/1/25 by the Director of Nursing and Staff Development Coordinator. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Director of Nursing or Unit Manager will audit medication administration for two residents 2 times weekly for 4 weeks then 2 residents weekly for 4 weeks to ensure all medication orders and administration procedures are followed. This will include observations of each shift including	

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 04/17/2025

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 759	Continued From page 45 not aware the medications should be administered individually, with water flushes used before and after each medication. An interview was conducted on 4/16/25 at 3:19 PM with the facility's Director of Nursing (DON). During the interview, the DON stated she would expect "that the orders are followed" for all medications administered to a resident.	F 759	weekends. DON will report the findings of audits to the monthly Quality assurance/Performance improvement committee for recommendations as indicated. Compliance Date: 06/01/25	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.	F 803		5/15/25

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 04/17/2025

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 803	Continued From page 46 This REQUIREMENT is not met as evidenced by: Based on a lunch meal tray line observation, staff interviews and record review the facility failed to follow the approved menu when pureed bread was not served to 11 of 11 residents on a pureed diet, salisbury steak was not served to 3 of 3 residents on a renal diet and 15 of 15 residents on a heart healthy diet, and the recipe for beef stroganoff was not followed for 55 residents receiving a regular and mechanical soft texture diet (200 Hall). The findings included: Review of the resident diet order report dated 4/16/25 documented 11 residents had orders for a pureed diet, 3 residents had orders for a renal diet, and 15 residents had orders for a heart healthy diet. The order report documented 55 residents received a regular or mechanical soft textured diet on the 200 Hall. Review of the facility's dietitian approved menu for 4/16/25 revealed the meal was beef stroganoff (beef in a cream sauce), buttered egg noodles, green peas, and a dinner roll. Residents on a heart healthy (lower fat) and renal (for residents with kidney disease) diet were to receive 3 ounces of salisbury steak instead of the beef stroganoff. Residents on a pureed diet were to receive pureed beef stroganoff, pureed noodles, pureed peas, and one #30 (standard size 1.22 ounce) scoop of pureed bread in place of the regular dinner roll. Continuous observation of the lunch meal on 4/16/25 from 12:05 PM to 1:27 PM revealed the Dietary Manager (DM) served beef stroganoff to	F 803	F803 Menus meet Resident Needs/Prep in Advance/Followed 1. Action Taken: All production staff were educated on following recipes and following diet spreadsheets 2. All residents have the potential to be affected 3. The manager and RDO conducted a review of the diet spreads and menu with the production staff and will continue this process through the huddle process to review the therapeutic and altered consistency spreadsheets and recipes with the production staff 4. As a systemic change the Manager or Designee will audit 10 meal trays to ensure correct food items, preferences (Including adaptive equipment) and serving sizes are being served 5 days/wk x 30 d 5. Manager or Designee will ensure recipes located in the recipe binders and spreadsheets are within close proximity to the cooks. Cooks will review and utilize all recipes and spreadsheets for meals to ensure accuracy. 6. The Manager or designee audit will be compiled monthly with findings reported to the QAPI committee for review	

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 04/17/2025

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 803	Continued From page 47 all residents on a regular, mechanical soft, and a puree diet. Residents on a pureed diet received pureed beef stroganoff, pureed noodles, and pureed peas as their entrée. There was no pureed bread served to residents on a pureed diet in place of the dinner roll served to residents on a regular diet and no pureed bread on the serving line. Residents on a heart healthy diet and a renal diet were served egg noodles, beef stroganoff, peas, and a dinner roll. There was no salisbury steak on the serving line. An observation on 4/16/25 at 12:32 PM revealed the DM went to the stove, took a large saucepan off the stove, and poured additional cream sauce onto the beef. The DM did not add more beef to the pan, just the sauce. Service continued with resident trays being put into the first cart for the 200 Hall. In an interview on 4/16/25 at 12:54 PM, the DM said all residents received the beef stroganoff, including residents on a renal diet and a heart healthy diet. He said the menu was the same as the regular diet, so they received the same meal. He said he did not serve a puree option in place of the regular dinner roll. He said he normally would puree the bread but he forgot that day and no other bread was served to residents on a puree diet. He said the extended menu with the detailed diet listing was kept in a drawer in his filing cabinet and not within easy reach to consult when needed. In an interview on 4/17/25 at 11:45 AM, the DM reviewed the menu and said he did not realize residents on a renal diet and a heart healthy diet should have received the salisbury steak instead of the beef stroganoff. He said he added	F 803	Compliance Date: 05/15/25	

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 04/17/2025

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 803	Continued From page 48 approximately 5 cups of sauce to the beef stroganoff. He said the beef had absorbed a lot of the sauce, and he was adding extra to make sure the meat did not dry out. He said he did not use the recipe to make the sauce and did not think adding more sauce would change the composition of the beef in cream sauce. In an interview on 4/17/25 at 12:28 PM, the Registered Dietitian said the beef stroganoff would have more fat because of the cream sauce that was added. She said the menus should have been followed so residents would get the nutrition they needed.	F 803		
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced	F 809		5/15/25

