PRINTED: 02/05/2014 FORM APPROVED OMB NO. 0938-0391

DEPARTM	MEMI OF HEVELLOR	AEDL#ACC				OMID MC	7, 0000 <del>00</del> 0 .
CENTERS	S FOR MEDICARE &	MEDICAID SERVICES	T 2400 3 10 11 11	TIDLE	CONSTRUCTION	(X3) DATE	
STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				COMP	LETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILD	ING			
						120	05/2013
		345460	B. WNG			1 121	00,2010
	ON ADED OD STIDDLIED			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PF	ROVIDER OR SUPPLIER			1	41 WILLOW ROAD		
GUILFORE	HEALTH CARE CENT	ER		G	REENSBORO, NC 27406		
			ID	<del>'</del>	PROVIDER'S PLAN OF CORRECTION	1	(X5) COMPLETION
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES  OY MUST BE PRECEDED BY FULL  DEFICIENCY DISCORDATIONS	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
PREFIX	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAC	3	DEFICIENCY)		
TAG	1,2002				<u> </u>		
							1/2/14
	LOG 40(-) DICUT TO	DE EREE FROM	F	221			112/17
F 221	Language DECTRA	AINTS					
SS=D	HHAPICAL KEDIKA						
	The regident has the	e right to be free from any					
1	The resident has the	nposed for purposes of					
1	discipline or conven	ience, and not required to					
	treat the resident's	nedical symptoms.					
	Heat the leadonts						
1							
]	This REQUIREMEN	IT is not met as evidenced					
	hv:				This POC F221		
1	Donad on observat	ions, staff interviews, and			The statements included are not an		
	record review, the f	acility failed to assess for the	Ì		admission and do not constitute		
<b> </b>	Least restrictive dev	rice before utilizing geo			agreement with the alleged deficient	cies	
	mattresses and bed	bolsters for 1 of 3 sampled			herein. The plan of correction is		
Į.	residents reviewed	for physical restraints			completed in the compliance of state	e and	
1	(Resident # 66). Th	ne findings included			federal regulations as outlined. To	remain	
					in compliance with all federal and st	tate	
1	Resident #66 was	readmitted to the facility on			regulations the center has taken or	will	-
1	14/49/42 The cumu	lative diagnoses included			take the actions set forth in the follo	wing	
-	hypertension diab	etes coronary artery disease,			plan of correction. The following plan	an of	
ļ	decemerative joint	disease, congestive neart	İ		correction constitutes the center⊡s		
	failure and dement	ia. The quarterly Minimum	1		allegation of compliance. All allege	ed	
	Data Set (MDS) da	ated 10/16/13, indicated that			deficiencies cited have been or will	be	
1	Dosident #66 real	ired extensive to total			completed by the dates indicated.		
1	I dependence with a	all activities of daily living. The			Completed by the		
1	MDS coded Resid	ent #66 as 1 person assistance			F271 How corrective action will be		
	Lucille Assessfore and	1 nergon assistance with			accomplished for each resident fou	and to	
	mobility The MDS	did not code Resident #00 with	ļ		have been affected by the deficient	it	
	l any ambulation co	oncerns or fails during the			practice: □Resident #66 bed bolste	ers	
	assessment perio	d. Review of the care area			were discontinued on 12/4/13. Ge	o mat	
	assessment for fa	ills dated 10/16/13, did not	Ì		with wings was discontinued on 12	<u>2</u> /20/13.	
1	identified any con	cerns for Resident #66 for fails			New Device/Restraint assessment	t	
	from had or whee	Ichair. The geo mattress and	1		completed on 12/11/13 and 12/20/	/13 to	
	had halster had b	een in place since 5/2/12 and			reflect current status. Fall care pla	ın	
	lidontified as defin	ing the parameters of the bed.			updated 12/11/13 and 12/20/13 to	reflect	
	There were no pl	nysician orders for either device.	Į		current status.		
- [	Ì				Oditori otatas.		
1	Reviewed of the	physical therapy evaluation	- ]		How corrective action will be		
	dated 10/2/13, re	vealed there was no					(X6) DATE
1	1				TITLE		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

