

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 000	Initial Comments  The Adult Care Licensure Section conducted an Annual Survey on September 8, 2015.	C 000		
C 154	<p>10A NCAC 13G .0501 (b) Personal Care Training And Competency</p> <p>10A NCAC 13G .0501 Personal Care Training And Competency</p> <p>(b) The facility shall assure that staff who perform or directly supervise staff who perform personal care tasks listed in Paragraph (i) of this Rule in facilities with heavy care residents successfully complete an 80-hour training program, including competency evaluation, approved by the Department according to Rule .0502 of this Section and comparable to the State-approved Nurse Aide I training.</p> <p>This Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to assure 1 of 3 Staff (Staff C) received the 80/25 hour personal care training and competency.</p> <p>The findings are:</p> <p>Review of Staff C's personnel file revealed: -Staff C was hired on 9/2/98 and worked as a weekend Supervisor-in- Charge (SIC) and Medication Aide (MA). -There was no documentation of completion of personal care training and competency.</p> <p>Telephone interview on 9/9/15 at 4:30 pm with Staff C revealed: -He had worked at the facility for 20 years.</p>	C 154		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 154	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>-He worked as a live-in Medication Aide (MA) and Supervisor in Charge (SIC) on the weekends.</li> <li>-His duties included providing personal care to some of the residents which included assisting with bathing, grooming, and shaving.</li> <li>-He completed a two day class several years ago and thought that was personal care training.</li> <li>-He was not a certified nursing assistant.</li> <li>-He completed a skills check list in nursing school and assumed that it covered the same material as the personal care training.</li> </ul> <p>Telephone interview on 9/9/15 at 12:10 am with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-She was unaware there was no documentation of completion of personal care training and competency for Staff C.</li> <li>-Staff C will be scheduled for personal care training and competency class.</li> <li>-The live-in SIC who worked weekdays would check all staff records to assure all required training and education were completed.</li> </ul>	C 154		
C 187	<p>10A NCAC 13G .0601 (b)(2) Management And Other Staff</p> <p>10A NCAC 13G .0601 Management And Other Staff</p> <p>(b) At all times there shall be one administrator or supervisor-in-charge who is directly responsible for assuring that all required duties are carried out in the home and for assuring that at no time is a resident left alone in the home without a staff member. Except for the provisions cited in Paragraph (c) of this Rule regarding the occasional absence of the administrator or supervisor-in-charge, one of the following arrangements shall be used:</p>	C 187		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 187	<p>Continued From page 2</p> <p>(2) The administrator shall employ a supervisor-in-charge to live in the home or reside within 500 feet of the home with a means of two-way telecommunication with the home at all times. When the supervisor-in-charge does not live in the licensed home, there shall be at least one staff member who lives in the home or one on each shift and the supervisor-in-charge shall be directly responsible for assuring that all required duties are carried out in the home; or</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to assure that at no time was a resident left alone in the home without a staff member present for 3 of 3 residents (Resident #1, #2, and #3).</p> <p>The findings are:</p> <p>A. Review of Resident #1's current FL2 dated 3/24/15 revealed: -Diagnoses included mild mental retardation, psychosis, impulse control disorder, hypertension, asthma and seizures. -Documentation of orientation was intermittent. -Functional limitations were documented as sight glasses. -Documentation of behaviors were verbal abuse, injury to self, injury to others, and injury to property.</p> <p>Observation on 9/8/15 at 1:45 pm revealed Resident #1 was found unsupervised sitting on</p>	C 187		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 187	<p>Continued From page 3</p> <p>the front porch of the facility until the Supervisor-in-Charge (SIC) returned at 2:55 pm.</p> <p>Observation on 9/8/15 at 1:45 pm revealed Resident #1 was neatly dressed in shorts, shirt, sock, and tennis shoes, sitting in a chair on the front porch of the facility.</p> <p>Inteview on 9/8/15 at 1:45 pm with Resident #1 revealed: -He had returned from a doctor's appointment and had rode the county transit bus back to the facility. -He had left the facility on 9/8/15 at 7:30 am and had gotten off the bus at 1:15 pm. -The SIC had been late a few times and he would sit on the porch and wait for her to return to the facility. -The SIC was enrolled in school and would be at the facility at 2:30 pm.