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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guilford Health Care Center	2041 Willow Road Greensboro, NC 27406

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to label and date leftover food stored for use, discard food past its use-by-date and discard food showing signs of spoilage in 1 of 1 walk-in cooler and 1 of 1 walk-in freezer. The facility also failed to maintain clean walls and ceilings that were free from damage and black substances in the facility's main kitchen area including the dish washing area, steamtable/food line, and food preparation area. These practices had the potential to affect food served to all residents. The findings included:a. During an initial observation of the facility's kitchen with the Dietary Manager on 3/15/2026 at 9:22 AM, the walk-in freezer was noted to have the following concerns: - An opened unsealed package of square cheese raviolis with signs of frost bite spots and discolored grayish brown patches. - An opened, unlabeled, and unsealed package of lasagna pasta sheets with signs of frost bite spots and discolored grayish brown patches. - One opened, unlabeled, unsealed box of dinner rolls with signs of frost bite spots and discolored grayish brown patches. - One opened, unlabeled, unsealed package of hamburger patties with ice crystal formation. b. During an initial observation of the facility's kitchen with the Dietary Manager on 3/15/2026 at 9:22 AM the walk-in refrigerator was noted to have the following concerns: - An opened and unlabeled 5-pound (lb.) bag of parmesan fancy shredded cheese. -An opened, and unlabeled, container of stewed apples with signs of brownish discolored surface and fruit appeared mushy and slimy. -An opened, and unlabeled 1lb. bag of shredded cheese. An interview was conducted with the Dietary Manager on 3/15/2026 at 11:34 AM. The Dietary Manager stated that labels and dates on open food items should be checked daily. The Dietary Manager further stated the items in the walk-in freezer needed to be discarded. The Dietary Manager stated items in the walk-in freezer should have an open date, be closed and sealed in the walk-in freezer and walk-in refrigerator. He further indicated whenever a staff member used an item they were to label when opened and the item should be closed. He further revealed any items needing to be discarded from the walk-in freezer will be removed by the cook or by himself daily. An interview with the Administrator on 3/18/2026 at 10:49 AM revealed all food and beverage items should be dated when they were opened, food with signs of spoilage should be discarded, and food items should be used or discarded according to use-by policies. He further stated the dietary department was responsible for food storage and safety daily. c. During an initial observation of the facility's kitchen with the Dietary Manager on 3/15/2026 at 10:00 AM the walls and ceilings were noted to have the following concerns: -A wall surface and ceiling surface in the dishwashing area was noted to have a black substance. -A ceiling area with an Air Conditioning (AC) vent covered with a black substance over the steamtable/food line area showing signs of deterioration on the sheetrock and plaster no longer being supported. -A ceiling area with an AC vent covered with a black substance over the food prep table showing signs of sheetrock deterioration and plaster no longer being supported. An interview with [NAME] #1 on 3/18/2026 at 10:30 AM revealed there was a cleaning schedule in the kitchen. He stated the dietary staff have assignments to clean the kitchen on their shift. He further revealed the dietary staff were not responsible for cleaning high walls or ceilings. On 3/18/2026 at 10:30 AM the Administrator, Dietary Manager and Maintenance Supervisor observed the black substance on the wall and ceiling during the observation. The (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Maintenance Supervisor stated he was working on getting proposals from outside vendors to have the repair work completed in the facility kitchen. The Administrator stated the facility was going to correct issues in-house when the issues had been identified August 2025 with their own staff but then decided to correct using outside vendors. The Administrator stated there had been no corrective actions taken to resolve the black substance on the walls or on the ceiling since August 2025. Both the Administrator and Maintenance Supervisor confirmed there was no work performed to remove the black substance on the walls and ceiling. They also confirmed there was no work performed to repair the ceiling sheetrock or plaster deterioration.