12/26/2013

**Electronically Signed** 

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

CENTED	S FOR MEDICARE &	MEDICAID SERVICES	<del>, · _</del>			ry3) DAT	E SURVEY
STATEMENT (	OF DEFICIENCIES	LIVAN PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	COM	PLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			
		345460	B. WING			112	2/05/2013
	- transpoo cupplice			1	REET ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER				41 WILLOW ROAD		
GUILFOR	D HEALTH CARE CENTE	ER		G	REENSBORO, NC 27406	CTION	(X5)
(X4) ID PREFIX TAG	JE VOLUDECICIENO	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
F 221	assessment or concepositioning in bed or use of the geo mattreapy goals include endurance and safe diner for improved dindependence and of the care Resident #66 was a related decreased of The goals included injury from a fall resident through next review usage of rails on be keep call bell in pla locked, pressure pask/encourage/assignationed to aid in place on bed to de reeducated resider transfers for safety	erns with Resident #66 a screen/evaluation for the ess or bed bolsters. The ed strengthening, balance, ty in order to return to walk to laily activities/quality of life overall health.  plan dated 10/22/13, identified at increased risk for falls cognition, decreased mobility. resident will not sustain any sulting in hospitalization at the approaches included ed to assist with bed mobility, ce, keep wheels on bed ad alarm, fall mat beside bed, ist resident to toilet, low bed preventions of falls, bolsters fine perimeters of the bed, at orders and progress notes	F	221	accomplished for those residents the potential to be affected by the deficient practice: □All current rewith geomat with wings and/or be bolsters have been re-assessed restrictive device by DON or destand whether meets the definition restraint per RAI. MDS modificated if indicated. Completion 1.  Measures to be put in place or schanges made to ensure practice re-occur: Any resident with a gewings, bed bolsters or both, will assessed for least restrictive dewhether meets the definition of per RAI. Quarterly and weekly Committee (DON, RN Unit Mar Rehab Director) in Quality Ass Risk meeting X 3 months and Quality Assurance meeting x 1 resolution is needed. Complet 1/2/2014.  How facility will monitor correct action(s) to ensure deficient pure action to the pure action to the process action to the pure action to the	e same esidents eed for least signee, n of tions /2/2014.  systemic ce will not eomat with I be evice and restraint by nager, surance Quarterly for further tion	
	revealed there we falls or the need for on bed. There was therapy screen for	re no concerns identified with or geo mattress or bed bolster is no medical justification or the use of the devices.			not re-occur: Any resident with with wings, bed bolsters or bo assessed for least restrictive of whether meets the definition of per RAI quarterly, weekly by 0	n a geomat th, will be device and of restraint	
	Resident #66 was mattress, bed bol of bed. Resident and drawn closely	ation on 12/4/13 at 8:10AM, If lying in bed with the geo sters in place and 1/4 rails at top looked stuffed in a tight place to the bolsters with no leg as in low position and beige floor re was no physical movement in			per RAI quarterly, weekly by Community (DON, RN Unit Manager, Refin Quality Assurance Risk me months and Quarterly Quality meeting x 1 for further resolution 1/2/201	eting X 3 Assurance tion is	ion sheet Page 2

CENTERS	FOR MEDICARE & DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			TRUCTION	CON	E SURVEY (PLETED
ND PLAN OF (	CORRECTION	IDENTIFICATION NUMBER:	A. BUILUM	4G			2/05/2013
		345460	B. WING		FADDRESS, CITY, STATE, ZIP CODE		2,00,201
NAME OF OR	OVIDER OR SUPPLIER				ILLOW ROAD		
					NSBORO, NC 27406		
GUILFORD	HEALTH CARE CENT			L	DECLEDED BY AN OF CORE	RECTION	(X5) COMPLETION
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREF TAG	1	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOOLD BE	DATE
F 221	Continued From pag	ge 2	   F	221			
	9:30AM, Resident # wheelchair room loo indicated that he has say that he was tra to wheelchair and r ago. His bed has to mattress. He indica put on his bed bec of bed." He indica needed it because used the call light short distance to to it stopped him from go to the bathroon was located next	on and interview on 12/4/13 at 1666 was seated in his oking out the window. He ad not fallen out of bed. He did insferring himself from a chair missed the chair about a month oliue bed bolster and geo ated that the bed bolster was ause "they said I use to roll out ted that he didn't think he he did not roll out of bed. He and he was able to walk the he bathroom. He further stated in getting up when he wanted to nor get in his chair. The chair to bed in corner. He stated that him they didn't want him to fall, "I of bed in years, I just want go to comething to eat."					
	Nurse#2 indicate verbalize his nee Nurse#1 further s bolster was in pla high risk for falls and for safety. N unaware of how bolster or geo m  During an obser	ew on 12/4/13 at 9:40AM, d that Resident #66 was able to ds and use the call light. Stated the geo mattress and bed ace because Resident #66 was a and to prevent him from falling urse #1 indicated that she was long the resident had the bed attress.  Vation on 12/4/13 at 9:50AM, as seated in his wheelchair with oncerns or repetitive movement.					
	i tarah tharani	view on 12/4/13 at 11:30AM, ist #1 indicated that she was sident #66 being assessed by			20%b) ID: 943221	If continu	ration sheet Page

CENTERS	FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	1	LE CONSTRUCTION	COM	E SURVEY IPLETED
ATEMENT OF	CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	S		2/05/2013
		^ 345460	B. WING			2/05/2010
		1	STREET ADDRESS, CITY, STATE, ZIF CODE  2041 WILLOW ROAD		DE	
NAME OF PR	OVIDER OR SUPPLIER	•				
OUIL EODE	HEALTH CARE CENT	ER	į	GREENSBORO, NC 27406		(X5)
GOIFLOIVE			ID.	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT)	ON SHUULU P⊏	COMPLETION
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CURRECTIVE ACT	JE W. Likot im	DATE
				•		
	Esom par	70 3	F 2	221		1
F 221	Continued From pag	itioning and she was unaware				
	therapy for bed pos	ad the geo mattress/bed				
	that Resident #60 ft	that the resident was being				
	l e	Mraneter and unaware or are		1		
	seen for ambulation	is for bed positioning devices.				
	assessment proces	19 101 100 644				
	During a follow up	interview on 12/4/13 at				
	to the standard of the cold	and the still ill the pea see				
	Not light out or ned a	o his chair or the bathroom.				
	During an interviev	w on 12/4/13 at 12:00PM,				
ĺ		1 that the riper itialiless are ~~~	ļ			
	I Listera had boon	in hiace silice of a re-				
				1		
	1 11 1	region that regionit to a firm				
	I a more falle from	n the nea tot tite past your arre				
	I are structured inclined	tor there were no concorne	ļ			
	the purce	Se notes to indicate of rencor				
	1 - 1 400 0410	mate to det dul ul bou vi vi v	Ì			
1	Letter morning the	re a medical reason for all		,		
	of the geo mattre	ss or bed bolster since the				
	resident did not r	have any falls. The team				
Ì	discussed option	s for referral to therapy and				
Ì	elected not to ret	fer to therapy since the devices ared a restraint and it was for				•
1	were not conside	eted a tearrain and it was				
}	resident safety.					
1	During an intend	iew on 12/4/13 at 12:05PM, the				
	lar Canouitor	A indicated that the geo matter				
	r 1 11- alabar	moe need to Dievell 1700/0011	ļ			•
1						
}	بطكمتني ببنا	A DAMEW DI LIB LECOLO 10 TO CONTE		,		ļ
	in decision was	o in hisce silice of 21 12. Rooms				
	تتصط فسندان فالصمندا	a and nashining concerns at all				
-		sacht did but have ally ions how				
	والمستران والما	mara than a veal. III auguett in """	1			
1	Ded of ottom it.	did not have any documentation		Facility iD: 943221	If continu	uation sheet Page

