CENTERS FOR MEDICARE &	& MEDICAID	SERVICES

OMB NO. 0938-0391

1	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2)MI	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:	A 01111	DINC	COMPLETED C	
		345148	B. WIN	DING	10/24/20	313
NAMEO	PROVIDER OR SUPPLIE		1	REET ADDRESS, CITY, STATE	•	712
i	HOMES AT GUILFO		1	S NEW GARDEN RD	, zir CODL	
TAILINDS	TIOMES AT COLLEG	NO.	1	REENSBORO, NC 27410		
	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
(X4)ID	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC	TION SHOULD BE	COMPLETION
PREFIX	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO	THE APPROPRIATE	DATE
TAG				DEFICIEN	· · · · · · · · · · · · · · · · · · ·	
				This Plan of Correction is	•	
				credible allegation compli	ance.	
				Preparation and/or execu	tion of this plan of	
		•		correction does not consti		
·				agreement by the provide		
				facts alleged or conclusion		-
				statement of deficiencies.	The plan of	
			i	correction is prepared and	•	
				because it is required by t	he provisions of	
F 000	INITIAL COMMENT	FQ	F000	federal and state law.		
1 000	HALLIVE COMMEN	13	1000	-The MDS for resident #4:	3 has been	
F 278	No deficiencies wer	re cited as a result of the	F278	corrected and submitted		11/4/13
SS=D	complaint investiga	tion survey. Event# CETO11		reflection of section K; un	planned severe	
	483.20(g) - (j) ASSI	COMMENT		weight loss. The subseque	ent corrected care	
		RDINATION/CERTIFIED		plan was completed.		
				-The corrective action will	he accomplished	11/14/13
		ust accurately reflect the		for those residents having	•	,_,,_
	resident's status.		Ì	affected by the same defi	•	
	A registered nurse	must conduct or coordinate		Interdisciplinary Team pe		
	each assessment w	vith the appropriate		scheduled review of the N		
	participation of hea	lth professionals.		assess for the accuracy of		
	A registered nurge	must sign and certify that the		correct any information d	eemeu maccurate.	
	assessment is com			-The measure put into pla	ce to ensure that	11/11/13
	400000,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	F.v v.		the deficient practice will		,,
		completes a portion of the		servicing of the Interdiscip	olinary Team on	
		ign and certify the accuracy of		"The need for Accuracy or		
	that portion of the a	ssessment.		Coded on Each MDS" Sect		
	Under Medicare an	d Medicaid, an individual who		servicing on the "Weight ( Exhibits #1 &# 2)	Change Policy." (See	
	willfully and knowin	gly certifies a material and		EXHIBITS #1 OH 2)		
		resident assessment is		-The facility plans to mon	tor its nerformance	
		oney penalty of not more than		to ensure that solutions a	•	
		sessment; or an individual who gly causes another individual		having the Quality Assura	•	
		and false statement in a		designee monitor, throug		
		nt is subject to a civil money		and record a review of the	•	
	penalty of not more	than \$5,000 for each		MDS section K. The result		
	assessment.			be brought to the Quarter Assurance Meeting to ens		
	Clinical dispareeme	ent does not constitute a		corrective action is achiev		
	material and false s			The Administrator/DON is		
		NT is not met as evidenced		overall compliance.	,	
	by:		}			
		view and interview with staff	C C101112	l Tirle		(VC) DATE

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.

CENTER	& MEDICAID SERVICES	OMB NO. 0938-039				0938-0391	
l	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2	)Ml	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAI	N OF CORRECTION	IDENTIFICATION NUMBER:	A B	EF 111	DING	COMPLETED C	
		345148			IG	10/24/2013	
NAME OF	PROVIDER OR SUPPLI	ER	·	ST	FREET ADDRESS, CITY, STATE,		
FRIENDS	HOMES AT GUILFO	PRD		:	25 NEW GARDEN RD		
					REENSBORO, NC 27410		
(X4)ID		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	JE PRE		PROVIDER'S PLAN O (EACH CORRECTIVE AC		(X5) COMPLETION
PREFIX	•	LSC IDENTIFYING INFORMATION	TA		CROSS-REFERENCED TO		DATE
TAG					DEFICIEN	CY)	
F 278	Continued From pa	nge 1	F278	8	This Plan of Correction is to credible allegation complic		:
	the facility failed to	code the annual (MDS)			Decreasion and for success	to a of this along of	
		ere weight loss accurately.			Preparation and/or execut correction does not constit		
		1 of 3 residents in the sample			agreement by the provider		
	reviewed for nutrition	on. Resident #43			facts alleged or conclusion		1
	Findings included:				statement of deficiencies. correction is prepared and		**AAAAA*******************************
	Resident had cumu included dementia.	ılative diagnoses which			because it is required by th		-
	monucea dementia.				federal and state law.		
		thly weight chart form revealed					
		ght was 5 feet. The monthly ndicated a weight history that					
	included in part:	- •					
	07/02/13 138 poun 07/31/13 134 lbs (v						
	09/02/13 128 lbs	veight for Augusty					
	10/02/13 121 lbs						
	loss of 17 lbs withir	n unplanned severe weight n 3 months.					
	Review of the annu	ral Minimum Data Set (MDS)					
		vealed under Section K rition, the weight loss column					
	was coded 0 (zero)	which indicated the resident					
		d a weight loss of 5% or more 10% or more in the last 6					
		was unknown. This coding					
	was inaccurate and	did not reflect weight loss.					
	Interview on 10/23/	13 at 4:40 pm with (NCM#1)					
		ger revealed " I did the wrong ng the degree of weight loss.			-		over it connected man
	Interview on 10/23/	13 at 4:50 pm with the					***************************************
		the director of food services					
		sultant dietitian indicated the have been assessed.					
		13 at 5:10 PM with director of					
	, ,	the Administrator regarding					
		elated inaccurate assessment. expectations would be that					
	the assessment wa	sn't missed, and we will be					
	revising the weight was just a human e	policy. The DON indicated it					
	was just a numan e	aiOi.					
F279	483.20(d), 483.20(l		F279	€	Corrective actions for resid	,	10/23/13
SS=D	COMPREHENSIVE	: CARE PLANS			the deficient practice are a albumin level recommend		10/24/13 11/13/13
		the results of the assessment			Registered Dietitian and or	dered by NP on	,,
	to develop, review	and revise the resident's			10/23/13. Lab results rece	ived on 10/24/13	