</p> <p>Review of Resident #1's Care Plan dated 3/24/15 revealed the resident required supervision for eating, dressing and personal hygiene and assessed as independent in ambulation and transfers.</p> <p>Attempted telephone interviews with Resident #1's guardian on 9/8/15 and 9/9/15 was unsuccessful.</p> <p>B. Review of Resident #2's current FL2 dated 7/23/15 revealed: -Diagnoses included sepsis, diabetes type II, schizophrenia, mental retardation and depression. -Documentation of mental status as intermittently. -Documentation of activities of daily living with supervision.</p>	C 187		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 187	<p>Continued From page 4</p> <p>Observation on 9/8/15 at 2:30 pm revealed Resident #2 was found unsupervised at the facility until the Supervisor in Charge (SIC) returned at 2:55 pm.</p> <p>Observation on 9/8/15 at 2:30 pm revealed Resident #2 had gotten off the county transit bus at the stop sign located directly beside the facility and walked to the facility front porch and sat in one of the chairs.</p> <p>Interview on 9/8/15 at 2:30 pm with Resident #2 revealed: -He attended a day program and had just returned to the facility via the transit bus. -The SIC was in class and she should be back around 2:30 pm. -The SIC had been late returning to the the facility 2 or 3 times in the past. -He always waited for her on the front porch.</p> <p>Review of Resident #2's Resident Register revealed he was his own guardian.</p> <p>C. Review of Resident #3's current FL2 dated 4/29/15 revealed: -Diagnoses included schizophrenia, depression and nicotine dependent. -No information documented for orientation, inappropriate behaviors or functional limitations.</p> <p>Observation on 9/8/15 at 2:20 pm revealed Resident #3 was found unsupervised at the facility until the Supervisor-in-Charge (SIC) returned at 2:55 pm.</p> <p>Observation on 9/8/15 at 2:20 pm revealed Resident #3 had arrived at the facility via walking, walked to the back door of the facility and tried to open the door, he then proceeded to walk around</p>	C 187		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 187	<p>Continued From page 5</p> <p>the facility to the front porch and sat in one of the chairs.</p> <p>Interview on 9/8/15 at 2:20 pm with Resident #3 revealed:                      -He had lived at the facility for 4 months.                      -He signed out on the facility log book on 9/8/15 around 7:10 am.                      -He denied attending a day program, and said he walked all day around town.                      -He ate lunch at the "kitchen" located downtown, and it's free.                      -The SIC attended class and usually returned around 2:30 pm, but she had been late 2 or 3 times.                      -He waited on the porch on the days the SIC was late until he could get into the facility.</p> <p>Interview on 9/9/15 at 11:10 am with Resident #3's guardian revealed:                      -He was aware Resident #3 walked daily around town everyday.                      -Resident #3 was to sign out daily when he left the facility to walk.                      -Resident #3 was safe to walk around town by himself.                      -Resident #3 had came by his office every Friday to pick up his check.                      -He was aware Resident #3 ate lunch at the "kitchen" downtown.                      -He was not aware Resident #3 was found unsupervised at the facility on 9/8/15.                      -Resident #3 was safe to stay by himself on 9/8/15 from 2:20 pm till 2:55 pm until the SIC returned to the facility.</p> <p>Observation on 9/8/15 at 1:45 pm revealed the facility front porch was covered with a roof and multiple chairs were placed on it.</p>	C 187		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 187	<p>Continued From page 6</p> <p>Review of the local television weather forecast for 9/8/15 revealed at 12:00 pm the high was 86 degrees with partly cloudy sky.</p> <p>Interview on 9/8/15 at 2:55 pm with the SIC revealed:</p> <ul style="list-style-type: none"> <li>-She was employed as the live-in SIC on Mondays through Fridays.</li> <li>-She was enrolled in a community college and attended classes Mondays through Thursdays.</li> <li>-She left the facility at 9:00 am and returned to the facility at 2:00 pm on those days.</li> <li>-Four of the five residents attended a day program and left the facility at 8:30 am and returned at 3:00 or 4:00 pm every day.</li> <li>-All the residents rode the county transit bus.</li> <li>-One resident signed out every morning and went walking around town daily.