DEPARTM	ENT OF HEALTH AN	MEDICAID SERVICES					TE SURVEY
CENTERS	FUR MEDICARE &	LV4V DROVINER/SUPPLIER/VLIA			CONSTRUCTION	( co	MPLETED
STATEMENT OF AND PLAN OF (	DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILD!	NG_		}	
			B. WING				2/05/2013
		345460	18.71		STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER				2041 WILLOW ROAD		
'au FORD	HEALTH CARE CENTI	≅R			GREENSBORO, NC 27406		
GUILFORE			ID		PROVIDER'S PLAN OF CORRE	CTION	(X5) COMPLETION
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
			_		4	•	
F 221	Continued From pag	ge 4	F	22	1		
	was the regident has	any falls from bed or had					
	been screen or a ph	ysician order for the use of					
	the devices.		ļ				
		12///13 at 2:10PM					
	During an interview	on 12/4/13 at 2:10PM, 2 indicated that he was	Ì				
	1 of the type	7 UF GEARCES OIL LASSINGER HOO					
i	I had the added that	resident was seen in therepy					
ì	Learnetorotive ambi	illation only. He added that	1				
	The staff was re	senonginie for determining ov					
ļ	I modification devices	nised for bed and mar moreh					
ļ	I be all not accomplished to	relybut tot au assessiment ioi					
ļ	the geo mattress/b	ed bolsters. He indicated that equired 1 person assistance.					
1	the resident only is	able to walk short distance with	Ì				
	Resident #00 was	e was not aware of a medical					
	concern for the us	e of the bed devices.					
1	1		Ì				
1	During a follow-up	interview on 12/4/13 at					
1	1 2-26DM the Nurse	a consultant indicated that the					
1	unit manager was	responsible for doing the nt form to include all the devices					
	device assessmen	sident. She indicated that the			1		
	had baleter and 0	en mattress was not assessed	}				
-	as a rootraint or c	oded on the MDS because the					
1	dovings Were USA	d as a satety measure to	ļ				
	I was out the reside	ant for falls. Other address with					
	it - vice a sucro in n	Jace since May 2012 and no					
1	falls from the bed	or any other location. The new					
	screen/evaluation	should have been done.					
	During an intend	ew on 12/4/13 at 2:50PM, NA#1	-				
j	i tu attacked that chi	a had Mulkell Mill Lagranic					
	an numorous occ	casions and on different Simus.					
	Ohe indicated the	at she was unaware or with the					
	and mottroce or	hed holster were in place offici	\				
	las introduced for or	return nrevent the resident nom					1
	Lewis Chaindic	bated that when the Deu Duisters					
1	were in place ar	id the resident wanted to get out	100711		Facility ID: 943221	If continu	lation sheet Page

ATEMENT O	ENTERS FOR MEDICARE & MEDICAID SERVICES  EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	PLE CONSTRUCTION  G	CON	E SURVEY IPLETED
D.E.D.T.C.	<b></b>	0.5160	B. WNG _			2/05/2013
	ROVIDER OR SUPPLIER	345460		STREET ADDRESS, CITY, STATE, ZIP CO 2041 WILLOW ROAD GREENSBORO, NC 27406	DE	
(X4) ID PREFIX TAG	EX. (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF C	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 221	of bed Resident ##bed. He generally or go sit in the charequired 1 person have many repetit was aware of and when he needed something to eat.  During an intervie indicated that she for a number of y resident generall early in the morn he could get in h to eat. She indicated that she for a number of y resident generall early in the morn he could get in h to eat. She indicated that we have any falls the throw his legs on he needed. She bolsters were to out of bed. He was needed and that movements in the dolsters in movements.  272 ASSESSMENT	either wanted something to eat air. She indicated that he assistance. Resident did not live movements or falls that she he was able to let staff know to go to the bathroom or wanted when on 12/4/13 at 2:55PM, NA #2 had worked with Resident #66 ears. She indicated that the y would attempt to get out of bed ing between 2 and 5AM so that is chair or he wanted something ated that Resident #66 would of the bed in order to get out of icated that the resident did not at she was aware of or he would wer the bolster trying to get what indicated that she was told the prevent the resident from falling was able to verbalize his basic Resident #66 did not have a lot of the bed.  Invation on 12/5/13 at 8:00AM, he bed in fetal position without the place. There were no physical of the conduct initially and periodically live, accurate, standardized ssessment of each resident's	F	F 272		1/2/14

