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

PRINTED: 06/24/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345474	B. WING			06/22/2011	
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES WEST				6	REET ADDRESS, CITY, STATE, ZIP CODE 100 W FRIENDLY AVENUE GREENSBORO, NC 27410		•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	Long Term Care Fa 06/21/11 - 06/22/11	mpliance with the CFR Part 483, Subpart B for acilities (annual recertification i Event ID# Z8YX11).		000			
LABORATOR\	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) 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.

PRINTED: 07/19/2011 DEPARTMENT OF HEALTH AND HUM. SERVICES JUL 29 2011 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/BUPPLIER/CLIA YEVRUE BYAD (EX) (X2) MULTIPLE CONSTRUCTION and Plan of Correction IDENTIFICATION NUMBER: COMPLETED A, BUILDING 01 - MAIN BUILDING 01 B. WING 345474 07/14/2011 NAME OF PROVIDER OR SUPPLIER SYREET ADDRESS, CITY, STATE, ZIP CODE 6100 W FRIENDLY AVENUE FRIENDS HOMES WEST GREENSBORO, NC 27410 SUMMARY STATEMENT OF DEFICIENCIES (X4) JD PROVIDER'S FLAN OF CORRECTION (X61 COMPLETION (EACH DEPICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEMOIENCY A- Beginning July 28, The Staff NFPA 101 LIFE SAFETY CODE STANDARD K 038 K 038 Development Director will provide SS≍D an in-sorvice (individual and Exit access is arranged so that exits are readily accessible at all times in accordance with section group) for allemployees to insure 7.1. 19.2.1 that they know the location and purpose of the Emergency Master Door Release Switch. This training will focus on the safety value of all employees knowing how to insure clear access to exits during This STANDARD is not met as evidenced by: an emergency. Also, beginning A. Based on observation on 07/14/2011 the staff July 28, 2011 all new employee 🐇 interviewed did not know about the master door orientations will include an release switch located at the nurses station. explanation of the Emergency B. Based on observation on 07/14/2011 the Master Door Switch loading dock did not have any protection to prevent some one from falling off it. The height 8/8/11 requires some tye of pretection.. B- We will install steel Cables at 42 CFR 483,70 (a) the edge of the lading dock, fast-K051 ened to steel posts on each end of K 051 NFPA 101 LIFE SAFETY CODE STANDARD SS×D the dock to prevent someone from A fire alarm system with approved components. accidentally falling. devices or equipment is installed according to The maintenance director or designee NFPA 72, National Fire Alarm Code, to provide of the maintenance staff will make effective warning of fire in any part of the building. daily inspections of the dock to Activation of the complete fire alarm system is by to insure the cables are ih place manual fire alarm initiation, automatic detection or If any concerns are identified, the extinguishing system operation. Pull stations in maintenance director working with patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of the director of nursing and her 3 nurse's stations. Pull stations are located in the staff will take corrective action path of cgress. Electronic or written records of and report such action at the tests are available. A reliable second source of quarterly QA meeting. power is provided. Fire alarm systems are 8/28/1 maintained in accordance with NFPA 72 and records of maintenance are kept readily available. K 051 We will work with fire alagm system There is remote annunciation of the fire alarm service company, Simplex Grinnell system to an approved central station. 19.3,4, to correct this defictency to 9,6 comply with this Life Safefy Code LABORATORY DIRECTOR'S OR PROVIDENSURPLIER REPRESENTATIVE'S SIGNATURE TITLE BTAG (6K) Administrator Iny Rumm

FORM CMS-2587(02-99) Previous Versions Obsolete

program participation.

Event ID: Z8YX21

Any deficiency which the institution may be excused from correcting providing it is determined that other eafequards 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

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

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A, BUIL	ULTIPLE CONSTRUCTION DING 01 * MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
	345474		B. WING	3	07/14/2011	
	PROVIDER OR SUPPLIER S HOMES WEST			STREET ADDRESS, CITY, STATE, ZIP COD 6100 W FRIENDLY AVENUE GREENSBORO, NC 27410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REPERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	
K 051	Continued From page 1		The maintenance director or design K051 of the maintenance staff will make monthly inspections to prevent the issue from recurring. If any concerns are observed, the			
				maintenance directo the director of nur will take correctives such action at the meeting.	sing and her staf e action and repo quarterly QA	
K 061 SS¤D	A. Based on observators alarm control panel AC power, Battery of 42 CFR 483.70 (a) NFPA 101 LIFE SAI Required automatic	s not met as evidenced by: /ation on 07/14/2011 the fire could not be tested for loss of or Telephone communications. FETY CODE STANDARD sprinkler systems have that at least a local alarm valves are closed. NFPA	K 06	We will work with o service company, Su Co, to correct this comply with this Li Standard. The maintence directof the maintenance make monthly inspecthis issue from recconcern is identificited.	nland Sprinkler deficiency to fe Safety Code tor or designee department will tions to prevent urring. If any ed, the maintenant th the director o	
K 145	A. Based on observences no low and high the dry sprinkler sys 42 CFR 483.70 (a)	not met as evidenced by: ation on 07/14/2011 there air pressure alarm switch on tem.	V 4.4	nursing and her star corrective action ar action at the quart	nd report such erly QA meeting.	
SS=D	The Type I EES is di	ivided into the critical branch, d the emergency system in	N 14	We will work with outransfer switch service carolina CAT to correct deficiency to comply Code Standards. The maintenance direct of the maintenance service controls	vice company, rect this with Life Safety ector or designee staff will make	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION 1G 01 - IMAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		3 4 5474	B. WING_		07/1	4/2011
	PROVIDER OR SUPPLIER S HOMES WEST			REET ADDRESS, CITY, STAYE, ZIP CODE 1100 W FRIENDLY AVENUE GREENSBORO, NC 27410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 145	This STANDARD is A. Based on observequired more than	s not met as evidenced by: valion on 07/14/2011 ATS #1 (10) ten seconds to crank and er lights were not working on	K 145	issue from recurring concern is identified ance director working director of nursing will take corrective report such action and weeting.	ed, the ng with and her e action at the q	nainten- the staff and

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