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 345474 B. WING 01/30/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6100 W FRIENDLY AVENUE FRIENDS HOMES WEST GREENSBORO, NC 27410 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) 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) Develop/Implement Comprehensive Care Plan F 656 F 656 2/18/20 SS=D CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-(A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITI F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

02/20/2020

PRINTED: 03/03/2020

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.

Electronically Signed

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 ____ 345474 B. WING 01/30/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6100 W FRIENDLY AVENUE FRIENDS HOMES WEST GREENSBORO, NC 27410 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (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 656 Continued From page 1 F 656 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident and family F-656 -- It is the intent of the facility to interview, staff interviews and record review, the develop and implement a comprehensive facility failed to implement a care plan care plan that addresses the care needs intervention for one of eleven residents reviewed of the resident. for comprehensive care plan. (Resident #15) Criteria 1. Corrective action to be Findings included: accomplished for those residents found to have been affected by the alleged Resident #15 was admitted to the facility on deficient practice. 12/28/2019 with diagnoses that included a fracture, muscle weakness, acute respiratory During the annual certification survey failure and dependence on oxygen. process the survey team identified R#15 to have an order offloading boots when An admission Minimum Data Set (MDS) dated R#15 was in bed and that these were not 12/30/2019 revealed Resident #15 had mild in place when noted to be in bed of cognitive impairment. He required assistance of 1-28-2020. one staff member with hygiene and toileting. Specific deficient practice affected one Assessment also revealed the resident had bed resident, Resident #15. The Director of mobility documented less than three times in the Nursing reviewed the medical records of seven day assessment period. Assessment resident #15 to ensure the resident did not further revealed Resident did not transfer out of have negative outcome related to the bed or utilize a wheelchair. Resident was reference in this report; specifically assessed to be at risk for pressure ulcer injury. worsening of pressure ulcers to the heals. R#15 s was admitted 12-28-2019 with a mattress that is a GEO Pressure Review of the resident's care plan revealed a care plan specific to pressure ulcers revised on Redistribution mattress. R#15□s care 01/15/2020. An intervention listed included: plan for Pressure Ulcers was initiated offloading boots to both heels to relieve pressure January 2, 2020. This care plan on 1-2every shift. 2020 included the following: a) Keep bony prominences from direct An observation of Resident #15 on 1/28/2020 at contact with one another with pillows, 4:00 PM revealed the resident's heels were foam wedges, etc. directly on the bed with no offloading boots in b) Keep clean and dry as possible; c) Keep linens clean, dry and wrinkle place.

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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 345474 B. WING 01/30/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6100 W FRIENDLY AVENUE FRIENDS HOMES WEST 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 656 Continued From page 2 F 656 free: The second observation of Resident #15, on d) Provide incontinence care after each 1/30/2020 at 8:38 AM revealed resident lying in incontinent episode and avoid friction on bed eating his meal with the heel of his feet on skin; the bed and no pressure relief or offloading heel Report any signs of skin breakdown; e) boots in place. Skin prep to heels BID: f) Use absorbent, skin-friendly g) An additional observation of Resident #15 on pad/briefs to maintain personal hygiene 1/30/2020 at 12:18 PM revealed resident lying in and dignity; bed with family at bedside. Offloading heel boots h) Use moisture barrier product to were not in place and resident's heels were perineal area. Zinc oxide as ordered; directly on the mattress. i) Assist with toileting as needed; j) Avoid shearing R#15 skin during An Interview was conducted with the Director of positioning, transferring and turning; Nursing (DON) on 01/30/2020 at 10:35 AM. k) Conduct a systematic skin inspection During this interview the DON stated the per facility (a Braden scale completed offloading boots should be placed on Resident upon admission and weekly x4) #15 when he is in the bed. Connect foley catheter to straight 1) drain bag when in bed; Interview was conducted with Resident # 15's m) Diet as ordered, mechanical soft with family member on 1/30/2020 at 12:18 PM. thin liquids: During the interview the family member stated n) Dry dressing to right hip incision line 4x4 gauze and paper tape done daily on 3 she had not seen the resident wearing soft boots on his feet. She further stated I have never seen -11 shift; anything on his feet but these socks. The family o) Ensure foley catheter is not pressing member then lifted the blanket to reveal Resident on skin for any length of time; #15 wearing yellow non-slip socks with his heels Evaluate and report labs as available; p) directly on the bed. and Examine feet and nails routinely and q) An interview was conducted with the Nursing provide care. Assistant (NA) assigned to Resident #15 on 1/30/2020 at 12:30 PM in the resident's room with The 1-2-2020 care plan for R#15 for family present. During the interview the NA stated Pressure Ulcers was updated on these that the resident 's offloading boots were not for dates: 1-11-2020, 1-13-2020, day shift. NA stated, "They were on for night shift 1-15-2020, 1-27-2020, 2-3-2020, and I removed them during dressing in the 2-7-2020, 2-11-2020, 2-12-2020 and morning. These are not for day shift." During this 2-18-2020. It continues to be updated on interview, Resident #15, interjected, "I wore those a regular basis. at first but have not been wearing them in a