CENTERS	FOR MEDICARE &	MEDICAID SERVICES	C/2) MINET	TPLE	CONSTRUCTION	(X3) DATE	SURVEY PLETED
TATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				001/11	LEICO
ND PLAN OF (	CORRECTION	<b>,, _</b>				1 12	/05/2013
		345460	B. WNG_		STREET ADDRESS, CITY, STATE, ZIP CODE	112	103/2010
NAME OF PR	OVIDER OR SUPPLIER				RTREET ADDRESS, CITT, STATE, 22 0002		ļ
					GREENSBORO, NC 27406		
GUILFORD	HEALTH CARE CENT	- K		<u>L</u>	DROMDER'S PLAN OF CORRECTION	)N	(X5) COMPLETION
(X4) ID PREFIX TAG	cooleste	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	U BE	DATE
F 272	A facility must make assessment of a res resident assessment by the State. The a least the following: Identification and de Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-the Physical functioning Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of the additional asserting per Set (MDS); as the same potential po	a comprehensive ident's needs, using the trinstrument (RAI) specified ssessment must include at emographic information;  patterns; peing; grand structural problems; and health conditions; hal status;  and procedures; al; summary information regarding essment performed on the care of the completion of the Minimum	F	272			
	by: Based on obser	ENT is not met as evidenced vations, staff interviews and e facility failed to assess for the levice before utilizing geod bolsters for 1 of 3 sampled			This POC F272 The statements included are no admission and do not constitute agreement with the alleged defi	ciencies	tion sheet Page 7

PRINTED: 02/05/2014

DEPARTM	IENT OF HEALTH AN	D HUMAN SERVICES			_	FORM OMB NO	APPROVE 0938-039
CENTERS	FOR MEDICARE & I F DEFICIENCIES CORRECTION	MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE S COMPI	Survey Eted
		345460	B. WNG _			12/0	05/2013
NAME OF PR	OVIDER OR SUPPLIER			204	REET ADDRESS, CITY, STATE, ZIP CODE		
GUILFORE	HEALTH CARE CENTE	ER		GF	REENSBORO, NC 27406  PROVIDER'S PLAN OF CORRECTION		(X6)
(X4) ID PREFIX TAG	- ALL DECIDIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	COMPLETION
F 272	residents (Resident Findings include:  Resident #66 was re 1/19/12. The cumula hypertension, diabed degenerative joint of failure and dementionata Set (MDS) dan Resident #66 required dependence with a MDS coded Reside with transfers and mobility. The MDS any ambulation con assessment period any negative consunderlying need for restrictive devices symptom the geot treating.	eadmitted to the facility on ative diagnoses included tes coronary artery disease, isease, congestive heart a. The quarterly Minimum ted 10/16/13, indicated that red extensive to total activities of daily living. The ent #66 as 1 person assistance of person assistance with did not code Resident #66 with the cerns or falls during the activities of restraint, the restraint, any other least or determine what medical mattress/bed bolsters was	F	272	herein. The plan of correction is completed in the compliance of star federal regulations as outlined. To in compliance with all federal and segulations the center has taken or take the actions set forth in the following plan of correction. The following plan of correction. The following plan of compliance. All allegation of compliance. All allegation of compliance. All allegationed by the dates indicated.  F272 How corrective action will be accomplished for each resident for have been affected by the deficient practice: Resident #66 bed bolsted discontinued on 12/4/13. Geometrian wings was discontinued on 12/20. New Device/Restraint assessment completed on 12/11/13 and 12/20. Teflect current status. Fall Care Fupdated 12/11/13 and 12/20/13 to current status.	remain tate will bowing lan of ed I be und to out ers were at with //13. out	
	Resident #66 was related decreased. The goals include injury from a fall rethrough next reviews usage of rails on keep call bell in plocked, pressure ask/encourage/aspositioned to aid places on hed to a	at increased risk for falls cognition, decreased mobility. It resident will not sustain any esulting in hospitalization ew. The approaches included bed to assist with bed mobility, lace, keep wheels on bed pad alarm, fall mat beside bed, esist resident to toilet, low bed in preventions of falls, bolsters define perimeters of the bed, ent about calling staff with all			accomplished for those residents the potential to be affected by the deficient practice:   All current rewith geomat with wings and/or be bolsters have been re-assessed restrictive device by DON or des Completion 1/2/2014.  Measures to be put in place or sechanges made to ensure practice re-occur: Any resident with a gewings, bed bolsters or both, will	esidents ed for least ignee. systemic ee will not omat with	

transfers for safety.