# **CENTERS FOR MEDICARE & MEDICAID SERVICES**

OMB NO. 0938-0391

	RS FOR MEDICARE & MEDICAID SERVICES	1 0/0	NA 41 11 71	DIE CONSTRUCTION	T	0938-0391
	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA N OF CORRECTION IDENTIFICATION NUMBER	1 '	2)MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	IDENTIFICATION NOWDER	í	BUILDING		COMPLETED	
	345148		WING_			13
NAME O	F PROVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE,		
FRIEND	S HOMES AT GUILFORD			IEW GARDEN RD		
			GREE	NSBORO, NC 27410		
	SUMMARY STATEMENT OF DEFICIENCIES	ID	i i	PROVIDER'S PLAN O		(X5)
(X4)ID PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREI		(EACH CORRECTIVE AC		COMPLETIO
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TA	i.G	CROSS-REFERENCED TO DEFICIEN	•	DATE
				DEFFOR		
	Continued From page 2					
F279	comprehensive plan of care.	F279	9 v	vere 3.4g/dl. NP reviewed	l serum albumin	
	The facility must develop a comprehensive care		- (	evel result and no new or		·
	plan for each resident that includes measurable			he care plan was updated	• •	
	objectives and timetables to meet a resident's			0/24/13 accordingly to a lbumin levels. The consul		ĺ
	medical, nursing, and mental and psychosocial			lietitian reassessed reside	~ ~	
	needs that are identified in the comprehensive assessment.			ecommended a protein s		
	docessment.			1/13/13. NP ordered a p		
	The care plan must describe the services that are			n 11/13/13. The resident	care plan was	
	to be furnished to attain or maintain the resident's	s	u	pdated on 11/13/13.		
	highest practicable physical, mental, and psychosocial well-being as required under		l c	orrective action for all re	sidents with the	
	§483.25; and any services that would otherwise			otential to be affected by		
	be required under §483.25 but are not provided			ractice is that all abnorm		
	due to the resident's exercise of rights under			e assessed and evaluated	•	
	§483.10, including the right to refuse treatment under §483.10(b)(4).			ither the NCM or the con lietitian. The results of th	•	
	ands, 3,001.10(b)(1).			e communicated to the N		
	This REQUIREMENT is not met as evidenced			Nutritional Communicat		
	by:		1)	Notebook implemented 1	.1/14/13) and	
	Based on observation, interview with staff and record review the facility failed to develop a		re	ecorded on the residents	care plan.	
	comprehensive careplan that addressed the low		١.	1-0		
	total protein and serum albumin levels. This was			leasures to be put into pi ne deficient practice will :		11/13/13
	evident in 1 of 3 residents in the sampled reviewer for nutrition. Resident#63	ed		bnormal albumin levels v		11/10/10
	Findings included:		e	valuated by the NP and b	y either the NCM or	
				onsultant Registered Die		
	Resident#63 was admitted to the facility on			ne assessment will be cor		
	6/24/13 with cumulative diagnoses which include anemia and diabetes.	a		IDS Coordinator via the Normunication Notebook	· ·	
	anoma and sideotoo.			ne resident care plan. In-		
	Review of the Minimum Data Set dated 9/25/13		c	onducted by the consulta	nt Registered	
	revealed resident required supervision with Activities of daily living and was cognitively intact			ietitian for licensed Nurs		
	Activities of daily living and was cognitively intact	•	1	lbumin and total protein f the Nutritional Commu	• •	
	Review of the hospital laboratory studies reveale	d		i the Nutritional Commu See Exhibit #3)	ilication woteopox.	
	on 6/18/13 a total protein level of 4.4 grams per		1"	ice extinoit noj		
	deciliters (g/dl) milligrams per deciliter and with a serum albumin level 2.0 g/dl. The reference		Ti	he Consultant Registered	Dietitian will	
	range for total protein level was 6.0-8.3 g/dl. The		- 1	ommunicate through a m		
	reference range for a serum albumin level was	j	- 1	dministrator or designee		
	3.5-5.5 g/dl.			rotein needs are address dministrator will meet wi		
	Review of the laboratory blood studies dated		1	oordinators to ensure the		
	7/1/13 revealed a total protein 5.1 g/dl and serum	,	1	een updated to address a	•	
	albumin of 3.1 g/dl.		al	bumin and protein levels	. Any concerns will	
				e reported to the Quarte		
	Review of the medical record revealed no			ssurance meeting to ensi		
:	careplan to address the low protein levels.			ctions are achieved and s dministrator /DON are re		
	Interview on 10/23/13 at 1:50 PM with the			oministrator /DON are re verall compliance.	ahousing tot	
	consultant dietitian via the phone revealed "we			. a. an compilance		
:	(referring to the facility) failed miserably, dropped					