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and Family Member and staff interviews, the facility failed to report an allegation of employee to resident physical abuse to law enforcement and State Survey Agency for Resident #82 within the required time frame. Adult Protective Services (APS) was not notified of the allegation of employee to resident abuse. The deficient practice occurred for 1 of 3 residents reviewed for reporting of abuse allegations (Resident #82). Findings included: Review of facility Abuse/Investigative Reporting Policy indicated all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of patient property are to be reported immediately but (a) not later than 2 hours after the allegation is made if the events that cause the allegation involves abuse or results in serious bodily injury or (b) not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Any staff member observing or suspecting abuse, neglect or mistreatment will remove the patient from danger immediately and report to their immediate supervisor. A licensed nurse will notify the Administrator and/or Director of Nursing immediately. The Administrator or Director of Nursing will notify their Regional Director of Clinical Services of the incident and will provide an update to the status of the center's immediate investigation and the plans for initiating the initial notification to the State Survey Agency and other appropriate agencies. The Administrator and/or his/her designee will immediately notify the State Survey Agency by filing the initial Facility Reported Incident Form, and other appropriate agencies. If the incident is reasonably believed to constitute a crime, the Administrator and/or his/her designee will also notify law enforcement. The Administrator is to maintain a copy. Resident #82 was admitted to the facility on [DATE]. An interview conducted with the Nurse Practitioner (NP) on 3/17/2026 at 11:08 AM revealed she was the NP on duty at the facility on 2/21/2026. She stated she entered Resident #82's room and observed the resident wiping water from the floor, along with a few ice cubes present. The NP stated Resident #82 told her that staff were throwing things at me, like mashed bananas. The NP further reported she did not observe any mashed bananas on the resident, nor did she observe the resident to be wet. She stated she contacted Nurse #5 so the Director of Nursing (DON) and Administrator could be notified. An interview was Nurse #5 on 3/17/2026 at 10:30 AM revealed she was the nurse manager on duty 2/21/2026. She received a telephone call from the Nurse Practitioner (NP) on 2/21/2026. She stated the NP informed her Resident #82 had thrown a banana at Nurse #3 and Resident #82 alleged water was thrown back at her. Nurse #5 stated she called the DON and the Administrator on 2/21/2026 at 3:13 PM. An interview was conducted with the Administrator on 3/17/2026 at 3:50 PM, revealed he was called on 2/21/2026 by Nurse #5 regarding an incident with Resident #82. He stated he asked Nurse #5 to call the DON and inform her of the altercation. The Administrator stated he called the Rehabilitation Manager and asked him to return to the facility on 2/21/2026 and investigate the concern with Resident #82. The Administrator indicated he received a call from the Rehabilitation Manager at 4:27 PM on 2/21/2026. The Administrator revealed Resident #82 was upset but there was no evidence of abuse at the time of the call being received. He further revealed this information was not reported to Adult Protective Services (APS) for an allegation of abuse. An interview with Rehabilitation Manager on 3/15/2026 at 12:30 PM revealed he was the manager on duty on 2/21/2026. He stated he received a call from the Administrator about an incident between a resident and a staff member and asked him if he would check on the concern. The Rehabilitation Manager indicated he came back to the facility at approximately 3:30 PM and interviewed staff as well as Resident #82. He stated Nurse #3 said Resident #82 threw a banana on her and Resident #82 confirmed a banana and water was thrown on her but did not state which staff members. The Rehabilitation Manager stated he called the Administrator and DON on 2/21/2026 at 4:27 PM and informed both of his investigation. A telephone interview conducted with Family Member #1 on 3/15/2026 at 12:44 PM revealed she had received a (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	call from Resident #82 on Saturday 2/21/2026 and Resident #82 told her a banana was thrown on her as well as water. She further revealed she spoke with the Rehabilitation Manager on 2/21/2026 and he told her that he was going to be taking care of the matter. The Family Member stated she called the facility on Monday 2/23/2026 and was told there was an investigation on-going. Initial Allegation Report completed by the Divisional Director of Nursing on 2/23/2026 revealed on 2/21/2026 at 1:30 PM Resident #82 alleged she had requested ice cream from staff three times. However, because she never received ice cream, she then threw mashed bananas on the nurse at the nurse's station and went back to her room. Later the nurse went to Resident #82 room and threw mashed bananas back on Resident #82. Another alleged staff member went into Resident #82 room and threw ice water on Resident #82. The confirmation sheet for the fax of the Initial Allegation Report indicated the report was submitted to the State