wings, bed bolsters or both, will be assessed for least restrictive device

D(_170****	MENT OF HEALTH AN	MEDICAID SERVICES					E SURVEY
CENTERS	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	COM	PLETED
STATEMENT O	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	NG_		}	ļ
41401040						1:	2/05/2013
		345460	B, WING		TREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PE	ROVIDER OR SUPPLIER				041 WILLOW ROAD		l
					REENSBORO, NC 27406		
GUILFOR	D HEALTH CARE CENTI	EK '			PROVIDED'S PLAN OF CORRECTION	DN MC	(X5)
(X4) ID PREFIX TAG	1	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG	١X	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	COMPLÉTION DATE
F 272	Review of physician revealed there were falls or the need for bolsters. There was therapy screen for to the property of the pr	orders and progress notes no concerns identified with the geo mattress or bed no medical justification or he use of the devices.  Ion on 12/4/13 at 8:10AM, in bed with the geo mattress, and 1/4 rails at top of bed. Luffed in a tight place and the bolsters with no leg room. If position and beige floor mat is no physical movement in any tion and interview on 12/4/13 at movement in any tion and interview on 12/4/13 at movement in any tion and interview on 12/4/13 at movement in any tion and interview on 12/4/13 at movement in any tion and interview on 12/4/13 at movement in any tion and interview on 12/4/13 at movement in any tion and interview on 12/4/13 at movement in any tion and interview on 12/4/13 at movement in any tion and interview on 12/4/13 at movement in any tion and interview on 12/4/13 at movement in any tion and interview on 12/5/13 at 9:00AM, the set (MDS) coordinator confirmed quarterly MDS dated 10/9/13, did no mattress/bed bolster as		: 272	(DON, RN Unit Manager, Rehab Dii in Quality Assurance Risk meeting 2 months and Quarterly Quality Assurated Completion 1/2/2014.  How facility will monitor corrective action(s) to ensure deficient praction re-occur: Any resident with a gwith wings, bed bolsters or both, wassessed for least restrictive device Quarterly, weekly by Committee (RN Unit Manager, Rehab Director Quality Assurance Risk meeting X months and Quarterly Quality Assurance Risk meeting X 1 for further resolution in needed. Completion 1/2/2014.	rance  ee will ecomat ill be e DON, ) in 3 urance s	ation sheet Page 9

PRINTED: 02/05/2014 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A, BUILDING AND PLAN OF CORRECTION 12/05/2013 R. WNG 345460 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2041 WILLOW ROAD GREENSBORO, NC 27406 **GUILFORD HEALTH CARE CENTER** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES PREFIX CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **PREFIX** DEFICIENCY) TAG F 272 Continued From page 9 F 272 restraint for Resident #66. The coordinator indicated that nursing was responsible for doing the assessment for devices and quarterly updates. She indicated that the geo mattress and bed bolsters was not reassessed on the recent MDS because they were implemented as a safety devices to prevent the resident from falling out of bed. During a follow-up interview on 12/4/13 at 2:26PM, the Nurse consultant indicated that the unit manager was responsible for doing the device assessment form to include all the devices needed for the resident. She indicated that the bed bolster and geo mattress was not assessed as a restraint or coded on the MDS because the devices were used as a safety measure to prevent the resident for falls. She added the devices were in place since May 2012 and no falls from the bed or any other location. The new screen/evaluation should have been done. 1/2/14 F 278 483.20(g) - (j) ASSESSMENT F 278 ACCURACY/COORDINATION/CERTIFIED SS=D The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

ATEMENT OF	FDEFICIENCIES	MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE COMP	LETED
ID PLAN OF	CORRECTION		B, WING			12/	05/2013
		345460	10.70	STI	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER			204	11 WILLOW ROAD		
OUIL EARD	HEALTH CARE CENT	ER .	ļ		REENSBORO, NC 27406		
GUILFURL			ID.		PROMPER'S PLAN OF CORR	ECTION	(X5) COMPLETION
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREF	i i	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	. DATE
F 278	Under Medicare and	d Medicaid, an individual who aly certifies a material and	F	278			
	false statement in a subject to a civil mo \$1,000 for each ass willfully and knowin to certify a material	resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each		•			
	material and false						
	by: Based on record and staff interview Minimum Data Se use of physical re The findings inclu				This POC F278 The statements included are admission and do not constitute agreement with the alleged do herein. The plan of correction completed in the compliance federal regulations as outline	ute eficiencies on is of state and d. To remain	
	1/19/12. The cum hypertension, dia degenerative join failure and deme Data Set (MDS) Resident #66 rec	s readmitted to the facility on hulative diagnoses included betes coronary artery disease, at disease, congestive heart ntia. The quarterly Minimum dated 10/16/13, indicated that quired extensive to total n all activities of daily living. The ident #66 as 1 person assistance			in compliance with all federal regulations the center has ta take the actions set forth in the plan of correction. The follown correction constitutes the ceallegation of compliance. All deficiencies cited have been completed by the dates indicates in the complete in the	l and state ken or will he following wing plan of nter⊡s I alleged i or will be	
	with transfers an mobility. The MI any ambulation assessment per bolster had bee	ident #00 as 1 points and 1 person assistance with DS did not code Resident #66 with concerns or falls during the iod. The geo mattress and bed in in place since 5/2/12 and fining the parameters of the bed. only sician orders for either device.			F278 How corrective action accomplished for each residence have been affected by the correctice: Resident #66 bed discontinued on 12/4/13. Givings was discontinued on	dent found to leficient bolsters were seo mat with 12/20/13.	n sheet Page