CENTER	S EOD MEDICADE	9. MEDICAID CEDVICES				FORM API	
	NT OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	/X2	\NAL	ILTIPLE CONSTRUCTION	(X3) DATE SURVEY	0938-0391
	N OF CORRECTION	IDENTIFICATION NUMBER:		•		COMPLETED	
		345148	A.BUILDING B. WING			•	
NANAE OE	PROVIDER OR SUPPLI		B. V		GREET ADDRESS, CITY, STATE	10/24/20	13
	HOMES AT GUILFO				5 NEW GARDEN RD	ZIF CODE	
	C213.41.44.0V.C	FATCH ACRIT OF OFFICIENCIES			REENSBORO, NC 27410	E GODDECTION	
(X4)ID		FATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL	ID PREI		PROVIDER'S PLAN O (EACH CORRECTIVE AC		(X5) COMPLETIC
PREFIX		LSC IDENTIFYING INFORMATION	TA		CROSS-REFERENCED TO		DATE
TAG	, , , , , ,		ļ		DEFICIEN	· · · · · · · · · · · · · · · · · · ·	
	Continued From pa	nge 3			This Plan of Correction is t credible allegation compli		
	the hall findicating	the facility failed to address the					
F279		rum levels]" "We were	F279	9	Preparation and/or execu- correction does not consti		
	focusing on the nu- sugars. "	rses concern of her blood			agreement by the provide		
	sugais.				facts alleged or conclusion statement of deficiencies.		
		13 at 4:50 pm with the and the director of food			correction is prepared and	. ,	
		The consultant dietitian			because it is required by th	ne provisions of	
		nsultant she should have albumin and total protein levels.			federal and state law.		
	addressed the low	albumin and total protein levels.					
		d on 10/24/13 at 5:20 PM with es (DON) and administrator					
	regarding the expe	ctations related to care				!	
		nt 's protein needs. The DON an needs to monitor more					
	closely. The admin	istrator indicated he would					
		d the dietitian once per month					
	are addressed.	nake sure the protein needs					
	463 30(4)(3) 463 4	0/L/O DICHT TO	F280	)	-The MDS for resident #43	has been corrected	11/4/13
280	483.20(d)(3), 483.1 PARTICIPATE PLA	ANNING CARE-REVISE CP			and submitted as an accur Section K; unplanned seve		
	The resident has th	e right, unless adjudged			subsequent corrected Care		
	incompetent or oth	erwise found to be			completed.		
		r the laws of the State, to ing care and treatment or			-The corrective action will	be accomplished for	
	changes in care an				those residents having the	potential to be	
	A comprehensive of	are plan must be developed			affected by the same defice Interdisciplinary Team per		
	within 7 days after	the completion of the			Review of the MDS of resi	~	
		sessment; prepared by an im, that includes the attending			the accuracy of Section K		
	physician, a registe	red nurse with responsibility			any information deemed t Any resident identified to		
		d other appropriate staff in mined by the resident's needs,			of 5% or more in a month	or 10% or more in	
	and, to the extent p	racticable, the participation of			the last six months will be interventions on their Care	•	
		sident's family or the resident's e; and periodically reviewed			#2)	(	
	and revised by a te	am of qualified persons after			-The measure put înto pla	e to ensure that the	11/11/13
	each assessment.				deficient practice will not		11/11/13
		NT is not met as evidenced by:			servicing of the Interdiscip		
		view and interview with staff update a nutritional care plan			"Nutritional Care Planning Nutritional Assessment Po		
	when a severe weigh	ght loss occurred. This was			#4)		
	evident in 1 of 3 rea for nutrition. Reside	sidents in the sample reviewed ent #43			-The facility plans to monit	or its performance	
	Findings included:				to ensure that solutions ar	e sustained by	
	Resident#43 had c	umulative diagnoses which			having the Quality Assurar designee monitor, through		
	included dementia.				and record a review of the		
	Review of the mon	thly weight chart form revealed			Nutritional Care Plans whe		
	the resident 's heig	ht was 5 feet. The monthly			loss occurs. The result of the brought to the Quarterly C	ì	
	weight chart form in	ndicated a weight history that			Meeting to ensure that the	e corrective action is	
					achieved and sustained. T	he	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/14/2013 FORM APPROVED OMB NO. 0938-0391

# **CENTERS FOR MEDICARE & MEDICAID SERVICES**

		& MEDICAID SERVICES	L				0938-0391
	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		-	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345148	B. V			10/24/2	013
	F PROVIDER OR SUPPLI S HOMES AT GUILFO			9:	TREET ADDRESS, CITY, STATE, 25 NEW GARDEN RD REENSBORO, NC 27410	· · · · · · · · · · · · · · · · · · ·	
(X4)ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAC	FIX	PROVIDER'S PLAN O	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	Continued From pa	age 4					
F280	the facility failed to when a severe wei	eview and interview with staff update a nutritional care plan ght loss occurred. This was sidents in the sample reviewed ent #43	F280	)	Administrator/DON is rest compliance.	oonsible for overall	
	Resident#43 had c included dementia.	umulative diagnoses which					
	the resident's height chart form in included in part: 07/02/13 138 poun 07/31/13 134 lbs 09/02/13 128 lbs 10/02/13 121 lbs	thly weight chart form revealed ght was 5 feet. The monthly indicated a weight history that ds (lbs)					
	dated 10/2/2013 re swallowing and nut was coded 0 (zero) had not experience	ral Minimum Data Set (MDS) vealed under Section K vition, the weight loss column which indicated the resident at a weight loss of 5% or more 10% or more in the last 6 was unknown.					
	nutrition revealed in	plan revised 7/9/13 addressing n part the goals were met risk for altered nutrition.					
	revealed no written	ed care plans dated 10/17/13 goals and approaches to ned severe weight loss.					
	Interview on 10/23/13 at 4:16 pm with MDS coordinator#2 revealed the interdisciplinary team did not do a careplan regarding nutrition because it did not appear on the CAA (care area assessment) summary determine if the facility should make a decision to careplan.						
***************************************	care manager (NCI	13 at 4:40 pm with nutrition M#1) revealed "I did the termining the degree of weight m Data Set (MDS) ated 10/2/13.					
о постоя не обстава на применения на применения на применения на применения на применения на применения на при	consultant dietitian services was held. indicated the weigh assessed. The diet consultant she sho	13 at 4:50 pm with the and the director of food The consultant dietitian t loss should have been itian also indicated as the uld have addressed the weight					
	loss on the carepla		<u></u>				