Survey Agency on 2/23/2026 at 1:47 PM by the Divisional Director of Nursing. Local law enforcement was notified of the allegation on 2/23/2026 at 12:40 PM. Notification to Adult Protective Services (APS) was not documented in the Initial Allegation Report. A telephone interview conducted with the Divisional Director of Nursing on 3/17/2026 at 10:34 AM revealed she completed the Initial Allegation Report for Resident #82 on 2/23/2026. She stated she was first informed of the allegation on 2/23/2026 and subsequently notified Law Enforcement and the State Survey Agency. The Divisional Director of Nursing further reported the Administrator was not in the facility on 2/23/2026 therefore she completed the initial allegation report. The Divisional Director of Nursing stated the allegation of abuse made by Resident #82 on 2/21/2026 should have been reported on the day of the allegation. She acknowledged the report was not submitted timely. Review of the Investigation Report dated 2/27/2026 completed by DON revealed the facility's investigation determined Nurse #3 and Nurse Aide #1 were suspended pending investigation and terminated. The facility's Investigation Report further revealed the termination was not related to the allegation for either Nurse #3 or Nurse Aide #1. Notification to Adult Protective Services (APS) was not documented in the Investigation Report. An interview conducted with the DON at 3/17/2026 at 2:55 PM revealed she completed the Investigation Report for the allegation of abuse on 2/27/2026. The DON stated she was unaware she needed to report the allegation of abuse to Adult Protective Services (APS). The DON indicated she received a call from Nurse #5 on 2/21/2026 at approximately 3:19 PM. She stated Nurse #5 informed her there was an issue with a resident and a nurse and items being thrown. The DON explained she asked that statements be collected and to contact Resident #82's family. The DON further revealed she was unaware of any other issues with abuse until further investigation completed on 2/23/2026. The DON stated an allegation of abuse was revealed after speaking with multiple staff and Resident #82 on 2/23/2026, and an investigation was started along with the suspension of Nurse #3 and Nurse Aide #1 pending investigation.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with resident, Assisted Living Executive Director, contracted Transportation Aide, Nurse Practitioner, and staff, the facility failed to provide the assisted living facility Resident #117 was discharging to with an accurate FL2 Form (a mandatory medical documented completed by a physician to certify a patient's medical needs and required level of care) resulting in the resident being denied admission. This was for 1 of 3 residents reviewed for discharge (Resident #117).The findings included:Resident #117 was admitted to the facility on [DATE] with diagnoses that included fracture of upper end of right tibia (a break of the upper part of the shinbone), hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (type of stroke) affecting the right non-dominate side, and difficulty in walking.The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #117 was cognitively intact and required partial assistance with wheeling self in wheelchair 50 feet. Her discharge goal was to return to the community.Resident #117's care plan dated 3/31/25 with a revision on 4/22/25 revealed a problem area that indicated the need for staff assistance with activities of daily living (ADL) due to chronic health conditions. Interventions included reminding the resident to use a quad cane for transfers and to use a wheelchair. The care plan also included a discharge goal to successfully return to the community with interventions that included coordinating with the resident's physician regarding discharge plans.A review of the Adult Care Home FL2 signed by Nurse Practitioner #1 on 5/5/25 revealed Resident #117's recommended level of care was assisted living level. The FL2 form indicated Resident #117 was semi-ambulatory and noted the initials of Nurse Practitioner #1 beside it. The FL2 form further revealed the medication list included three medications that were struck through and did not indicate Nurse Practitioner #1 had approved the medication changes. The names of the three medications were unreadable due to the strike through.An MDS discharge assessment dated [DATE] revealed Resident #117 was discharged to an assisted living facility.An MDS entry tracking record dated 5/13/25 revealed Resident#117 was admitted from the community.A telephone interview was conducted with Resident #117 on 3/16/26 at 3:48 PM. The resident indicated that on the morning of 5/13/25 she was transported to the assisted living facility for admission but when she arrived, the Assisted Living Executive Director came out to the parking lot and told Transportation Aide #1 and Resident #117 that he could not accept Resident #117 because the nursing facility had not provided the required paperwork for admission. Transportation Aide #1 transported her (the resident) back to