		ID HUMAN SERVICES			FORM APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		345148	B. WING		11/09/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
FRIENDS	HOMES AT GUILFORD			925 NEW GARDEN ROAD GREENSBORO, NC 27410	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 371 SS=E	STORE/PREPARE/S The facility must - (1) Procure food from considered satisfacto authorities; and	ERVE - SANITARY sources approved or ry by Federal, State or local stribute and serve food	F 37	1	11/28/16
	by: Based on observatio facility failed to ensure discarded in the walk- items were sealed, la storage room, cookwa together wet and food clean. This had the por residents who reside Findings Included: An observation of the am revealed:	I preparation equipment was otential to affect 48 of the 48 in the facility. kitchen on 11/07/16 at 9:30		This Plan of Correction is the provider credible allegation of compliance. Preparation and/or execution of this pla of correction does not constitute admission or agreement by the provide the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely becau it is required by the provisions of federa and state law.	an er of of use al
	expiration date of 11/ container of sour creat 11/5/16 were availabl walk-in-cooler. 2. 4 open packages dated in the dry stora 3. A case of choppe were not labeled or da prevent exposure to t	am with an expiration date of e for use in the s of pasta were not labeled or ge room. ed pecans and cocoa powder ated and were not sealed to he air in the dry storage		 To correct the issue of expired foods o best used by date: All perishable food under refrigeration will be discarded by the expiration or best used by date. Th following procedures will be followed: 1. The AM supervisor will complete a daily audit (See Attached) which include discarding any foods that have reached the expiration or best used by date. The AM supervisor will complete a daily audit (See Attached) which include discarding any foods that have reached the expiration or best used by date. The AM supervisor will complete a daily audit (See Attached) which include discarding any foods that have reached the expiration or best used by date. The AM supervisor will complete a daily audit (See Attached) which include discarding any foods that have reached the expiration or best used by date. The AM supervisor will complete a daily audit (See Attached) which include discarding any foods that have reached the expiration or best used by date. 	e les d e
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	:	TITLE	(X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

11/24/2016

PRINTED: 12/16/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345148 B. WING 11/09/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 925 NEW GARDEN ROAD FRIENDS HOMES AT GUILFORD GREENSBORO, NC 27410 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 371 Continued From page 1 F 371 first In First Out rule will be followed. room. (Starting 11/23/16 and on-going) An observation of the kitchen on 11/09/16 at 10:00 am revealed: The Kitchen Manager or Chef will 2. randomly spot check a minimum of three 1. 3 of 6 sheet pans with food particles on them times per week as a backup measure and were stored on shelf and ready for use. sign off on the audit for the day. (Starting 2. 15 of 15 steam table pans were stacked 11/23/16 and on-going) together wet and stored on shelf and preparation table ready for use. 3. The Food Preparation Staff will be 3. 3 of 3 ingredient bins had build-up of food in-serviced on proper storage practices. particles around bases and labels. (Completed 11/23/16 and 11/28/16) 4. The flame grill had a heavy build-up of blackened food particles and grease on the grill Any concerns will be reported to the grates and around the base. Quarterly Quality Assurance Committee to 5. The under shelf of the cooks preparation ensure that corrective actions are table had sheet pans with spices stored on them achieved and sustained. The and the sheet pans had food particles and food Administrator/Director of Dietary is spills on them. responsible for overall compliance. (Starting 11/23/16 and on-going) An interview with the Dietary Manager and the To correct the issue of labeling, dating and Assistant Dietary Manager on 11/09/16 at 4:17 sealing dry goods: All dry goods will be pm revealed that their expectation was that wrapped tightly after opening or placed in expired food products should not have been in a sealed container. The following the walk-in-cooler and available for the staff to procedures will be followed: use. They stated that their expectation was that food products are sealed, labeled and dated in all 1. The AM Supervisor will complete a daily audit (See Attached) which will storage areas. The Assistant Dietary Manager stated that steam table pans should not have include ensuring all foods that have been been stacked together wet and that the ingredient opened are tightly sealed and labeled. bins and under shelf with the spices should have (Starting 11/23/16 and on-going) been clean. He also stated that the flame grill should have been cleaned after use and that the 2. The Kitchen Manager or Chef will cook had forgotten to clean it. randomly spot check a minimum of three times per week as backup measure and An interview with the facility Administrator on sign off on the audit for that day. (Starting 11/09/16 at 4:31 pm revealed that it was his 11/23/16 and on-going)