</li> <li>-There had been a wreck on the highway and that was the reason she was not at the facility at 2:00 pm on 9/8/15.</li> <li>-On 9/8/15 was the first time she had arrived late at the facility, "The residents know to wait on the front porch."</li> <li>-She had not contacted the Administrator on 9/8/15 when she had arrived late to the facility.</li> </ul> <p>Interview on 9/8/15 at 4:20 pm with the Adminstrator revealed;</p> <ul style="list-style-type: none"> <li>-She was aware four of the five residents in the facility attended a day program.</li> <li>-She was aware the SIC attended class Mondays through Thursday from 9:00 am to 2:00 pm.</li> <li>-She was aware no staff were present at the facility from 9:00 am to 2:30 pm.</li> <li>-The day program staff were to call her or the SIC if they released the residents early.</li> <li>-She was "Very Shocked" to hear the residents were found unsupervised on 9/8/15 from 1:45 pm to 2:55 pm.</li> </ul>	C 187		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 187	<p>Continued From page 7</p> <ul style="list-style-type: none"> <li>-The SIC was to call her if she was to be late and could not make it to the facility by 2:30 pm.</li> <li>-The SIC had not called her on 9/8/15.</li> </ul> <hr/> <p>The Administrator submitted a Plan of Protection on 9/8/15 as follows:</p> <ul style="list-style-type: none"> <li>-Immediately the SIC and the Administrator will assure all residents are safe and accounted for.</li> <li>-The SIC or the Administrator will be available 24/7 to meet the residents' needs.</li> <li>-The SIC will have a back person (another SIC) if she is going to be late returning to the facility and they will be available 24/7.</li> <li>-The SIC will assure the public transportation and the day programs have the phone numbers for her as well as the Administrator.</li> <li>-The SIC will schedule all appointments and meetings for the residents on Fridays when she is at the facility all day.</li> </ul> <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED October 9, 2015 .</p>	C 187		
C 243	<p>10A NCAC 13G .0901(b) Personal Care and Supervision</p> <p>10A NCAC 13G .0901 Personal Care And Supervision</p> <p>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 3 residents (Resident #1, #2, and #3) who</p>	C 243		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 243	<p>Continued From page 8</p> <p>were left unsupervised on 9/8/15 at the facility, waiting for staff to return to the facility.</p> <p>The findings are:</p> <p>A. Review of Resident #1's current FL2 dated 3/24/15 revealed:</p> <ul style="list-style-type: none"> <li>-Diagnoses included mild mental retardation, psychosis, impulse control disorder, hypertension, asthma and seizures.</li> <li>-Documentation of orientation was intermittent.</li> <li>-Functional limitations were documented as sight glasses.</li> <li>-Documentation of behaviors were verbal abuse, injury to self, injury to others, and injury to property.</li> </ul> <p>Observation on 9/8/15 at 1:45 pm revealed Resident #1 was found unsupervised sitting on the front porch of the facility until the Supervisor in Charge (SIC) returned at 2:55 pm.</p> <p>Observation on 9/8/15 at 1:45 pm revealed Resident #1 was neatly dressed in shorts, shirt, sock, and tennis shoes, sitting in a chair on the front porch of the facility.</p> <p>Inteviu on 9/8/15 at 1:45 pm with Resident #1 revealed:</p> <ul style="list-style-type: none"> <li>-He had returned from a doctor's appointment and had rode the county transit bus back to the facility.</li> <li>-He had left the facility on 9/8/15 at 7:30 am and had gotten off the bus at 1:15 pm.</li> <li>-The SIC had prepared a bag lunch for him to take with him 9/8/15.</li> <li>-The SIC had been late a few times and he would sit on the porch and wait for her to return to the facility.</li> </ul>	C 243		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 243	<p>Continued From page 9</p> <p>Review of Resident #1's Care Plan dated 3/24/15 revealed resident required supervision for eating, dressing and personal hygiene and assessed as independent in ambulation and transfers.</p> <p>Attempted telephone interview with Resident #1's guardian on 9/8/15 and 9/9/15 was unsuccessful.</p> <p>Attempted telephone interview with Resident #1's physican on 9/9/15 was unsuccessful.</p> <p>B. Review of Resident #2's current FL2 dated 7/23/15 revealed: -Diagnoses included sepsis, diabetes type II, schizophrenia, mental retardation and depression. -Documentation of mental status as intermittently. -Documentation of activities of daily living with supervision.</p> <p>Observation on 9/8/15 at 2:30 pm revealed Resident #2 was found unsupervised at the facility until the SIC returned at 2:55 pm.</p> <p>Observation on 9/8/15 at 2:30 pm revealed Resident #2 had gotten off the county transit bus at the stop sign located directly beside the facility and walked to the facility front porch and sat in one of the chairs.