CENTERS FOR MED	CARE & ME	EDICAID SERVICES			OMB NO.	0938-0391
STATEMENT OF DEFICIE AND PLAN OF CORRECT		PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345148		NG	10/24/20	113
NAME OF PROVIDER OR FRIENDS HOMES AT (			S 9	TREET ADDRESS, CITY, STATE 125 NEW GARDEN RD GREENSBORO, NC 27410		,13
(X4)ID (EACH DE	FICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL ENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
Continued F	om page 5			This Plan of Correction is t credible allegation compli		
of nurses (D their expecta weight loss her expecta and it was ju 483.25(i) M/ UNLESS UN	ON) and the tions related eing Care Pons would be tan human einTAIN NUTAVOIDABLE	RITION STATUS		Preparation and/or execu correction does not consti agreement by the provide facts alleged or conclusior statement of deficiencies, correction is prepared and because it is required by the federol and state law.	tute admission or r of the truth of the as set forth in the The plan of I/or executed solely	
resident - (1) Maintain: status, such unless the re demonstrate	the facility nacceptable as body weight sident's clinications that this is a therapeuti	nust ensure that a parameters of nutritional pht and protein levels,	F325	1)The corrective action waresident #43 affected by the re-starting of her R with the addition of chocopreference) administered medication pass.  -The corrective action will	he deficient practice esource Supplement plate syrup (as is her with each be accomplished for	10/24/13
by: Based on ot interviews w nurse practit and provide weight loss,	servation, re- th staff, cons oner, the fac outritional int and for low p	not met as evidenced cord review, and ultant dietitian, and ility failed to assess for erventions for a severe rotein and serum sampled residents		those residents having the affected by the same defic Interdisciplinary Team ide weekly Weight Manageme residents with a severe we accordance with the parar Change Policy. (Exhibit #2)	cient practice by the ntifying at their ent Meeting those eight loss in neters in the Weight	
Findings inci  1. Record re cumulative of Review of th dated 10/2/2 severely imp dependent of experienced more in the 1 6 months.  Review of th addressed in were met reg nutrition.  Review of th the resident	riew indicate agnoses whi e annual Min 113 revealed aired cognition staff for eal a weight loss at month or a care plan retrition, revealed in the care plan retrition, revealed in the care plan restriction are care plan restriction.	d Resident #43 had ich included dementia. imum Data Set (MDS) the resident had on, was totally ing and had not so f 5 percent (%) or 10 % or more in the last evised 7/9/13, which aled in part the goals at risk for altered ight chart form revealed is 5 feet. The monthly d a weight history which s.)		The measure put into place deficient practice will not servicing of the Interdiscip Weight Change Policy and facility staff nurses at the Meeting. (See Exhibits #2 at the Interdiscip Weight Change Policy and facility staff nurses at the Meeting. (See Exhibits #2 at The facility plans to monitor to ensure that solutions are having the Quality Assurar designee monitor through and record a review of the plan interventions related with a severe weight loss. audits will be brought to the Assurance Meeting to ensure corrective action is achieve. The Administrator/DON is overall compliance.  2)Corrective actions for reby the deficient practice at albumin level recommend Registered Dietitian and or	occur is the in- dinary Team on the in-servicing of the Monthly Nurses and #5)  or its performance e sustained by nce Nurse or her a monthly audit, accuracy of care to those residents The results of the ne Quarterly Quality ure that the ed and sustained. responsible for  sident #63 affected re a repeat serum ed by the consultant	11/11/13 11/13/13

FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	0938-0391
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	{X2	2)N	MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	0550 0551
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:		·		COMPLETED	
		2.54.0	A.E	BU	ILDING	c	
		345148	B. WING 10/24/2013				
	F PROVIDER OR SUPPLI S HOMES AT GUILFO			9	STREET ADDRESS, CITY, STATE 925 NEW GARDEN RD GREENSBORO, NC 27410	, ZIP CODE	
	SUMMARY S	FATEMENT OF DEFICIENCIES	10	Ď	PROVIDER'S PLAN C	F CORRECTION	(X5)
(X4)ID PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRE TA		X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETIOI DATE
	Continued From pa	age 6					
F325	Resident #43 from	ond weight loss experienced by 07/02/13 to 10/02/13 equates ont severe weight loss during period.	F32	!5	10/23/13. Lab results rec were 3.4g/dl. NP reviewed level result and no new or The care plan was update	d serum albumin rders were received. d on 10/23/13 and	10/23/13 10/24/13
	Review of the revised care plan dated 10/17/13 revealed no written goals and approaches to address the unplanned weight loss.				10/24/13 accordingly to a albumin levels. The consu Dietitian reassessed residu recommended a protein s	lting Registered ent and upplement on	11/13/13
	physician orders fo orders for a regular	t #43 's the October 2013 or October 2013 revealed or diet and an order for a pplement of 120 milliliters twice	s the October 2013  per 2013 revealed  and an order for a  nt of 120 milliliters twice		on 11/13/13. The resident updated on 11/13/13.	on 11/13/13. The resident care plan was	
	Review of the intak 2013 through Octo	te monitoring sheets from July ber 23, 2013 revealed the d fluid intake varied from 50 %			potential to be affected by practice is that all abnorm be assessed and evaluate either the NCM or the cor	y the same deficient nal albumin levels will d by the NP and by	
	to 100 % at differer Review of Residen revealed a 10/10/1 nutritional supplem calories per millilite	nt meals. t #43 's physician orders 3 to receive 120 milliliters of a ent which provided two rr. This order was discontinued			Dietitian. The results of the becommunicated to the I a Nutritional Communicate recorded on the residents	ne assessment will MDS Coordinator via ion Notebook and	
	100%. Review of the documentation to de supplement was di	te the resident consuming ne medical record revealed no letermine why this liquid scontinued nor that other s were implemented.			Measures to be put into p the deficient practice will abnormal albumin levels v evaluated by the NP and b Consultant Registered Die	not occur are that will be assessed and by either the NCM or	11/13/13
		ntinued the supplement on vailable at the time of the riew			the assessment will be con MDS Coordinator via the I Communication Notebook the resident care plan. In-	mmunicated to the Nutritional k and recorded on	
	Interview on 10/23/13 at 3:08 PM with Nurse# 2 revealed he provided a carton of chocolate liquid supplement with a straw to the resident and she consumed all of it. Nurse#2 indicated sometimes he gave her more when he administered her medications.		con Diet albu of ti		conducted by the consulta Dietitian for licensed Nurs albumin and total protein of the Nutritional Commu (See Exhibit #3)	ant Registered ing staff on serum and on the purpose	
	assistant (NA) #3 r almost anything. " l had a problem feed	•			The Consultant Registered communicate through a m Administrator or designee protein needs are address administrator will meet w	nonthly report to the to ensure resident sed. The ith the MDS	
	revealed the reside eggs and hot cerea	akfast on 10/22/13 at 8:30 AM ent consumed 100 % of the all with the assistance of staff.			Coordinators to ensure the been updated to address albumin and protein level be reported to the Quarte	any abnormal serum s. Any concerns will erly Quality	
	revealed the reside consumed 75 % of				Assurance meeting to ens actions are achieved and s Administrator /DON are re overall compliance.	sustained. The	
	s consultant dietitia services was held i	13 at 4:50 PM with the facility the facility and the director of food regarding Resident #43 as. The dietitian stated, "The	ent ID:		TO11	If continuation cheet	