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 923180

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148		(X2) MULTIPLI	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
			A. BUILDING			
		B. WING		11/09/2016		
NAME OF PROVIDER OR SUPPLIER			S			
FRIENDS	HOMES AT GUILFORD		9			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 371	the walk-in-cooler an He stated that he exp would be clean and a	e 2 red products would not be in d that all equipment is clean. bected the steam table pans allowed to air dry and that all be stored appropriately with	F 371		tices.) e nittee to d pots n food d dry. llowed: heck they ck at be dirty cked. o ng will s per he day.	

Event ID:6W1E11

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		X MEDICAID SERVICES		ECONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		(X3) DATE SURVEY COMPLETED	
				11/09/2016	
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD				· ·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 371	Continued From page 3		F 371	 Dishwashing and Utility Sta in-serviced on proper dishwashi practices. This in-service will be full-time and part-time staff. (Co 11/23/16 and 11/28/16) Any concerns will be reported to Quarterly Quality Assurance Co ensure that corrective actions an achieved and sustained. The Administrator/Director of Dietary responsible for overall complian (Starting 11/23/16 and on-going 	ng given to mpleted o the mmittee to re r is ce.
				To correct the issue of cleanline shelves and food storage bins: A prep table shelves and food stor will be clean and free of spills. T following procedures will be fold 1. All shelves under food prep and the outside of the food stora will be cleaned daily as per the o schedule assignment. (Starting and on-going)	All food rage bins 'he owed: tables age bins cleaning
				 The AM Supervisor will che and bins during the daily audits that they are clean and report to Kitchen Manager or Chef if they attention. (Starting 11/23/16 and The Kitchen Manager or Ch 	to ensure o the need d on-going)

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345148		IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		B. WING		11/09/2016	
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD				·	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 371	Continued From page 4		F 37	1 measure a minimum of three time week and sign off on the audit for (See Attached) (Starting 11/23/16 on-going)	r the day.
				4. Cleaning schedules will be n with staff.(Completed 11/23/16 at 11/28/16)	
				Any concerns will be reported to Quarterly Quality Assurance Con ensure that corrective actions are achieved and sustained. The Administrator/Director of Dietary responsible for overall compliance (Starting 11/23/16 and on-going)	nmittee to e is
				To correct the issue of the cleanli the grill: The grill will be free of bl food particles and grease build-u following procedures will be follow	lackened p. The wed:
				 Cooks will clean grates after with a wire brush and wipe down exterior cabinet. (Starting 11/23/ on-going) 	the
				2. The AM Supervisor will check cooking equipment as part of the audit (See Attached) and report to Kitchen Manager or Chef who wi cleaning duty if needed to ensure clean. (Starting 11/23/16 and on-	daily o the Il assign e they are

Event ID: 6W1E11

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If continuation sheet Page 5 of 6

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148		(X2) MULTIP	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOMBER:	A. BUILDING	A. BUILDING	
		B. WING		11/09/2016	
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETI
F 371	Continued From pag	e 5	F 37	1	
				3. Cooks will be in-serviced or proper cleaning procedure for th (Completed 11/23/16 and 11/28	ne grill.
				Any concerns will be reported to Quarterly Quality Assurance Co ensure that corrective actions a achieved and sustained. The Administrator/Director of Dietary responsible for overall complian (Starting 11/23/16 and on-going	mmittee to re / is ce.

Event ID: 6W1E11

Facility ID: 923180

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