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	MPLETED	
		345474	B. WING			1/30/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
FRIENDS				6100 W FRIENDLY AVENUE GREENSBORO, NC 27410			
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE	
F 656	Continued From page	e 3	F 65	6			
	"I have not seen thos here." At the conclusi #15 remained withou A second interview w on 01/30/2020 at 12:4 offloading boots shou	er also spoke up and stated, e during the day when I am ion of this interview Resident t offloading boots in bed. as conducted with the DON 44 PM. The DON stated the IId be in place when in bed nurse to put them on at that		 R#15□s admission orders incluing: a) Braden Scale upon admisis weekly x 4 (total of 5 Braden Stassessments); b) Skin prep to heels bid On 12-30 2019 R#15□s receive order for a) Skin prep to heels bid b) Zinc oxide to buttocks after episode and as needed for red When the surveyor spoke with Director of Nursing on 1-30-20 p.m. to notify the DON the office boots were not in place for R## DON had the wound specialist R#15□s wound assessment. The adverse change noted from week□s assessment for R#15□A copy of the R#15□s pressurplan, orders, and care guide and information on the GEO Redist mattress information are attact The nursing assistant was in-st the Staff Development Coordir same day (1-30-2020) and the in-serviced therapy staff on the responsibility to replace offload 	sion and cale ed new er every ness. the 20 at 12:44 pading 15, the update here was the prior s heels. e ulcer care nd the tribution mment A. erviced by nator that SDC		
				on R#15 s feet when in bed. E verbalized understanding. Eac member working 1-31-2020, fo shifts, were in-serviced on the 1-31-2020. A copy of these in-services are attachment B. Criteria 2. Corrective action to accomplished for those resider	h staff r all three same, also		

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	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	IDENTIFICATION NUMBER:	· /	COMPLETED	
	345474	B. WING		01/30/2020
ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE		
HOMES WEST				
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLÉTIO
Continued From page	ge 4	F 656	 potential to be affected by the same alleged deficient practice. Residents have the potential to be affected by were reviewed and ident through an audit and have been incline in the audits of measures in place in accordance with each of the respectate plans. The licensed nurses will be or have educated by the Director of Nursing designee, on the importance and motof applying offloading boots to R#15 actions to take should a R#15 or the spouse of R#15 remove these boots in R#15 is in bed. Licensed nurses wor have been educated by the Director of Nursing, or designee, on the importand and means of applying offloading boots to resident with those physician orders. On 1-30-2020 the Director of Nursing conducted a 100% audit of all resided who could potentially be affected and found there were 3 residents with of loading type boots to be applied to the feet. This audit included R#15. The were in place for each of those three residents. This is attachment C. Affected residents with off-loading bows audited daily by the DON, begin 1-30-2020. Other residents who could 	tified luded h tive been , or eans 5, and e s when will be ctor of ance pots to ls ag ents ad ff the boots e voots nning ild be
	DF DEFICIENCIES F CORRECTION ROVIDER OR SUPPLIER HOMES WEST SUMMARY S (EACH DEFICIEN REGULATORY OF	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA F CORRECTION IDENTIFICATION NUMBER: 345474 ROVIDER OR SUPPLIER	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345474 B. WING	CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345474 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE MOMES WEST SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREPER PREPER: TAG PROVIDER SPEAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY Continued From page 4 F 656 Continued From page 4 F 656 Residents have the potential to be affected by were reviewed and ident through an audit and have been incl in the audits of measures in place in accordance with each of the respect care plans. The licensed nurses will be or have educated by the Director of Nursing designee, on the importance and m of applying offloading boots to R#15 actions to take should a R#15 or have been ducated by the Director of Nursing orders. On 1-30-2020 the Director of Nursing orders.