TEMENT OF E	DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE S COMPL	ETED
ID PLAN OF CO	DRKECTION		B. WING_			12/0	5/2013
NAME OF PRO	VIDER OR SUPPLIER	345460	B, VVINO	STF 204	REET ADDRESS, CITY, STATE, ZIP CODE		•
GUILFORD I	HEALTH CARE CENT	ER		GR	PROVIDER'S PLAN OF CORRECTION	N N	(X5)
(X4) ID PREFIX TAG		IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	/9⊑ !	COMPLETION DATE
	revealed there were falls or the need for There was no mediscreen for the use of the screen for the screen in place. There was direction.  During an interview Minimum Data Screen the most recent quantities for Resident for Res	orders and progress notes no concerns identified with geo mattress or bed bolsters. cal justification or therapy		278	New Device/Restraint assessment completed on 12/11/13 and 12/20/13 reflect current status. Fall care plan updated 12/11/13 and 12/20/13 to recurrent status.  How corrective action will be accomplished for those residents in the potential to be affected by the selection to practice: □All current residents have been re-assessed for restrictive device by DON or design and whether meets the definition of restraint per RAI. MDS modification made if indicated. Completion 1/2/2014.  Measures to be put in place or systemages made to ensure practice re-occur: Any resident with a geory wings, bed bolsters or both, will be assessed for least restrictive device whether meets the definition of reper RAI. Quarterly and weekly by Committee (DON, RN Unit Mana Rehab Director) in Quality Assurance meeting x 1 for resolution is needed. Completice 1/2/2014.  How facility will monitor correction action(s) to ensure deficient pranot re-occur: Any resident with a with wings, bed bolsters or both assessed for least restrictive device whether meets the definition of per RAI quarterly, weekly by Component (DON, RN Unit Manager, Rehab Facility ID: 943221	aving same dents lar least nee, of sins 1/2014.  stemic will not mat with e ice and estraint lar ger, rance varterly or further on vectice will a geomat lar, will be evice and restraint ommittee ib Director)	n sheet Page

CENTERS !	OR MEDICARE &	MEDICAID SERVICES			DNSTRUCTION	(X3) DATE	SURVEY PLETED
TATEMENT OF CO	DEFICIENCIES DRRECTION	IDENTIFICATION NUMBER:	A, BUILDIN	IG		12	2/05/2013
		345460	B. WNG_		EET ADDRESS, CITY, STATE, ZIP CODE	=	
	VIDER OR SUPPLIER		1		1 WILLOW ROAD		1
			1	ZU4	EENSBORO, NC 27406		
GUILFORD 1	HEALTH CARE CENT		<del></del>		THOUSE DE AN OF CORRECTIO	)N	(X5) COMPLETION
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	J DC	DATE
Ì	Continued From pag falls from the bed or screen/evaluation s	ge 12 any other location. The new hould have been done.	F	278	in Quality Assurance Risk meeting a months and Quarterly Quality Assur meeting x 1 for further resolution is needed. Completion 1/2/2014.	〈 3 rance	1/2/14
F 441 SS=D	SPREAD, LINENS	CONTROL, PREVENT	F	441			
	Infection Control Plaste, sanitary and to help prevent the of disease and infection Control The facility must expense.	ol Program stablish an Infection Control					
	in the facility; (2) Decides what	ontrols, and prevents infections procedures, such as isolation, to an individual resident; and ecord of incidents and corrective infections.					
	(1) When the Info determines that a prevent the spre isolate the reside (2) The facility m	oust prohibit employees will a					
	from direct contact w (3) The facility n	act with residents of their tood, in ill transmit the disease. nust require staff to wash their h direct resident contact for which s indicated by accepted					
	(c) Linens	_			Facility ID: 943221	If continua	ition sheet Page 13

RRECTION (X6) A SHOULD BE COMPLETION DATE
RRECTION (X5) SHOULD BE COMPLETION
SHOULD BE COMPLETION
SHOULD BE COMPLETION
SHOULD BE COMPLETION
APPROPRIATE
•
e not an
itute
deficiencies
1000
to of state and
160' to tettion.
ial alla state
(SKell of Am
the following lowing plan of
center 🗆 s
All alleged
GIT OF AME DO
dicated.
on will be
sident found to
3 CHICICIT
een educated by
linator Policy frements. Nurse
nt observation for
echnique by Staff
or X 1.
014.
1
ill be
ill be residents having
ole in tice he brouger

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345460	B. WNG			12/0	05/2013
NAME OF PROVIDER OR SUPPLIER GUILFORD HEALTH CARE CENTER				20	TREET ADDRESS, CITY, STATE, ZIP CODE 941 WILLOW ROAD REENSBORO, NC 27406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441	nurse picked up the sprayed the sacral are and tossed each gaus opened the skin prep wound discarding the Nurse #1 then applie area, pulled her pen of the date and initials of then attempted to rentattered at the right resite at the lower back directly from the kidne Nurse #1 removed he into the trash and tied and dropped the trash passing 2 sanitizer strontinued down the histation past a bathroom hall. During interview she was going to was indicated she was go to wash them. She us the resident's room, a didn't this time.  During an interview of Director of Nursing in to wash their hands e care. The hand sanit there was no excuse	nts #157 wound and g into the trash can. The wound cleanser bottle ea and cleaned it with gauze the into the trash. She then and wiped around the used pads into the trash. It is discovered to the dressing to the wound but of her pocket and wrote in the dressing. The nurse hove some tape that was exphrostomy site, (a surgical with a catheter coming by draining into a bag). For gloves and tossed them in the bag. Then left the room in into the hall trash bin, actions on the hall. She hall to the front of the nursing but on the right side of the inverse #1 was asked when when her hands and she her hands and she hall washed her hands in and couldn't say why she in 12/5/13 at 3:46 PM, the dicated staff was expected ach time they do patient lizers were everywhere and not to use them. The essing change was shared	F	441	Nursing Staff will have Handwashing education including treatment technique using Policy #401. Completion 1/2/201 Measures to be put in place or systemichanges made to ensure practice will re-occur: Treatment Observation will be done on 2 Licensed nurses weekly X 4 weeks, 2 Licensed Nurses X 2 weeks fone month, and 2 Licensed nurses monthly X 3 months by DON or design All New hire Licensed Nurses will receive Handwashing education including treatment technique using Policy #401. Completion 1/2/2014  How facility will monitor corrective action(s) to ensure deficient practice we not re-occur: Treatment Observation where the done on 2 Licensed nurses weekly weeks, 2 Licensed Nurses X 2 weeks for 1 month, and 2 Licensed nurses month X 3 months by DON or designee. All Now hire Licensed Nurse will receive Handwashing education including treatment technique using Policy #401. Results of treatment observations will be reviewed weekly in Quality Assurance Risk meeting weekly X 6 months, and Quarterly Quality Assurance Meeting X quarters for further resolution if needed Completion 1/2/2014	d.  c not ee.  for ee.  fill vill X 4 for hly lew  coe in C 2	