the nursing facility, and she was admitted back the same day. Resident #117 indicated at the time of discharge from the nursing facility on 5/13/25 she was able to transfer from her wheelchair to bed while using her cane and she used her wheelchair to ambulate long distances. Resident #117 further revealed she remained at the nursing facility until 5/17/25 and she chose to discharge home. A telephone interview was conducted with the contracted Transportation Aide #1 on 3/18/26 at10:47 AM. He indicated he transported Resident #117 to the assisted living facility on the morning of 5/13/25 and when they (the resident and Transportation Aide #1) arrived the Assisted Living Executive Director met them in the parking lot and told them Resident #117 would not be able to be admitted to the assisted living facility because he did not have an approved FL2 which was required for admission. Transportation Aide #1 indicated that he contacted the nursing facility and spoke with the Social Work Assistant and she sent over another FL2 but the Assisted Living Executive Director continued to refuse to admit Resident #117. He reported that he transported Resident #117 back to the nursing facility.An interview was conducted with the Social Work Assistant on 3/18/26 at 12:47 PM and she indicated she was contacted by Transportation Aide #1 on 5/13/25 regarding Resident #117 not being allowed admission to the assisted living facility. She further revealed she spoke with the Assisted Living Executive (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director and an amended FL2 had been provided to the Assisted Living Executive Director while Resident #117 was still in the transportation van. She could not recall if she personally sent the amended FL2, or if it was sent by the Discharge Planner. She explained that the Assisted Living Executive Director continued to refuse admission as the changes to the FL2 form had not been approved by a provider. The Social Work Assistant indicated she did not recall who wrote Nurse Practitioner #1's initials beside the change in ambulatory status. A telephone interview was conducted with the Assisted Living Executive Director on 3/16/26 at 3:39 PM. He revealed he contacted the nursing facility's Discharge Planner on the afternoon of 5/12/25 to rescind the bed offer he had made to Resident #117 due to the FL2 form indicating that Resident #117 was non-ambulatory. The Assisted Living Executive Director revealed that Transportation Aide #1 and Resident #117 arrived at the assisted living facility on the morning 5/13/25 and he (the Assisted Living Executive Director) came to the parking lot and inquired about the identity of the resident. The Assisted Living Executive Director reported he was told by Transportation Aide #1 that he had transported Resident #117 for her admission to the assisted living facility. The Assisted Living Executive Director explained he made the Transportation Aide #1 aware that he could not accept Resident #117 because the facility had not provided an approved FL2 form that was required for admission. He further explained that Transportation Aide #1 called someone at the nursing facility (he was not aware who was called) and then he (the Assisted Living Executive Director) received another FL2 form dated 5/5/25 (the same date as the initial FL2 form that was sent by the nursing facility). The FL2 form indicated a check mark by semi-ambulatory status and the box next to non-ambulatory status appeared to have been whited out and there were three unreadable medications that had been struck through. The Assisted Living Executive Director further revealed that he contacted the Social Work Assistant to let her know that he would not be able to admit Resident #117 as the changes to the FL2 form did not contain a provider's signature which was needed to indicate the provider approved of the changes. The Assisted Living Executive Director indicated he then requested that Transportation Aide #1 transport Resident #117 back to her nursing facility.An interview was conducted with the Discharge Planner on 3/16/26 at 4:44 PM. She indicated Resident #117 was scheduled to discharge to an assisted living facility on the morning of 5/13/25. The Discharge Planner revealed that the Assisted Living Executive Director contacted her (the Discharge Planner) during the afternoon of 5/12/25 to let her know that the FL2 form that he received indicated Resident #117 was non-ambulatory and therefore he would not be able to admit Resident #117 to the assisted living facility. The Discharge Planner indicated that she made the Assisted Living Executive Director aware that Resident #117 was semi-ambulatory and she would provide a corrected FL2 form to the assisted living facility. The Discharge Planner indicated that she felt that after the issue was clarified with the Assisted Living Executive Director that the admission to the assisted living facility was still set to occur on 5/13/25. The Discharge Planner further explained she had made four corrections to the FL2 form which included changing