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 03/03/2020 RM APPROVED IO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345474	B. WING _	B. WING			1/30/2020
NAME OF PI	ROVIDER OR SUPPLIER			1/30/2020			
	FRIENDS HOMES WEST			61	100 W FRIENDLY AVENUE		
FRIENDS				G	REENSBORO, NC 27410		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From page	e 5	F	656			
	••••••••••••••••••••••••				present. This is attachment D.		
					It should be noted during this audit, F refused boots several times documer in the nursing notes. This is attachme	nted	
					R#15⊡s BIMS score is 10 as assess -30-2019. Attachment F.	ed 12	
					The MDS Coordinator completed a 1 audit of all residents to identify if each resident has a Pressure Ulcer Care p It was noted all residents have a pres ulcer care plan completed 2-18-2020 Attachment G.	n Ian. ssure	
					The facility protocol has each bed wit GEO Pressure Redistribution mattres unless the physician has ordered differently. Mattress specs are include Attachment H.	S,	
					Criteria 3. Measures to be put into pla or systemic changes made to ensure the alleged deficient practice will not occur.		
					Nursing staff will be or have been educated by Director of Nursing, or designee on the importance and mea following the care plan for R#15 and actions to take should another event noted by staff.	the	
					The Director of Nursing, or designee audit R#15 for 10 days. Any other res identified in the 100% audit (2 others were monitored each shift for 1 week	sident)	

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			(VO) 1 ** *			<u>10. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		TE SURVEY MPLETED
		345474	B. WING		c	1/30/2020
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		ZIP CODE	
FRIENDS	FRIENDS HOMES WEST			6100 W FRIENDLY AVENUE GREENSBORO, NC 27410		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	NOF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 656	Continued From page 6		F 656	 days). Attachment C. Newly hired nursing states on following the care plaguides. Following these audits of and 7 days for 2 others on a every shift, 3 x a weater the second bill be conditioned by the second by the second bill be conditioned by the second bill be conditioned by the second by the s	(10 days for R#15) will be conducted veek for 1 month. nducted by the esignee for all affected; then with s audit will be 1x ese audits and the ese audits will be	
				Criteria 4. Facility □s pla performance so solution and integrated into the assurance system. Data obtained from the analyzed by the DON a patterns, trends and/or further educational oppi analysis. The trends/pa education and disciplina reported to the Quality / Performance Improvem Committee at its April 2 meeting.	ns are sustained facility □s quality se audits, will be nd/or designee for the need for ortunities based on tterns noted, ary action taken Assurance tent (QA/QAPI)	
				The QAPI Committee w effectiveness of the plan plan, as needed, based identified in the audits.	n and adjust the I on trends	

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Facility ID: 933179

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		MEDICAID SERVICES		OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED
		345474	B. WING		01/30/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
FRIENDS	HOMES WEST			3100 W FRIENDLY AVENUE GREENSBORO, NC 27410	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETIC
F 656	Continued From page	97	F 656	is responsible to see that the QAPI recommendations are acted upon in a timely manner.	a
F 686 SS=D	Treatment/Svcs to Pr CFR(s): 483.25(b)(1)	event/Heal Pressure Ulcer (i)(ii)	F 686		2/18/20
	resident, the facility n (i) A resident receives professional standard pressure ulcers and o ulcers unless the indi demonstrates that the (ii) A resident with pre- necessary treatment with professional star promote healing, pre- new ulcers from deve This REQUIREMENT by:	s care, consistent with Is of practice, to prevent Joes not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent adards of practice, to vent infection and prevent cloping.			
	Based on observation, resident and family interview, staff interviews and record review, the facility failed to provide physician ordered offloading boots for one of one resident reviewed for pressure ulcers. (Resident #15)			F-686 It is the intent of the facility to ensure resident receives care to prevent/treat pressure ulcers consister with professional standards of practic and to develop and implement approp plans of action to correct identified qu	ent e priate
	Findings included:			deficiencies and to sustain the correct actions.	tive
	12/28/2019 with diag	kness, acute respiratory		Criteria 1. Corrective action to be accomplished for those residents four have been affected by the alleged deficient practice.	nd to
	12/30/2019 revealed	m Data Set (MDS) dated Resident #15 had mild He required assistance of		During the annual certification survey process the survey team identified R#	