</p> <p>Interview on 9/8/15 at 2:30 pm with Resident #2 revealed: -He attended a day program and had just returned to the facility via the transit bus. -The SIC prepared a bag lunch daily for him to eat at the day program. -The SIC had been late returning to the the facility 2 or 3 times in the past. -He always waited for her on the front porch.</p>	C 243		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 243	<p>Continued From page 10</p> <p>Review on 9/9/15 of Resident #2's care plan dated 4/8/15 revealed:</p> <ul style="list-style-type: none"> <li>-Documentation Resident #3 required supervision for eating, dressing and personal hygiene.</li> <li>-Documentation of mental and social history was "wandering" as well as mental illness.</li> </ul> <p>Interview on 9/9/15 at 11:30 am with the SIC revealed:</p> <ul style="list-style-type: none"> <li>-She was aware three weeks ago that Resident #2's day program had been decreased to three days weekly.</li> <li>-Resident #2 had not attended the day program on Thursdays and Fridays.</li> <li>-Resident #2 was to take the county transit bus bus to the Administrator home on Thursdays.</li> <li>-She was in the facility all day on Fridays.</li> <li>-She contacted the day program on 9/9/15 and had learned Resident #2's hours had been decreased as of 9/8/15.</li> <li>-She was not aware Resident #2's day program hours had been decreased to 5 hours daily 9:30 am to 2:30 pm until 9/9/15.</li> <li>-She relied on the staff at the day program to contact her if any changes were made to the resident's schedule.</li> </ul> <p>Review of Resident #2's Resident Register revealed he was his own guardian.</p> <p>Attempted telephone interview with Resident #2's mental health provider on 9/9/15 at 11:45 am was unsuccessful.</p> <p>C. Review of Resident #3's current FL2 dated 4/29/15 revealed:</p> <ul style="list-style-type: none"> <li>-Diagnoses included schizophrenia, depression and nicotine dependent.</li> <li>-No information documented for orientation, inappropriate behaviors or functional limitations.</li> </ul>	C 243		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 243	<p>Continued From page 11</p> <p>Observation on 9/8/15 at 2:20 pm revealed Resident #3 was found unsupervised at the facility until the SIC returned at 2:55 pm.</p> <p>Observation on 9/8/15 at 2:20 pm revealed Resident #3 had arrived at the facility via walking, walked to the back door of the facility and tried to open the door, he then proceeded to walk around the facility to the front porch and sat in one of the chairs.</p> <p>Interview on 9/8/15 at 2:20 pm with Resident #3 revealed:                      -He had lived at the facility for 4 months.                      -He signed out on the facility log book on 9/8/15 around 7:10 am.                      -He denied attending a day program, and said he walked all day around town.                      -He ate lunch at the "Kitchen" located downtown, and it's free.                      -He liked the food at the Kitchen, but might eat at the facility if staff was there.                      -The SIC usually returned around 2:30 pm, but she had been late 2 or 3 times.                      -He waited on the porch on the days the SIC was late until he could get into the facility.</p> <p>Review on 9/9/15 of the facility sign out log revealed Resident #3 had signed out of the facility daily for walks in the past two months.</p> <p>Review of Resident #3's record revealed:                      -He was treated in the emergency room (ER) for a dog bit on 5/16/15.                      -Resident #3 was given a tetanus shot, the wound was cleaned, and he was placed on Augmentin (an antibiotic used to treat bacterial infections) 875mg daily for 20 days.                      -He returned to the facility on 5/16/15.</p>	C 243		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 243	<p>Continued From page 12</p> <p>Review of Resident #3's incident report completed 5/17/15 by the weekend SIC revealed: -On 5/16/15 Resident #3 was walking down the road and a neighbor's dog had gotten out of the house and had bitten Resident #3 on the ankle. -The neighbor had returned Resident #3 to the facility after the dog bite. -The SIC had called 911 for Resident #3 and he was taken to the Emergency Room for treatment. -Animal control was notified by the SIC on 5/16/15, and the dog was quarantined for 10 days.</p> <p>Review of the facility log book revealed Resident #3 was signed out of the facility, documentaion as "walking" on 9/9/15, and not available for interview on 9/9/15.