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 04/17/2025

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 809	Continued From page 49 by: Based on observations, resident and staff interviews, the facility failed to provide snacks when requested for 4 of 4 residents reviewed for resident council and 1 of 1 resident who reported feeling hungry between meals (Resident #17, Resident #32, Resident #84, Resident #52, and Resident #90). The findings included: a. Resident #17 was admitted to the facility on 09/27/23. Review of the annual Minimum Data Set (MDS) dated 1/06/25 revealed that Resident #17 was cognitively intact for daily decision making and was independent with eating. b. Resident #32 was readmitted to the facility on 7/02/21. Review of the annual Minimum Data Set (MDS) dated 3/24/25 revealed that Resident #32 was cognitively intact for daily decision making and was independent with eating. c. Resident #84 was admitted to the facility on 08/29/24. Review of the significant change Minimum Data Set (MDS) dated 2/18/25 revealed that Resident #84 was cognitively intact for daily decision making and was independent with eating. d. Resident #52 was readmitted to the facility on 9/23/22. Review of the quarterly Minimum Data Set (MDS)	F 809	F809 Frequency of Meals/Snacks 1. Action Taken: Manager and RDO reviewed the snack availability in all nourishment areas □ all areas had snacks available 2. All residents have the potential to be affected 3. Manager or designee will ensure snacks are stocked twice daily in unit pantries 4. Manager or designee will conduct daily audits, 5 days per week over 30 d to ensure snack availability 5. As a systemic change the manager or designee will conduct an all community food/snack preference audit 6. The manager or designee will attend Resident Council meetings as invited by the Resident Council President to discuss resident food concerns 7. The manager or designee audits will be compiled monthly with findings reported to the QAPI committee for review Date of compliance: 5/15/2025	

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 04/17/2025

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 809	Continued From page 50	F 809		

dated 3/22/25 revealed that Resident #30 was moderately cognitively impaired for daily decision making and required set up assistance with eating.

e. Resident #90 was readmitted to the facility on 1/01/25.

Review of the significant change Minimum Data Set (MDS) dated 1/27/25 revealed that Resident #90 was cognitively intact for daily decision making and was independent with eating.

In an interview on 4/14/25 at 10:12 AM, Residents #84 and #90 said they did not get any snacks throughout the day. They said when they would get hungry, they would ask the staff, who would tell them there were no snacks and that they were busy and could not go to dietary to get snacks. The residents said they would go themselves to the kitchen to request snacks but were also told by dietary there were no snacks. The residents reported that snacks were put into each unit's nourishment room, which had a cabinet that used to be full of snacks. They said the kitchen staff would bring 1-2 trays full of variety of sandwiches and cookies that would be put in the unit fridge, but snacks were no longer always available between meals. The residents said they had met with the Dietary Manager several times and he knows and his response is corporate tells the kitchen manager what food can be ordered/ served so he has tried to do what he could to help but not able to resolve the concern.

Interviews conducted during a Resident Council meeting on 4/16/25 at 1:00 PM with four residents, Residents # 17, # 32, #84, and #52, revealed residents voiced concerns about snacks

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 04/17/2025

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 809	Continued From page 51	F 809		

not being available throughout the day. Residents reported they were told by nursing staff (Nurse Aides and Nurses) they did not have snacks available. The residents stated they were hungry throughout the day and would have to go to the dietary department to request snacks, which they said were sometimes not available.

The Resident Council Minutes noted concerns that snacks were not available at the meetings on 3/27/25, 12/16/24, and 10/21/24.

In an observation on 4/16/25 at 3:04 PM, the nourishment room on the 200 hall did not have any snacks in the snack cabinet.

In an interview with Nurse Aide (NA) #3, who was present during the observation, said the dietary department would send evening snacks in the late afternoon, but snacks were not consistently brought to the unit during the day. If a resident requested a snack, the resident or the staff would have to go to the kitchen. She said at times when staff was busy, the resident would go to the kitchen themselves.

An observation on 4/16/25 at 3:17 PM of the 100 Hall nourishment room-revealed there was a bag of bread with three slices in it and a bottle of mustard in the snack cabinet.

In an interview with NA #4, who was present during the observation, she said the dietary department would bring snacks for the evening, such as cookies and sandwiches. She said there would be gelatin and pudding snacks in the refrigerator during the day. She looked in the refrigerator and identified one snack container of mandarin oranges but no pudding or gelatin. She

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 04/17/2025

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 809	Continued From page 52	F 809		

said families would mostly bring in snacks for the residents on the unit, so residents had snacks they liked.

In an interview on 4/17/25 at 8:31 AM, the Dietary Manager (DM) indicated that he has been the DM at the facility for about 8 months. He shared that he had been made aware verbally by the residents and the Activity Director of dietary concerns from the resident council members and had attended 3 resident council meetings, the last meeting he attended was in March. Residents expressed concern that there were not enough snacks, soups, and sandwiches available and that they were hungry between meals. He explained that the contracted dietary company determined the budget and provided him with an order guide that did not include snacks. He said he attempted to address their concerns by ordering additional turkey and ham for sandwiches but it was still not enough for the residents to not feel hungry.

In an interview on 4/17/25 at 5:17 PM, the Administrator said he knew that the residents had concerns about snacks and said snacks should be available for the residents. He said he knew the DM was working with the contracted dietary company to supply snacks for the residents, but was not aware there were no snacks in the nourishment rooms.