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

JAN 2 1 2014

PRINTED: 01/08/2014 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES  TATEMENT OF DEFICIENCIES TATEMENT OF DEFICIENCIES TO PROVIDE SUPPLIES (X1) PROVIDER SUPPLIES (LIA IDENTIFICATION NUMBER:		(X2) MULT	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	CON	E SURVEY IPLETED	
ND PLAN O	F CORRECTION		B. WING_		12/	27/2013_
		345460	B. WING_	STREET ADDRESS, CITY, STATE, ZIP		
NAME OF F	ROVIDER OR SUPPLIER			2041 WILLOW ROAD		
GUILFOF	RD HEALTH CARE C	ENTER		GREENSBORO, NC 27406		(VE)
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	A SHOOFD DE	COMPLETION DATE
K 000	This Life Safety Conducted as per at 42 CFR 483.70. Health Care section publications. This one story with a consystem.  The deficiencies of are as follows: NFPA 101 LIFE Stranger and the following. 19.3.5.1  This STANDARD Based on observation of the following. 19.3.5.1  This STANDARD Based on observation of the following. 19.3.5.1  This STANDARD Based on observation of the following. 19.3.5.1	code(LSC) survey-was The Code of Federal Register (a) using the 2000 Existing on of the LSC and its referenced building is type V construction, complete automatic sprinkler  determined during the survey  SAFETY CODE STANDARD  tion type and height meets one 19.1.6.2, 19.1.6.3, 19.1.6.4,  is not met as evidenced by: vations and staff interview at 30 am onward, the following compliance, specific findings	K	The statements included are admission and do not const agreement with the alleged herein. The plan of correct completed in the compliance and federal regulations as or remain in compliance with and state regulations the ce taken or will take the action in the following plan of correct constitutes the center's alleged decited have been or will be do by the dates indicated.  K012  Unsealed openings around heads were corrected on 12 Unsealed openings in clear room and laundry rooms with 1/18/15.  Sprinkler main penetration was sealed on 12/30/13.  All walls and firewalls have inspected for openings and any, made on 1/17/14.  Maintenance Director or conspect for openings week then monthly x 2 months compliance.  Results will be reported to Assurance Risk meeting for resolution is needed. Co	deficiencies deficiencies de deficiencies de of state utilined. To all federal inter has as set forth rection. detion gation of diciencies completed  sprinkler 2/30/13. a utility were repaired in firewall we been d repairs, if designee will ly x 4 weeks, for the Quality for further	1/28/1

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 Obsolete

Facility ID: 943221

If continuation sheet Page 1 of 6

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

TATEMENT (	OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 0	CONSTRUCTION  1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		345460			12/27/201	
GUILFOR		ENTER  ATEMENT OF DEFICIENCIES  WANTED BE PRECEDED BY FULL	ID PREFIX	REET ADDRESS, CITY, STATE, ZIP CODE 41 WILLOW ROAD REENSBORO, NC 27406  PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVINCE ACTION SHOULD CROSS-REFERENCED TO THE APPROVINCE ACTION SHOULD CROSS-REFERENCED TO THE APPROVINCE ACTION SHOULD SHOU		(X5) COMPLETION DATE
K 012	Continued From page 42 CFR 483.70(a) NFPA 101 LIFE S. Doors protecting of required enclosure hazardous areas at those constructed wood, or capable minutes. Doors in required to resist no impediment to are provided with the door closed.	age 1  AFETY CODE STANDARD  corridor openings in other than es of vertical openings, exits, or are substantial doors, such as of 1½ inch solid-bonded core of resisting fire for at least 20 a sprinklered buildings are only the passage of smoke. There is the closing of the doors. Doors a means sultable for keeping Dutch doors meeting 19.3.6.3.6	K 012 K 018	K018 Doors to rooms 110, 117 and stor room have been adjusted to close latch.  All other doors have been inspect ensure they close and latch, and adjustments, if any, made to ensulatching.  Maintenance Director or designe inspect 12 doors for latching wee 4 weeks, then monthly x 2 month compliance.  Results will be reported to the Q Assurance Risk meeting for furth resolution is needed. Completic 1/28/2014.	age and ted to ted to te will okly x as for uality	t/28/14
K 050 SS≃1	Based on obser- approximately 9: items were none include: 1. residents room and latch for sme 2. storage room 42 CFR 483.70(	door not latening.	К 05	9		