</p> <p>Interview on 9/9/15 at 4:30 pm with the weekend SIC revealed: -He had worked on 5/16/15 when Resident #3 had been dog bitten. -He had not seen the incident happen, but the neighbor had brought Resident #3 back to the facility and confirmed her dog had bitten Resident #3. -He had called 911 for transport to the ER, animal control, Resident #3's guardian and the Administrator. -Resident #3 returned to facility on 5/16/15.</p> <p>Interview on 9/9/15 at 11:10 am with Resident #3's guardian revealed: -He was aware Resident #3 walked daily around town everyday. -Resident #3 was to sign out daily when he left the facility to walk. -Resident #3 was safe to walk around town by himself.</p>	C 243		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 243	<p>Continued From page 13</p> <ul style="list-style-type: none"> <li>-He was aware Resident #3 had been bitten by a dog on 5/16/15 and had received medical treatment.</li> <li>-That was the only time Resident #3 had anything like that happen.</li> <li>-He was not aware Resident #3 was found unsupervised at the facility on 9/8/15.</li> <li>-Resident #3 was safe to stay by himself on 9/8/15 from 2:20 pm till 2:55 pm until the SIC returned to the facility.</li> </ul> <p>Observation on 9/8/15 at 1:45 pm revealed the facility front porch was covered with a roof and multiple chairs were placed on it.</p> <p>Review of the local television weather forecast for 9/8/15 revealed at 12:00 pm the high was 86 degrees with partly cloudy sky.</p> <p>Interview on 9/8/15 at 2:55 pm with the SIC revealed:</p> <ul style="list-style-type: none"> <li>-She was employed as the live-in SIC on Mondays through Fridays.</li> <li>-She was enrolled in a community college and attended classes Mondays through Thursdays.</li> <li>-She left the facility at 9:00 am and returned to the facility at 2:00 pm on those days.</li> <li>-There had been a wreck on the highway and that was the reason she was not at the facility at 2:00 pm on 9/8/15.</li> <li>-Four of the five residents attended a day program and left the facility at 8:30 am and returned at 3:00 or 4:00 pm every day.</li> <li>-All the residents ride the county transit bus.</li> <li>-One resident signed out every morning and went walking around town daily.</li> <li>-She was not sure where Resident #3 walked to daily.</li> <li>-She was aware Resident #3 had been bitten by a dog on 5/16/15 while walking.</li> </ul>	C 243		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 243	<p>Continued From page 14</p> <p>-On 9/8/15 was the first time she had arrived late at the facility, "The residents know to wait on the front porch." -She had not contacted the Administrator on 9/8/15 when she had arrived late to the facility.</p> <p>Interview on 9/8/15 at 4:20 pm with the Adminrator revealed; -She was aware the SIC attended class Mondays through Thursdays from 9:00 am to 2:00 pm. -She was aware no staff were present at the facility from 9:00 am to 2:30 pm. -She was "Very Shocked" to hear the residents were unsupervised on 9/8/15 from 1:45 pm to 2:55 pm. -The SIC was to call her if she could not make it to the facility by 2:30 pm. -The SIC had not called her on 9/8/15. -If residents could get themselves on and off the bus she felt they could stay on the front porch by themselves till the SIC had gotten to the facility. -The day program staff were to call her or the SIC if they released the residents early, and they had not called on 9/8/15.</p> <p>Review of the facility admission contract signed by the residents or the guardians and the Adminrator revealed services that were provided included 24 hour care by a capable, caring, trained staff.</p> <p>On 9/8/15 at 4:30 pm Adult Protective Services were notified Resident #1, #2 and #3 were unsupervised at the facility until the Supervisor in Charge returned at 2:55 pm.</p> <p>_____ The Administrator submitted a Plan of Protection on 9/915 as follows: -Immediately the SIC and the Adminrator will assure all residents are supervised at all times.</p>	C 243		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 243	<p>Continued From page 15</p> <ul style="list-style-type: none"> <li>-The SIC or the Adminstrator will be available for residents at all times to supervise residents.</li> <li>-Contact the day program to assure they have contact numbers for the SIC and the Adminstrator.</li> <li>-The SIC will have a back person (another SIC) if she is going to be late returning to the facility and they will be available 24/7.</li> <li>-The SIC will assure the public transportation and the day programs have the phone numbers for her as well as the Adminstrator.</li> </ul> <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED October 9, 2015 .</p>	C 243		