Resident #117's ambulatory status from non-ambulatory to semi-ambulatory and she had struck through three medications that Resident #117 was no longer prescribed. The Discharge Planner explained that it was her intention to have a provider review and sign the revised FL2 form prior to the resident's discharge. The Discharge Planner indicated she did not recall who wrote Nurse Practitioner #1's initials beside the change in ambulatory status. The Discharge Planner further revealed at the time of Resident #117's discharge to the assisted living facility on 5/13/25 the changes to the FL2 form were an accurate reflection of Resident #117 but had not yet been approved by a provider. The Discharge Planner explained that the provider had not come into the facility to approve the FL2 before Resident #117 was scheduled to be transported to the assisted living facility at 9:00 AM. The Discharge Planner indicated it was her intention to have the provider approve the change to the FL2 and send the approved FL2 to the assisted living facility that day. The Discharge Planner indicated when Resident #117 arrived at the assisted living facility on the morning of 5/13/25 the Assisted Living Executive Director met Transportation Aide #1 in the parking (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lot and refused to admit Resident #117. The Discharge Planner revealed that the corrected FL2 was sent over while Resident #117 was still onsite at the assisted living facility but the Assisted Living Executive Director refused to accept Resident #117 because the changes that were made to the FL2 form had not been approved by the provider. The Discharge Planner indicated Resident #117 was then admitted back to the facility. On 3/17/26 at 11:43 AM a telephone interview was conducted with Nurse Practitioner #1. She indicated that she signed Resident #117's FL2 on 5/5/25 but did not approve any changes to the FL2 form. Nurse Practitioner #1 indicated that she was not able to recall any specifics about the FL2 she signed on 5/5/25. She further revealed her last working day at the facility was on 5/5/25.An interview was conducted with the Administrator on 3/17/26 3:05 PM and he indicated that Resident #117 should have remained at the facility until the Discharge Planner had provided the assisted living facility with an accurate and provider approved FL2 and he did not know why this had not been done.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to post cautionary, safety signage that indicated the use of oxygen for Resident #3 and Resident #13 and failed to have a physician order for oxygen use for Resident #13 for 2 of 3 residents reviewed for respiratory care (Resident #3 and Resident #13).The findings included: The facility permits smoking for residents, staff and visitors. This was confirmed with the Administrator on 3/15/2026 at 9:55 AM. The facilities policy dated 1/29/2024 stated Oxygen therapy will be administered by provider's order, according to current standards of practice and equipment will be maintained and stored in a safe and appropriate manner. Included under the safety guidelines it stated post oxygen in use signage on all door frames of rooms with oxygen in use. a. Resident #3 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure. Resident #3's physician orders dated 7/22/2025 revealed an order for oxygen to be administered continuously via nasal cannula at 2 liters per minute (lpm). Resident #3's annual Minimum Data Set (MDS) dated [DATE] indicated Resident #3 was coded for receiving oxygen. Observations on 3/15/2026 at 9:50 AM and 11:42 AM, and 3/16/26 at 11:25 AM and 2:38 PM revealed Resident #3 was lying in bed in her room wearing a nasal cannula with oxygen administered at 2 lpm. There was no cautionary or safety signage posted at Resident #3's room to indicate oxygen was in use during the observations. An interview with Nurse #6 was completed on 3/16/2026 at 3:38 PM. He stated Resident #3 was not assigned to him that day but had cared for her on other days. Nurse #6 was unaware of why there wasn't a sign on the door. He stated if oxygen was being used the cautionary oxygen in use sign should be posted at the doorway. NA # 5 was interviewed on 3/17/2026 at 11:40 AM. The NA stated she was aware that the residents assigned to her were on oxygen from the staff briefing before shift and observation of the concentrator and nasal canula. She stated she doesn't always observe the cautionary signage at the door. The NA could not recall if Resident #3 had a sign and was unable to explain why a sign had not been placed at the door. An interview was conducted with Nurse #3 on 3/17/2026 at 11:58 AM. Nurse #3 stated that the facility will post oxygen in use signs on the door of residents that were receiving oxygen. She stated she had not observed that there was no sign on Resident #3's door. Nurse #3 was unaware of why Resident #3 did not have cautionary oxygen in use signage on her door. NA #6 was interviewed on 03/17/2026 at 2:03 PM. NA #6 stated the facility had oxygen in use signs on doors for residents