**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 10/24/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE FRIENDS HOMES AT GUILFORD 925 NEW GARDEN RD **GREENSBORO, NC 27410** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (X4)ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) TAG Continued From page 7 weight loss should have been assessed, and as F325 F325 the consultant, I should have addressed the weight loss. " On 10/24/13 at 5:10 PM an interview with the Director of Nurses (DON) and the administrator was held regarding their expectations related to the resident's weight loss The DON indicated her expectations would be that it (referring to the weight loss) wasn't missed and the facility would be revising the weight loss policy. 2. Resident#63 had cumulative diagnoses which included anemia and diabetes. Review of the Minimum Data Set dated 9/25/13 revealed resident required supervision with activities of daily living and was cognitively intact. Review of the medical record revealed no careplan to address the low protein levels. Review of the resident's hospital laboratory studies revealed on 6/18/13 a total protein level of 4.4 grams per deciliter (g/dl) and a serum albumin level 2.0 g/dl. The reference range for total protein level was 6.0-8.3 g/dl. The reference range for a serum albumin level was 3.5-5.5 g/dl. Review of the laboratory blood studies dated 7/1/13 revealed a total protein 5.1 g/dl and serum albumin of 3.1 g/dl. Review of the admitting nutritional assessment form dated 6/24/13 and authored by nutrition care manager (NCM#1) revealed a notation indicating a total protein level 5.1 g/dl and 3.1 g/dl serum albumin level. There was no assessment of the resident's estimated protein needs or recommendations to address the low protein markers. Interview on 10/23/13 at 10:21 AM with NCM#1 revealed the low albumin levels were not brought to her attention. NCM #1 revealed she was unaware of Resident #63 's low protein and albumin levels of 06/24/13, so she had not made any recommendations to address these abnormal laboratory results. Review of the 7/25/13 nutrition assessment form authored by NCM#2 revealed no indication of the low protein levels. Nor were the resident 's low protein needs addressed. Interview on 10/23/13 at 11:30 AM via the phone with NCM#2 revealed she did not address the resident's low protein and albumin levels on the

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## **CENTERS FOR MEDICARE & MEDICAID SERVICES**

OMB NO. 0938-0391

		& MEDICAID SERVICES	T				0938-0391	
	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2	2)M(	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
,			1		DING	С		
		345148	B.\	WIN		02/24/20	2012	
	F PROVIDER OR SUPPLI S HOMES AT GUILFO			92	FREET ADDRESS, CITY, STATE, 25 NEW GARDEN RD REENSBORO, NC 27410	ZIP CODE		
		FATEMENT OF DEFICIENCIES	IE	)	PROVIDER'S PLAN O		(X5)	
(X4)ID PREFIX TAG		CY MUST BE PRECEDED BY FULL. LSC IDENTIFYING INFORMATION	PRE TA		(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETION DATE	
	Continued From pa	age 8			This Plan of Correction is to credible allegation complice	*		
F325	07/25/13 nutritiona		F32	5	Preparation and/or execut			
	Continued review of the nutritional assessment progress notes dated 9/25/13 and 10/4/13 revealed the facility still did not address the low protein levels or conducted an assessment of the resident's estimated protein needs.  Interview on 10/23/13 at 1:50 PM with the consultant dietitian via the phone revealed a				agreement by the provider facts alleged or conclusion statement of deficiencies. correction is prepared and because it is required by the federal and state law.	r of the truth of the is set forth in the The plan of /or executed solely		
	confirmation that the Resident #63 's low An interview on 10 consultant dietitian services was held. specified she shou albumin and total p	via the phone revealed a se facility failed to address or protein and albumin levels. 123/13 at 4:50PM with the and the director of food. The consultant dietitian displayed the low rotein levels and should have ent's estimated daily protein.						
	PM with the director administrator regar to the assessment needs. The DON reexpected the facility	onducted on 10/24/13 at 5:20 r of nurses (DON) and the ding the expectations related of the resident's protein evealed she would have y to implement measures to 63's low albumin and total						
F431	Practitioner (NP) w indicated she was i		F431	1	1) 5		10/23/13	
SS=E	LABEL/STORE DR The facility must er a licensed pharmac of records of receip controlled drugs in	UGS & BIOLOGICALS  nploy or obtain the services of  ist who establishes a system  t and disposition of all  sufficient detail to enable an			For resident #29 found affected by the deficient p medication, the corrective return the expired medical pharmacy and new supply ordered and received from	ractice of expired action was to tion to the of medication was	20, 20, 30	
	records are in orde	ion; and determines that drug r and that an account of all maintained and periodically			The corrective action for the having potential to be affer deficient practice is to edunursing staff on medication	cted by the same cate all licensed	11/13/13	
	be labeled in accordar professional princip	als used in the facility must ace with currently accepted ales, and include the			expiration dates per the pl medication storage and ex Exhibit #6}	narmacy policy of		
- In Control of the C	appropriate access instructions, and th applicable.	ory and cautionary e expiration date when			Measures to be put into pl the deficient practice will r weekly audits of medication	not occur will be in storage and		
**************************************	facility must store a	State and Federal laws, the Il drugs and biologicals in Its under proper temperature			expiration dates to be con- nurses on the 11pm-7am s Medication Cart and Medi- Weekly Audit.	hift as part of the		