C 254	<p>10A NCAC 13G .0903(c) Licensed Health Professional Support</p> <p>10A NCAC 13G .0903 Licensed Health Professional Support</p> <p>(c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:</p> <ol style="list-style-type: none"> <li>(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;</li> <li>(2) evaluating the resident's progress to care being provided;</li> <li>(3) recommending changes in the care of the resident as needed based on the physical</li> </ol>	C 254		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 254	<p>Continued From page 16</p> <p>assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure a quarterly assessment was performed by a qualified health professional quarterly for 1 of 3 sampled residents (Resident # 2) with the Licensed Health Professional Support (LHPS) tasks of collecting and testing fingerstick blood sugars.</p> <p>The findings are:</p> <p>Review of Resident #2's current FL2 dated 7/23/15 revealed: -Diagnoses included depression, diabetes type 2, schizophrenic, mental retardation, and sepsis. -An order for finger stick blood sugar (FSBS) once weekly. -A medication order for Metformin (an oral diabetes medicine that helps to control blood sugar levels) 850 mg two times daily.</p> <p>Review of the Resident Register revealed Resident #2 was admitted to the facility on 12/20/06.</p> <p>Interview on 9/8/15 at 2:30 pm with Resident #2 revealed: -He had been a diabetic for a long time. -He did not take insulin but took a pill "for his sugar". -The facility staff checked his blood sugar weekly and when he felt bad. -He relied on the staff to collect his finger stick blood sugar.</p>	C 254		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 254	<p>Continued From page 17</p> <p>Review of Resident #2's LHPS review dated 1/17/15 revealed: -The LHPS review was completed and signed by a registered nurse on 1/17/15. -Documentation of an LHPS marked task for finger stick blood sugars. -No further documentation of LHPS quarterly reviews completed.</p> <p>Review of Resident #2 Medication Administration Record for July, August, and September 2015 revealed: -An entry for FSBS checks weekly on Mondays at 7:00 am. -FSBS were documented as completed weekly. -July 2015 FSBS ranged from 89-94. -August 2015 FSBS ranged from 104-94. -September 7, 2015 FSBS was 102.</p> <p>Interview on 9/9/15 at 11:48 with the Supervisor in Charge (SIC) revealed: -The LHPS nurse had quit after the LHPS tasks reviews were completed on 1/17/15, and the facility was in the process of finding another nurse. -She was aware LHPS tasks were to be reviewed quarterly by a registered nurse (RN). -An RN came to the facility on 6/10/15 and completed drug reviews, but she had not completed the LHPS tasks reviews. -The Administrator contacted the contract pharmacy to send an RN out to complete the LHPS reviews.</p> <p>Interview on 9/9/15 at 11:50 am with the contract RN revealed: -She was employed by the facility contract pharmacy. -She had completed pharmacy medication drug reviews on 6/10/15.</p>	C 254		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 254	<p>Continued From page 18</p> <p>-She was unaware the facility had wanted the LHPS task completed on the residents on 6/10/15.</p> <p>-The service the facility requested were for pharmacy medication reviews and not LHPS quarterly reviews.</p> <p>-The facility would need to apply for the LHPS service from the contract pharmacy before she could complete the LHPS reviews quarterly.</p> <p>Telephone interview on 9/9/15 at 12:10 am with the Administrator revealed:</p> <p>-She was aware LHPS reviews were to be completed quarterly for the residents.</p> <p>-The LHPS nurse had quit and they were looking for another RN to complete the LHPS reviews.</p> <p>-She was unaware the RN that completed pharmacy medication reviews on 6/10/15 had not completed LHPS reviews.</p> <p>-It was her expectations the RN would have completed both the medication reviews as well as the LHPS reviews on the same day.</p> <p>-The SIC called the contract pharmacy on 9/9/15 and added the LHPS reviews service to be completed as soon as possible.</p>	C 254		
C 912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents</p>	C 912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 912	<p>Continued From page 19</p> <p>received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding Management and Other Staff and Supervision.</p> <p>The findings are:</p> <p>A. Based on observations, interviews, and record reviews, the facility failed to assure that at no time was a resident left alone in the home without a staff member present for 3 of 3 residents (Resident #1, #2, and #3). [Refer to Tag 0187 10A NCAC 13G .0601(b) (Type A2 Violation).]</p> <p>B. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 3 residents (Resident #1, #2, and #3) who were left unsupervised on 9/8/15 at the facility, waiting for staff to return to the facility. [Refer to Tag 0243 10A NCAC 13G .0901(b) (Type A2 Violation)].</p>	C 912		