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

PRINTED: 01/08/2014 FORM APPROVED OMB NO. 0938-0391

JAN 2 1 2014 OMB NO. 0938-0391
(x3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE	PLETED
		345460	B. WING		3	12/2	7/2013
	PERMIT DESIGNED	ENTER  TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	20 GI	REET ADDRESS, CITY, STATE, ZIP CODE 41 WILLOW ROAD REENSBORO, NC 27406  PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTICIENCY)	RECTION (X5) SHOULD BE COMPLET	
Firm van The the assignment of	rying conditions, e staff is familiar at drills are part of sponsibility for posigned only to coalified to exercise nouncement materials. 19.7.1.2 his STANDARD ased on observation device).  2 CFR 483.70(a) FPA 101 LIFE Sequired automaterials supervised ill sound when the sponsibility of the sequired automaterials. 19.7.2.1	at unexpected times under at least quarterly on each shift. I with procedures and is aware of established routine. I shanning and conducting drills is empetent persons who are to leadership. Where drills are in 9 PM and 6 AM a coded by the used instead of audible with the constant of a shanning and staff interview at the common and staff interview at the common and staff that was interview to set off fire alarm system(pulling).		050	Individual staff member was reinserviced on fire drills on 1/10/14 Staff members were re-inserviced fire drills during the period 1/18/14 2/3/14.  Maintenance Director or designee conduct one fire drill per shift more for 3 months.  Results will be reported to the Quantition is needed. Completion 2/3/2014.  K061  Tamper switch and accelerator at have been repaired or replaced, and high & low pressure switch is now supervised. Repairs were made by qualified technicians.  All other aspects of the automatic system were checked and found to in compliance.  Maintenance Director or designee test system weekly x 4 weeks, the monthly x 2 months for compliant Results will be reported to the Quantition is needed. Completic 2/7//2014.	will nthly riser nd wy y co be e will en uce. uality ner	2/7/14

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

		A MEDICAID SERVICES	CVALLUET	······································	1	E SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		MPLETED
	345460		B. WING_	1	12/	27/2013
	ME OF PROVIDER OR SUPPLIER UILFORD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2041 WILLOW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETIO DATE
K 061 K 062 SS=E	include: 1. tamper switch in 2. accelerator valve switch are not supe 42 CFR 483.70(a) NFPA 101 LIFE SA Required automatic continuously mainta condition and are in	riser room not working. and high and low pressure	K 06	K062 Sprinkler heads in laundry were cleaned on 12/27/14. All other sprinkler heads were inspected for compliance. Spare sprinkler head	box uired will ce.	1/48/14
SS=E	Based on observat approximately 9:30 Items were noncominclude 1. sprinkler heads ir excess lent on bulb, 2. sprinkler heads ir not of same temp. the same temp. The same temp of the same temp of the same temp. The same temp of the same temp of the same temp. The same temp of the same	n spare box in fiser room are type in building.  FETY CODE STANDARD is are adopted and include no ing provisions:	K 060	Results will be reported to the Qual Assurance Risk meeting for further resolution is needed. Completion 1/28/2014.  K066  Proper ash trays and a metal self closing container have been placed the designated resident smoking are There is only one smoking area on the second state of the designated resident smoking area on the second second smoking area on the second	at a. he vill	ા <i>[</i> 28/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		345460	345460 B. WING			
	PROVIDER OR SUPPLIER RD HEALTH CARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 WILLOW ROAD GREENSBORO, NC 27406	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 068	<ul> <li>(2) Smoking by patiresponsible is prohidirect supervision.</li> <li>(3) Ashtrays of nond design are provided permitted.</li> <li>(4) Metal containers devices into which a</li> </ul>	ge 4 ents classified as not bited, except when under combustible material and safe in all areas where smoking is with self-closing cover ashtrays can be emptied are all areas where smoking is	K 06			
K 072 SS=E	Based on observati approximately 9:30 a items were noncomp include: at time of st proper ash trays and container in smoking 42 CFR 483.70(a) NFPA 101 LIFE SAF Means of egress are of all obstructions or use in the case of fir furnishings, decorati		K 072	K072 Blood pressure machine was model 12/27/13.  Staff have been inserviced on postorage of equipment and that has must remain clear.  Maintenance Director or designed inspect hallways twice daily 5 the per week for 2 weeks, then once 15 times per week for 2 weeks, the weekly for 8 weeks for compliant Results will be reported to the Quantum Assurance Risk meeting for further resolution is needed. Completio 2/7/2014.	roper allways ee will mes daily en ace. uality	2/7/14

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

STATEMENT OF DEFICIENCIES (X1) PRO AND PLAN OF CORRECTION IDEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				E SURVEY PLETED
:		345460	B. WING			12/	27/2013
NAME OF PROVIDER OR SUPPLIER  GUILFORD HEALTH CARE CENTER				20	REET ADDRESS, CITY, STATE, ZIP CODE 041 WILLOW ROAD REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 072	This STANDARD Based on observa approximately 9:30 Items were noncon	is not met as evidenced by: tions and staff interview at am onward, the following appliance, specific findings are was not moved on 200 hall	KO	72			