STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345148	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friends Homes at Guilford	925 New Garden Road Greensboro, NC 27410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on record review and staff interviews, the facility failed to provide a safe transfer resulting in the resident falling to the floor. The resident sustained no injuries. This was for 1 of 3 (Resident #25) residents reviewed for accidents. The findings included: Resident #25 was admitted to the facility on [DATE] with diagnoses of dementia, unsteadiness on feet, muscle weakness, localized edema, and cognitive communication deficit. Review of Resident #25's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was severely cognitively impaired and required substantial/maximal assistance with toileting and transfers. Review of the Resident #25's care plan revised on 09/17/24 revealed the resident required assistance with mobility due to weakness, unsteadiness on feet, and gate problem. The goal was staff would continue to assist Resident #25 in her current mobility status while she maintained comfort and safety. Interventions included Resident #25 required at times 2 person assist with transfers from sit to stand and to utilize the toilet grab bar for toilet transfer due to Resident #25's right knee giving out. Review of Resident #25's care guide as of 10/17/24 revealed Resident #25 required extensive assistance with toilet transfer and toileting care with toileting hygiene. The care guide further revealed Resident #25 was to utilize toilet grab bar for transfer and required extensive assist due to her right knee could give out. Review of progress note dated 10/17/24 completed by Nurse #1 revealed Resident #25 had a witnessed fall in the resident's bathroom where staff assisted the resident to the floor. The note further revealed Resident #25 was alert, vitals were taken, and skin was intact. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an incident report dated 10/17/24 and completed by Nurse #1 revealed Resident #25 had a witnessed fall with Nurse Aide #1. It further revealed Nurse #1 was called to Resident #25's room and observed Resident #25 sitting upright against the toilet with legs outstretched. Nurse Aide #1 had assisted Resident #25 with toileting and the resident lost balance and was assisted to the floor with NA #1. Resident #25 was unable to tell what had happened but was assessed and obtained no injuries. A phone interview conducted with Nurse Aide (NA) #1 on 10/23/24 at 11:30 AM revealed on 10/17/24 during third shift she assisted Resident #25 to the toilet. NA #1 further revealed she assisted Resident #25 up from the wheelchair and when the resident went to pivot to sit on the toilet the resident became weak and started to fall to the ground. NA #1 indicated she assisted Resident #25 to the ground and sat her up so she could retrieve the Nurse. NA #1 stated Resident #25 did not express or show any signs of pain or injury. NA #1 indicated she had worked with the resident for 2 months consistently and was educated by a nurse to have two people to assist with transfers for Resident #25. NA #1 indicated she had also been educated to check the residents' care guide for assist information. NA #1 revealed it was a busy day and she failed to retrieve another staff member to assist her when she took Resident #25 to the restroom. A phone interview conducted with Nurse #1 on 10/23/24 at 11:05 AM revealed she was the assigned Nurse for Resident #25 on 10/17/24. Nurse #1 further revealed NA #1 retrieved her and went to Resident #25's room and found her sitting up against the toilet in her restroom. Nurse #1 indicated she completed an assessment, and the resident did not show any signs of pain and did not obtain any injuries. Nurse #1 revealed Resident #25 often had weak legs and was unable to hold her weight. Nurse #1 stated Resident #1 required two people for transfers and NA #1 should have had another person with her to assist the resident. Nurse #1 reported she verbally educated NA #1. Nurse #1 revealed staff had been educated to look at the resident's care guide and care plan. Nurse #1 stated she educated staff that Resident #25 was a two-person assist for transfers due to having a decline and being weaker. Nurse #1 indicated NA #1 knew Resident #25 was a two person assist before the incident on 10/17/24. An interview conducted with Nurse #2 on 10/23/24 at 2:00 PM revealed she had cared for and assisted Resident #25 since April 2024 and the resident had always been a two person assist. Nurse #2 further revealed Resident #25 often was weak and unable to hold herself up. Nurse #2 indicated staff had been educated to look at the resident's care guide and care plan. Nurse #2 stated she had educated the aides she worked with that Resident #25 was a two person assist due to her muscle weakness and unable to hold her own weight. An interview conducted with the Director of Nursing on 10/24/24 at 9:00 AM revealed Resident #25's incident occurred during third shift on 10/17/24. It was further revealed Resident #1 often had fluid and edema in her legs which caused muscle weakness. The DON indicated she expected for nursing staff to follow the assistance that the resident is coded for the residents in the care plan and care guides.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725 Based on staff and consultant pharmacist interviews and record reviews, the facility failed to limit the duration of psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) ordered on an as needed (PRN) basis to 14 days and/or indicate the duration and rationale for the PRN order to be extended beyond 14 days, when appropriate. This occurred for 1 of 5 residents whose medications were reviewed (Resident #59). The findings included: 1. Resident #59 was admitted to the facility on [DATE]. Her cumulative diagnoses included dementia with mild anxiety. A review of the resident's electronic medical record (EMR) revealed the following medication orders were received for Ativan (an antianxiety medication). Ativan is a psychotropic medication and a controlled substance medication. -A physician's order was received on 8/8/24 for 0.5 milligram (mg) Ativan to be given as one tablet by mouth every 4 hours as needed (PRN) for anxiety. The resident's most recent Minimum Data Set (MDS) was a significant change assessment dated [DATE]. Resident #59 was reported to have intact cognition with no behaviors nor rejection of care. The Medication section of the MDS revealed Resident #59 did not receive an antianxiety medication during the 7-day look back period. Resident #59's EMR indicated the physician's order for the PRN Ativan (ordered on 8/8/24) as active orders up through the date of the review on 10/24/24. A review of Resident #59's Medication Administration Records (MARs) revealed 2 doses (8/8/24 and 9/1/24) of PRN Ativan were administered to Resident #59 from 8/8/24 through the date of the review 10/24/24. The last dose of PRN Ativan was documented as having been administered on 9/1/24. Further review of Resident #59's EMR revealed no evidence of justification of the extended use of the PRN Ativan. An interview was conducted on 10/24/24 at 11:52 AM with nurse practitioner (NP #1) and she indicated that she ordered the 0.5 mg of Ativan PRN on 8/8/24 but failed to include an end date of 14 days. She further revealed that this was an oversight, and the order should have included a stop date of 14 days and then be reviewed for further orders. A telephone interview was conducted on 10/24/24 at 11:26 AM with the facility's consultant pharmacist. During the interview, the pharmacist reported she completed a medication regime review for Resident #59 on 9/5/24 but did not realize the PRN Ativan order that was started on 8/8/24 did not include a 14 day stop date. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 10/24/24 at 12:05 PM with the facility's Director of Nursing (DON). During the interview, the DON reported that she was aware that orders for PRN psychotropic medications required a stop date, and that additional documentation was required to continue PRN psychotropic medications (other than antipsychotic medications) for an extended duration. She further revealed that Resident #59's PRN Ativan order should have been ordered with a 14 day stop date and that the consultant pharmacist should have caught the error during her September 2024 medication regimen review, and this was an oversight.