using oxygen. She stated she does not recall if Resident #3 had a sign posted at any time. NA #6 was unaware of why Resident #3 did not have cautionary sign at her door. b. Resident #13 was admitted to the facility on [DATE] with a history of congestive heart failure (CHF) and tracheostomy status (surgical intervention that establishes an airway through an incision in the neck into the trachea). The quarterly MDS dated [DATE] revealed Resident #13 had moderate cognitive impairment. Oxygen use was not indicated on the MDS. A progress note from NP #3 was dated 3/13/26 at 12:45 PM and stated Resident #13 was seen for hypoxia and nursing reports with oxygen levels in the 80's with room air. Resident #13 was placed on 3 lpm of supplemental oxygen and his oxygen levels then were noted for 95%. A phone interview was completed with Nurse Practitioner (NP) #3 on 3/17/2026 at 11:06 AM. She stated she treated Resident #13 on 3/13/2026 for concerns with his oxygen levels. NP #3 stated Resident #13's oxygen levels were dropping below 90 percent. NP #3 stated she gave a verbal order for continuous oxygen at 2 to 5 lpm through tracheostomy mask to maintain Resident #13's oxygen level at 90 percent or greater for oxygen saturations. She stated she expected the facility to follow her order and have the order in the record. NP #3 stated there was no reason for the order not to be in resident #13 record on 3/13/2026. She was unaware of why an order was not in Resident #13's record before 3/16/2026. The NP stated the verbal order was given to Nurse #7 who was assigned to Resident #13 on 3/13/2026. Multiple attempts to interview Nurse #7 by phone were made and were unsuccessful. Nurse #7 did not return (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	messages left to speak with her. Observations on 3/15/2026 at 10:00 AM, 11:38 AM, 12:49 PM, and 3/16/26 at 11:26 AM and 2:42 PM revealed Resident #13 was in wheelchair in his room receiving oxygen at 2 liters per minute (lpm) through his tracheostomy mask. Observation on 3/16/2026 at 11:26 AM Resident #13 was ambulating in his wheelchair with a portable tank attached appropriately to the back of his wheelchair. Oxygen was being administered at 2 lpm. There was no cautionary or safety signage posted at Resident #13's room to indicate oxygen was in use during the observations. Resident #13 had a physician order dated 3/16/26 at 7:00 AM for oxygen to be administered continuously via trach mask at 2 lpm to keep oxygen level above 90% (normal range for oxygen level is 92-96%). An interview with Nurse #6 was conducted on 3/16/2026 at 3:38 PM. Nurse #6 stated he was assigned to Resident #13 that day and he did not work the previous weekend (3/13/2026-3/15/2026). Nurse #6 was unsure why there was no oxygen order in place until 3/16/2026 for Resident #13. He stated that if Resident #13 was using oxygen there should have been an order in his medical record. Nurse #6 confirmed there was no PRN (as needed) order or order for oxygen prior to the order on 3/16/2026. He confirmed there was no oxygen signage on Resident #13's door and was unable to give a reason why there was no cautionary oxygen signage on the door. On 03/17/2026 at 12:15 PM NA #3 was interviewed and stated he was aware of resident using oxygen with observation. He stated the facility post signs on the resident's door that are using oxygen. NA #3 was unaware of why there was not a sign resident #13 door earlier in the week. Oxygen in use sign was posted on resident #13 door at this time. The Director of Nursing (DON) was interviewed on 03/18/2026 at 1:48 PM. She stated she expected staff to follow policy and post oxygen in use signs on the residents' doors where oxygen was being used. The DON was unable to explain why there was no oxygen in use signs posted on Resident #3 and Resident #13's doors during observations on 3/15/2026 and 3/16/2026. The DON stated the residents should have had cautionary oxygen signage posted on their doorways per the facilities oxygen policy. The DON was unable to explain why Resident #13 did not have an order for oxygen from 3/13/26 to 3/15/2026. She stated an order should have been in Resident #13's medical record when oxygen was ordered by NP #3 and was being administered. The DON agreed that the facility should have followed through with putting NP #3's verbal order for oxygen to be administered in Resident #13's medical record. An interview with the Administrator was completed on 03/18/26 at 2:40 PM. The Administrator was unaware that Resident #3 and Resident #13 did not have oxygen in use signs posted on their doorways on 3/15/2026 and 3/16/2026. He stated signs should have been posted per the facilities oxygen policy regarding cautionary signage would be posted where oxygen was being used. The Administrator was unable to explain why the order for oxygen for Resident #13 was not in place from 3/13/26 to 3/15/2026. He stated he expected his staff to follow NP #3's orders, and an order should have been in Resident #13's medical record when the verbal order for oxygen was given on 3/13/2026.