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#### CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 (Y2)MILITIPLE CONSTRUCTION (X3) DATE SURVEY

STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2)MU	LTIPLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED			
		345148		A.BUILDING C  B. WING 10/24		2012	
	PROMINER OF CHEST	<u> </u>			10/24/20	112	
l .	F PROVIDER OR SUPPLI S HOMES AT GUILFO		3	REET ADDRESS, CITY, STATE, 5 NEW GARDEN RD	ZIP CODE		
PRIEMDS	HOWES AT GOILE	אסאס	1	REENSBORO, NC 27410			
	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)	
(X4)ID	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC		COMPLETION	
PREFIX	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO		DATE	
TAG				DEFICIEN	ICY)		
	Continued From page	ana 0					
	Continued From pa	age 9	<u> </u>				
F431	controls, and perm	nit only authorized personnel to	F431	The facility's plan is to mo	nitor its		
	have access to the	e keys.		performance and ensure t			
	The facility must be	rovide separately locked,		sustained through Implen			
		d compartments for storage of		Medication Storage and E	xpiration Audit.		
	controlled drugs lis	sted in Schedule II of the		The audit will be given to	the Quality		
	Comprehensive Dr	rug Abuse Prevention and		Assurance Nurse for revie	<del>-</del>		
]	Control Act of 1976	6 and other drugs subject to		reported to the Quarterly			
		en the facility uses single unit ribution systems in which the	1	Committee to ensure that	· · · · · · · · · · · · · · · · · · ·		
	quantity stored is r	ninimal and a missing dose can		action is achieved and sus			
	be readily detected			Administrator/DON is resp	onsible for overall		
	This DECEMBERS	NIT is not met as suideneed		compliance.			
	This REQUIREME by:	NT is not met as evidenced					
	Based on observa	tions, record review and staff					
	interviews, the faci	ility failed to discard an expired					
		cified by the drug manufacturer					
	in 1 of 4 medicatio	n carts (Oaks); and failed to dications in 3 of 4 wound care					
		aples, Oaks, and Cedars).					
	The findings include	ted:					
		of the Oaks medication cart on M revealed an opened bottle of					
		spray 200 Units per actuation					
		ay used for the treatment of					
		e medication cart drawer for					
j		bottle was labeled as opened					
		expiration date of 10/4/13 was e label. A review of Resident					
		13 Physicians Orders revealed					
	there was a currer	nt order for the					
		spray dispensed as generic for					
		dose bottle delivering 200 Units en as one spray in alternating					
	nostrils every day.						
		's product information					
		of calcitonin-salmon spray may temperature for up to 35 days.					
		ned bottles left at room					
		ore than 35 days must be					
		nal information from the	ŀ				
-		cated that more than 30 doses	}				
		d from one bottle. After 30 may not deliver the correct					
		tion with each spray.					
		• •					
		conducted with the nurse					
		aks medication cart (Nurse #1) 3 PM. Upon inquiry, Nurse #1					
		een that (the expiration date) I		a.			
		ered it. The nurse noted she	İ				
	1	er bottle of calcitonin-salmon on					
		rt and subsequently reported					
	none was found in refrigerator.	the medication store room					
	reingerator.						
CODM CM	S-2567 (02-99) Previous \	Vorcions Obsolete F	vent ID:CET	011 Facility ID: 923180	If continuation she	at Page 10 of 14	

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEME	NT OF DEFICIENCIES N OF CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A.BUI	MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED C	
	F PROVIDER OR SUPPL S HOMES AT GUILFO		1	NG 10/24/201 STREET ADDRESS, CITY, STATE, ZIP CODE 925 NEW GARDEN RD GREENSBORO, NC 27410	3
(X4)ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
	Continued From p	age 10			
F431	Development Coo 4:25 PM. The SDC calcitonin-salmon the date the medic it expired. She als from the medicatic Nurse #1 inquired expired calcitonin-	spray should be labeled with cation was opened and the date o indicated it should be pulled on cart upon expiration. When as to what to do with the salmon spray, the SDC ake it off of the medication cart	F431		
	9:46 AM, the DON expired calcitonin- on the Oaks medi- situation had been her expectation w	w with the DON on 10/24/13 at I stated she was aware that salmon spray had been found cation cart and that this in resolved. The DON indicated ould be for an expired bottle of spray to be promptly removed on cart.	The state of the s		
	Storage and Expir Biologicals, Syring included the follow "Facility should e biologicals, includ securely stored in	e facility 's Policy entitled, " ration of Medications, ges and Needles, "dated 1/1/13 ving statement: nsure that all medications and ing treatment items, are a locked cabinet/cart or locked that is inaccessible by residents	And the Late of Control of Contro	2A-2C) No residents were reported to be directly affected by this practice.  The corrective action for those residents having the potential to be affected by the same deficient practice will be accomplished by ensuring that all items, per facility policy for "storage and expiration of medications, biological, syringes and needles" including	
	10/21/2013 at 10: door to room D11 Maples hall was of care treatment care with the cart's loci out/unlocked posistaff member near cart. During the community of the care of the c	the facility was conducted on 45 AM. During this tour, the 1 (a clean utility room) on the observed to be open. A wound it was observed in the room king mechanism in the tion. There was no nurse or other in the room or utilizing the ontinued tour of the Maples hall 11:00 AM, the door to room pen and the cart remained ints, visitors, and staff were the open room containing the other observation was made and the wound care		treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.  The measures put into place to ensure that the deficient practice will not occur will be to educate all licensed nursing staff on medication storage per our facility policy. The key to each treatment cart will remain in the possession of the charge nurse on each assigned hall. The charge nurse will sign a log to verify that the treatment cart will remain locked. (See Exhibits #6 and #7)  The sustained solution to monitor the facility's	11/13/13
FORM CN	treatment cart ins There was no nur room or utilizing t was observed lea both the door to t inside were obse	ide the room was unlocked. rse or staff member near the he cart. At 12:55 PM Nurse #6 rving room D111. Upon her exit, he room and the treatment cart rved to be unlocked.  f the Maples treatment cart on	Event ID:	performance will be through random weekly cart audits to ensure storage is achieved per our facility policy. The results of the audits will be reviewed and reported to the Quarterly Quality Assurance Committee by the Quality Assurance Nurse. The Administrator/DON will be responsible for overall compliance.  CETO11 Facility ID: 923180 If continuation shee	t Page 11 of 14