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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 345474 B. WING 01/30/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6100 W FRIENDLY AVENUE FRIENDS HOMES WEST GREENSBORO, NC 27410 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) 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 686 Continued From page 8 F 686 to have an order offloading boots when one staff member with hygiene and toileting. Assessment also revealed the resident had bed R#15 was in bed and that these were not mobility documented less than three times in the in place when noted to be in bed of seven day assessment period. Assessment 1-28-2020. further revealed Resident did not transfer out of Specific deficient practice affected one bed or utilize a wheelchair. Resident was resident. Resident #15. The Director of assessed to be at risk for pressure ulcer injury. Nursing reviewed the medical records of resident #15 to ensure the resident did not Review of Resident #15's chart revealed new have negative outcome related to the diagnosis of pressure ulcer injuries to the right reference in this report; specifically heel and top of left foot dated 01/15/2020. The worsening of pressure ulcers to the heals. resident acquired the pressure ulcers at the R#15 s was admitted 12-28-2019 with a nursing home. mattress that is a GEO Pressure Redistribution mattress. R#15 s care Review of the resident#15's care plan revealed a included a Braden Scale observation, skin new diagnosis of pressure ulcer injuries to the prep to the heels BID and an air mattress right heel and top of left foot dated 01/15/2020. overlay with the pump located on the foot The care plan specific to pressure ulcers was board and the function of the pump/air also revised on 01/15/2020. An intervention listed overlay checked each shift. R#15 s plan included: offloading boots to both heels every of care for Pressure Ulcers was initiated shift on 1-2-2020 and included the following at that time: a) Keep bony prominences from direct Review of Resident #15's physician orders revealed an order written on 1/15/2020 that read: contact with one another with pillows, " Offloading boots to bilateral lower extremities." foam wedges, etc. Keep clean and dry as possible; b) An observation of Resident #15 on 1/28/2020 at Keep linens clean, dry and wrinkle c) 4:00 PM revealed the resident's heels were free; directly on the bed with no pressure relieving Provide incontinence care after each d) incontinent episode and avoid friction on device in place. skin: The second observation of Resident #15, on e) Report any signs of skin breakdown; 1/30/2020 at 8:38 AM revealed resident lying in f) Skin prep to heels bid; bed eating his meal with the heel of his feet on q) Use absorbent, skin-friendly the bed and no pressure relief or offloading heel pad/briefs to maintain personal hygiene boots in place. and dignity; h) Use moisture barrier product to An additional observation of Resident #15 on perineal area. Zinc oxide as ordered; 1/30/2020 at 12:18 PM revealed resident lying in Assist with toileting as needed; i)