C 934	<p>G.S.131D-4.5B (a) ACH Infection Prevention Requirements</p> <p>G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements</p> <p>(a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the</p>	C 934		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 934	<p>Continued From page 20</p> <p>continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to assure 1 of 3 sampled staff (Staff C) completed the state mandatory annual infection prevention training for Medication Aides (MA).</p> <p>The findings are:</p> <p>Review of Staff C's personnel record revealed: -Staff C was hired as a MA and Supervisor-in-Charge. -Staff C passed the Medication Aide test on 9/2/98. -There was no documentation of the mandatory annual infection prevention training for Staff C.</p> <p>Telephone interview on 9/9/15 at 4:30 pm with Staff C revealed: -He had worked at the facility for 20 years. -He worked as a live-in MA/SIC on the weekends. -He provided personal care needs to the resident's on the weekends as well as medication administration. -He was aware the state required a mandatory infection prevention training for MAs. -He had completed infection prevention in nursing school and assumed that it covered the same material as the state infection prevention training class. -He was in class on the day the facility staff completed the mandatory state infection</p>	C 934		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C 934	<p>Continued From page 21</p> <p>prevention training class, and did not attend. -He was aware the facility had scheduled another infection prevention training class, and he would attend.</p> <p>Telephone interview on 9/9/15 at 12:10 pm with the Administrator revealed: -She was aware MAs were required to complete the state mandatory infection prevention training class. -She was aware Staff C had not completed the state infection prevention training. -Staff C had attended school the day the facility offered the mandatory state infection training class and was unable to complete to mandatory state infection training class. -The weekday SIC had scheduled a state infection prevention training class within the next 2 weeks and Staff C would attend.</p>	C 934		
C935	<p>G.S. § 131D-4.5B (b) ACH Medication Aides; Training and Competency</p> <p>G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.</p> <p>(b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration.</p>	C935		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C935	<p>Continued From page 22</p> <p>b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.</p> <p>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.</p> <p>(3) Within 60 days from the date of hire, the individual must have completed the following:</p> <p>a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:</p> <ol style="list-style-type: none"> <li>1. The key principles of medication administration.</li> <li>2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.</li> </ol> <p>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 sampled staff ( Staff C) who administered medications had not completed the clinical skills validation competency evaluation prior to administration of medications.</p> <p>The findings are:</p> <p>Review of Staff C's personnel file revealed: -Staff C was hired on 9/2/98 and was a</p>	C935		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL041018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD ADULT CARE #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 LOWDERMILK STREET GREENSBORO, NC 27401</b>
---	--

(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) COMPLETE DATE
C935	<p>Continued From page 23</p> <p>Medication Aide (MA) and Supervisor-in-Charge. -Staff C had passed the Medication Aide test on 3/25/98. -There was no documentation of completion of medication administration skill validation checklist and competency.</p> <p>Telephone interview on 9/9/15 at 4:30 pm with Staff C revealed: -He had worked at the facility for 20 years. -He worked as a live-in MA and SIC on the weekends. -His duties included daily medication administration to the residents. -A nurse had reviewed administration of medications with him a long time ago but was unsure where the documentation was located. -He recalled having 2 personnel files due to the length of employment at the facility.</p> <p>Review on 9/9/15 of the Medication Administration Records (MAR's) for July 2015, August 2015, and September 2015 revealed documentation Staff C had administered medications to the residents on the weekends when he worked.</p> <p>Telephone interview on 9/9/15 at 12:10 am with the Administrator revealed: -She was unaware there was no documentation for Staff C's medication skills validation and competency. -Staff C will be scheduled immediately for clinical skills medication competency and be validated by a Registered Nurse. -The live-in SIC who worked weekdays would check all staff records to assure all required training and education were completed.</p>	C935		