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### OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2)MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A,BUILDING 345148 B. WING 10/24/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 925 NEW GARDEN RD FRIENDS HOMES AT GUILFORD GREENSBORO, NC 27410 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 1D $\{X5\}$ COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (X4)ID CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION TAG **PREFIX** DEFICIENCY) TAG Continued From page 11 10/22/13 at 2:16 PM revealed the treatment cart F431 F431 was stored in Room D111. The door to the room was aiar (not latched). The room was unlocked and the treatment cart was noted to be unlocked and unattended. Prescription topical medications stored in the second drawer of the unlocked treatment cart included the following: 4 tubes of nystatin-triamcinolone cream (a prescription antifungal-steroidal cream); one bottle of ketoconazole shampoo (an anti-fungal agent); one tube of silver sulfadiazene cream (an antiseptic typically used for the treatment of burns); 2 tubes of mupirocin ointment (an antibiotic medication); 1 tube of ketoprofen gel (a nonsteroidal anti-inflammatory medication); and one vial of NyStop powder (an anti-fungal agent). Two tubes of over-the-counter (OTC) creams were also stored in the second drawer of the treatment cart. On 10/23/2013 at 10:02 AM, the facility's Assistant Director of Nursing (ADON) was observed storing the unlocked wound care treatment cart in room D111 on the Maples hall. Room D111 was left unlocked. Residents, staff, and visitors were observed passing the unlocked room storing the unlocked wound care treatment An observation of the Maples treatment cart on 10/24/13 at 9:25 AM revealed the treatment cart was stored in Room D111. The room was unlocked. The treatment cart was unlocked and unattended. Topical prescription medications were stored in the second drawer of the cart. An interview was conducted with Nurse #3 on 10/24/13 at 9:30 AM. Nurse #3 was the staff nurse on duty for the Maples neighborhood. Nurse #3 stated all staff nurses used the treatment cart. She indicated the treatment cart was kept in the clean utility room with the doors closed. She also stated that staff using the cart needed to make sure it was locked. During an interview with the DON (Director of Nursing) on 10/24/13 at 9:46 AM, the DON indicated that her expectation would be for the treatment carts to be kept in the clean utility room and locked unless it was in use. 2b) A review of the facility 's Policy entitled, " Storage and Expiration of Medications, Biologicals, Syringes and Needles, "dated 1/1/13 included the following statement: " Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents

PRINTED: 11/14/2013

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2)MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A.BUILDING\_ B. WING 345148 10/24/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 925 NEW GARDEN RD FRIENDS HOMES AT GUILFORD **GREENSBORO, NC 27410** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)ťΩ (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (X4)ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG DEFICIENCY) TAG Continued From page 12 and visitors. " F431 F431 An observation of the Oaks treatment cart on 10/22/13 at 2:01 PM revealed the treatment cart was stored in Room B111 (a clean utility room). The room was unlocked. The treatment cart was unlocked and unattended. Two 60-gram tubes of nystatin-triamcinolone cream (a prescription antifungal-steroidal cream) were sitting on top of the treatment cart. Prescription topical medications stored in the second drawer of the unlocked treatment cart included the following: 1 tube of Nizoral cream (an anti-fungal agent); 2 tubes of nystatin-triamcinolone cream; one tube of a compounded prescription cream (a medication compounded by the pharmacy which contained 6 prescription ingredients formulated in accordance with a prescriber's specifications); one tube of Prudoxin (a topical cream typically used for nerve pain); and one tube of Voltaren gel (a nonsteroidal anti-inflammatory medication). Four tubes of over-the-counter (OTC) creams were also stored in the second drawer of the treatment cart and additional over-the-counter topical products were stored in the third drawer of the cart. An observation of the Oaks treatment cart on 10/23/13 at 9:50 AM revealed the treatment cart was stored in Room B111. The room was unlocked. The treatment cart was unlocked and unattended. Topical prescription medications were stored in the second drawer of the cart. An observation of the Oaks treatment cart on 10/24/13 at 9:25 AM revealed the treatment cart was stored in Room B111. The room was unlocked. The treatment cart was unlocked and unattended. Topical prescription medications were stored in the second drawer of the cart. An interview was conducted with Nurse #2 on 10/24/13 at 9:35 AM. Nurse #2 was the staff nurse on duty for the Oaks neighborhood. Nurse #2 stated the treatment cart was kept in the clean utility room. Upon entry into the utility room, the treatment cart was unlocked. Upon inquiry, Nurse #2 indicated the treatment cart should be locked but stated he had just used it. He locked the treatment cart prior to leaving the room. During an interview with the DON (Director of Nursing) on 10/24/13 at 9:46 AM, the DON indicated that her expectation would be for the treatment carts to be kept in the clean utility room

and locked unless it was in use.