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	O. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	CON	IPLETED	
		345474	B. WING		0	1/30/2020
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
FRIENDS	HOMES WEST			6100 W FRIENDLY AVENUE GREENSBORO, NC 27410		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 686	Continued From pag	e 10	F 68	36		
				 The nursing assistant was in-set the Staff Development Coordina same day (1-30-2020) and the S in-serviced therapy staff on the responsibility to replace offloadi on R#15□s feet when in bed. E verbalized understanding. Each member working 1-31-2020, for shifts, were in-serviced on the s 31-2020. A copy of these in-services are attachment C. Criteria 2. Corrective action to b accomplished for those residen potential to be affected by the s alleged deficient practice. Residents have the potential to affected by were reviewed and through an audit and have beer in the audits of measures in pla accordance with eah of the resp care plans. The licensed nurses will be or h educated by the Director of Nur designee, on the importance an of applying offloading boots to F actions to take should a R#15 c spouse of R#15 remove these the set of the	ator that SDC ng boots ach staff all three ame by 1- e ts having ame be dentified n included ce in bective ave been sing, or d means R#15, and r the	
				in R#15 is in bed. Licensed nurs or have been educated by the I Nursing, or designee, on the im and means of applying offloadir each resident with those physic orders.	Director of portance ig boots to	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	D: 03/03/2020 MAPPROVED D: 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345474	B. WING			01/30/2020		
NAME OF PF	ROVIDER OR SUPPLIER	1		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 1		
FRIENDS	FRIENDS HOMES WEST			61	00 W FRIENDLY AVENUE			
				G	REENSBORO, NC 27410			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 686	Continued From page	e 11	F6	686				
					On 1-30-2020 the Director of Nursing conducted a 100% audit of all residen who could potentially be affected and found there were 3 residents with off- loading type boots to be applied to the feet. This audit included R#15. The bo- were in place for each of those three residents. This is attachment D. It should be noted during this audit, R refused boots several times documen in the nursing notes. This is attachmed Criteria 3. Measures to be put into pla or systemic changes made to ensure the alleged deficient practice will not occur. Nursing staff will be or have been educated by Director of Nursing, or designee on the importance and mea following the care plan for R#15 and t actions to take should another event the noted by staff. The Director of Nursing, or designee of audits R#15 for 10 days. Any other resident identified in the 100% audit (co thers) were monitored each shift for week (7 days). Attachment D. Following these audits (10 days for Ra and 7 days for 2 others) will be condu on a every shift, 3 x a week for 1 mon	e poots #15 ted nt E. ce that ns of he pe will 2 1 #15 cted		
					These audits will be will be conducted the Director of Nursing or designee for residents who could be affected; then	r all		

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		MEDICAID SERVICES	(X2) MI II TIP	LE CONSTRUCTION	OMB NO. (X3) DATE SI	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLE		
		345474	B. WING		01/30	0/2020
NAME OF F	ROVIDER OR SUPPLIER			CODE		
FRIENDS	HOMES WEST			6100 W FRIENDLY AVENUE GREENSBORO, NC 27410		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 686	Continued From page	je 12	F 68	 no issues identified, this au weekly for 4 weeks. These necessity continuing these re-evaluated at the April Q. Criteria 4. Facility s plan to performance so solutions a and integrated into the faci assurance system. Data obtained from these a analyzed by the DON and/patterns, trends and/or the further educational opportu analysis. The trends/patter education and disciplinary reported to the Quality Ass Performance Improvement Committee at its April 2020 meeting. The QAPI Committee will e effectiveness of the plan an plan, as needed, based on identified in the audits. The is responsible to see that the recommendations are acted timely manner. Preparation and execution correction in no way constite admission or agreement by Homes West of the truth of alleged in this statement of plan of correction. In fact, the comply with state and fede because the facility has be 	audits and the audits will be API meeting. o monitor its are sustained lity □ s quality audits, will be or designee for need for unities based on ns noted, action taken urance : (QA/QAPI) 0 quarterly evaluate the hd adjust the trends e Administrator he QAPI d upon in a of this plan of tutes an / Friends i the facts i deficiency and his plan of lusively to ral law, and	

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Facility ID: 933179

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM): 03/03/2020 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345474	B. WING _		01/30/2020		
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		00/2020
	FRIENDS HOMES WEST			61	00 W FRIENDLY AVENUE		
FRIENDS	HOMES WEST			GI	REENSBORO, NC 27410		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From pag	e 13	F	586	with termination from the Medicare/Medicaid program if it fails t so. The facility contends that it was in substantial compliance with all requirements on the survey dates and denies that any deficiency exits or exi or that any such plan is necessary. Neither the submission of such plan, r anything contained in the plan, should construed as an admission of any deficiency, or of any allegation contain in this survey report. The facility has r waived any of its rights to contest any these allegations or any other allegati or action. This report of correction and plan of correction serves as the allegation of substantial compliance.	l sted nor l be ned not of	
	7(02-99) Previous Versions Ob	solete Event ID: RG			ility ID: 933179 If contin		t Page 14 of 14

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