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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guilford Health Care Center	2041 Willow Road Greensboro, NC 27406

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on record review, observations and staff interviews, the facility failed to secure a medication cart that was left unlocked and unattended, failed to secure insulin syringes that were left unsecured on top of an unattended medication cart, failed to dispose of medications that were refused and dropped on the floor that were stored in 1 of 6 medication carts reviewed for medication storage (100 Hall Bottom Medication Cart).The findings included:a. A continuous observation and interview were conducted on 3/17/26 from 8:35 am to 9:35 am of the 100 Hall Bottom Medication Cart and Nurse #1. The medication cart was unlocked (lock was out indicating it was unlocked) while Nurse #1 was in a Resident's room. When Nurse #1 returned to the cart at 8:38 am she started preparing medication for another resident and confirmed that the medication cart was unlocked. During the continuous observation at 8:52 am, Nurse #1 prepared medication for another resident and when she went to administer the medications, Nurse #1 left three unused multiple dose insulin syringes in a plastic bag on top of the medication cart unattended. When Nurse #1 returned to the medication cart an unlabeled medicine cup containing digoxin 125 micrograms (mcg), docusate 100 milligram (mg), two torsemide 20 mg, and spironolactone 50 mg was observed in the top drawer of the cart. Nurse #1 stated she prepared the digoxin 125 mcg, docusate 100 mg, two torsemide 20 mg, and spironolactone 50 mg for Resident #119 and he refused. Nurse #1 stated she placed the medication in the drawer because she was going to offer the medication again. Further observation at 9:00 am revealed Nurse #1 preparing Resident #125's medication which included a finasteride (used to treat enlarged prostrate) 5 mg. When Nurse #1 administered the medication to Resident #125 at 9:10 am, the finasteride tablet dropped on the floor. Nurse #1 was observed picking the tablet up off the floor and placing the finasteride 5mg in a medicine cup and placing it in the medication drawer beside another cup of medications that were unlabeled.An interview was conducted on 3/17/26 at 9:51 am with Nurse #1, the nurse responsible for administering medication during the day shift (7:00 am to 3:00 pm). Nurse #1 confirmed she left the medication cart unlocked and unattended. Nurse #1 stated the medication cart should have been locked before she stepped away. Nurse #1 stated someone gave her the plastic bag with the three unused multiple dose insulin syringes earlier, and they should not have been left sitting unattended on top of the medication cart. When she received the insulin, it should have been locked inside the medication cart. Nurse #1 stated she prepared the digoxin 125 mcg, docusate 100 mg, two torsemide 20 mg, and spironolactone 50 mg for Resident #119 and he refused. She placed the medication in the drawer because she was going to offer the medication again. Nurse #1 stated she still needed to waste the finasteride that was dropped on the floor.b. During observations of drug storage in the 100 Hall Bottom Medication Cart with Nurse #1 on 3/17/26 at 9:40 am three unlabeled medication cups containing medications were observed in the top right drawer. One cup contained one pill, one cup contained 5 pills of various size, shapes, and colors, and one cup contained 3 pills of various size, shapes, and colors. Nurse #1 indicated that one cup of the medications was left by Nurse #2 from the previous shift. She indicated she should have wasted the medications and not stored them on the cart and typically wasted medications in the sharp's container on the medication cart.An interview was conducted on 3/17/26 at 9:47 am with Nurse #2 who confirmed that a resident had refused his medications at 6:00 AM and that she should have disposed of the medications and not left them on the 100 Hall Bottom Medication Cart.An interview was conducted on 3/17/26 at 10:05 am with the Director of Nursing (DON) in the presence of the Nurse Consultant. The DON stated she would expect her staff to secure the medication cart when they stepped away, and the three insulin syringes should have been secured inside the medication cart. She also indicated that unlabeled medication that had been refused or medication that needed to be wasted should not be stored inside a medication cart together and should have been disposed of. She stated the medication should have been wasted in the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Drug Buster (a substance use to deactivate non-hazardous medications).An interview was conducted on 3/18/26 at 3:40 pm with the Administrator. The Administrator stated he would expect his staff to keep the medication carts locked and follow the facility's policy and procedures for storing medication.