2c) A review of the facility 's Policy entitled, "

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2)MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A.BUILDING B. WING 345148 10/24/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 925 NEW GARDEN RD FRIENDS HOMES AT GUILFORD **GREENSBORO, NC 27410** PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (X4)ID CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG **DEFICIENCY**) TAG Continued From page 13 Storage and Expiration of Medications, F431 F431 Biologicals, Syringes and Needles, "dated 1/1/13 included the following statement: Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. ' An observation of the Cedars treatment cart on 10/22/13 at 2:10 PM revealed the treatment cart was stored in Room A135 (a clean utility room). The room was unlocked. The treatment cart was unlocked and unattended. Prescription topical medications stored in the second drawer of the unlocked treatment cart included the following: 8 tubes of nystatin-triamcinolone cream (a prescription antifungal-steroidal cream); two tubes of mupiricin ointment (an antibiotic medication); and one tube of hydrocortisone cream (a steroidal cream). An observation of the Cedars treatment cart on 10/23/13 at 9:35 AM revealed the treatment cart was stored in Room A135. The room was unlocked. The treatment cart was unlocked and unattended. Topical prescription medications were stored in the second drawer of the cart. An observation of the Cedars treatment cart on 10/24/13 at 9:25 AM revealed the treatment cart was stored in Room A135. The room was unlocked. The treatment cart was unlocked and unattended. Topical prescription medications were stored in the second drawer of the cart. An interview was conducted with Nurse #4 on 10/24/13 at 9:32 AM. Nurse #4 was the staff nurse on duty for the Cedars neighborhood. Nurse #4 stated each pod had a treatment cart and that cart was kept in the clean utility room. Upon entry into the clean utility room, the treatment cart was unlocked. Upon inquiry, Nurse #4 stated the treatment cart should be locked and she subsequently locked it. During an interview with the DON (Director of Nursing) on 10/24/13 at 9:46 AM, the DON indicated that her expectation would be for the treatment carts to be kept in the clean utility room and locked unless it was in use.

Event ID:CETO11

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/02/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING				SURVEY PLETED
		345148	B. WING			11/21/2013	
NAME OF S	PROVIDER OR SUPPLIER	343140	D. ()(D		TREET ADDRESS, CITY, STATE ZIP CODE		<u>, 1/2013</u>
	-			92	15 NEW GARDEN RD		
FRIENDS	HOMES AT GUILFO	RD		G	REENSBORO, NC 27410		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDERS PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	KULD BE	(XS) COMPLETIOI DATE
K 000	INITIAL COMMEN	TS	K	ю0			
	conducted as per I at 42CFR 483.70(a Care section of the publications, This b construction, fire re	ode(LSC) survey was The Code of Federal Register I); using the 2000 New Health LSC and its referenced ouilding is Type 11I(111) etardant treated wood with a complete automatic					
K 029 SS=0	NFPA 101 LIFE SA Hazardous areas a with 8.4. The area fire-rated barrier, w without windows (in	iciencles noted during survey. AFETY CODE STANDARD  are protected in accordance is are enclosed with a one hour with a 3/4 hour fire-rated door, in accordance with 8.4). Doors automatic closing in 2.1.8. 18.3.2.1	K	029	The door latch on the soiled linen room (B129) which did not latch will be correct the door will close and latch. The Maintenance Director or his/her de make monthly inspections to prevent the fan issue is identified, the Maintenanc working with the Director of Nursing and staff, will take corrective action and repactions at the Quarterly Quality Assurance Meeting.	cted to assure signee will is issue. e Department d his/her ort such	M
K 061 SS≂D	A. Based on obse to the soiled linen when closed. 42 CFR 483.70 (at NFPA 101 LIFE SA Required automativatives supervised will sound when the 72, 9.7:2.1	ic sprinkler systems have so that at least a local alarm e valves are closed. NFPA is not met as evidenced by:	K	061	We will work with our Sprinkler Service and Fire Alarm Systems Service Comcorrect this deficiency to comply with Safety Code Standard.  The Maintenance Director or his/her of will make monthly inspections to preview. If an issue is identified the Main Director working with the Director of Nhis/her staff will take corrective action such actions to the Quarterly Quality of Committee Meeting	pany to NFPA 101 lesignee ent this stenance lursing and and report	12/16/201
	A. Based on obse	rvation on 11//21/2013 the elerators were not electrically			Communes meening		

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.

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

Event ID: CETO21

Facility ID: 923180

ADMINISTRATOR

If continuation sheet Page 1 of 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/02/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CEIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 0Z - MAIN BUILDING			(X3) DATE SURVEY COMPLETED		
	•	345148	B. WING		11/	21/2013		
	PROVIDER OR SUPPLIER S HOMES AT GUILFO	RD	STREET ADDRESS, CITY, STATE, ZIP CODE 925 NEW GARDEN RD GREENSBORO, NC 27410					
(X4) ID PREFIX TAG	(EACH DETICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE		
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FORM CMS-2587(02-99) Previous Versions Obsolete Event ID: CETO21 Facility ID: 923180 If continuation sheet Pag								

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.

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72, 9.7.2.1

This STANDARD is not met as evidenced by:

A. Based on observation on 11//21/2013 the valves on the accelerators were not electrically

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Event iD: CETO21

Facility ID: 923180

Committee Meeting

Issue. If an issue is identified the Maintenance Director working with the Director of Nursing and his/her staff will take corrective action and report such actions to the Quarterly Quality Assurance

TITLE

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(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE'& MEDICAID SERVICES

PRINTED: 12/02/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION		(Xa) DATE SURVEY		
			A. BUILDING 02 - MAIN BUILDING		COMPLETED		
345148 NAME OF PROVIDER OR SUPPLIER		B. WING		11/21/2013			
FRIENDS HOMES AT GUILFORD			STREET ADDRESS, CITY, STATE, ZIP CODE  925 NEW GARDEN RD  GREENSBORO, NC 27410				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	N SHOULD BE E APPROPRIATE	
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