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	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to assess for the least restrictive device before utilizing geo mattresses and bed bolsters for 1 of 3 sampled residents reviewed for physical restraints (Resident # 66). The findings included Resident #66 was readmitted to the facility on 1/19/12. The cumulative diagnoses included hypertension, diabetes coronary artery disease, degenerative joint disease, congestive heart failure and dementia. The quarterly Minimum Data Set (MDS) dated 10/16/13, indicated that Resident #66 required extensive to total dependence with all activities of daily living. The MDS coded Resident #66 as 1 person assistance with transfers and 1 person assistance with mobility. The MDS did not code Resident #66 with any ambulation concerns or falls during the assessment period. Review of the care area assessment for falls dated 10/16/13, did not identified any concerns for Resident #66 for falls from bed or wheelchair. The geo mattress and bed bolster had been in place since 5/2/12 and identified as defining the parameters of the bed. There were no physician orders for either device. Reviewed of the physical therapy evaluation dated 10/2/13, revealed there was no	F 221	This POC F221 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F271 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: □Resident #66 bed bolsters were discontinued on 12/4/13. Geo mat with wings was discontinued on 12/20/13. New Device/Restraint assessment completed on 12/11/13 and 12/20/13 to reflect current status. Fall care plan updated 12/11/13 and 12/20/13 to reflect current status. How corrective action will be	1/2/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/26/2013

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	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 1 assessment or concerns with Resident #66 positioning in bed or a screen/evaluation for the use of the geo mattress or bed bolsters. The therapy goals included strengthening, balance, endurance and safety in order to return to walk to diner for improved daily activities/quality of life independence and overall health. Review of the care plan dated 10/22/13, identified Resident #66 was at increased risk for falls related decreased cognition, decreased mobility. The goals included resident will not sustain any injury from a fall resulting in hospitalization through next review. The approaches included usage of rails on bed to assist with bed mobility, keep call bell in place, keep wheels on bed locked, pressure pad alarm, fall mat beside bed, ask/encourage/assist resident to toilet, low bed positioned to aid in preventions of falls, bolsters place on bed to define perimeters of the bed, reeducated resident about calling staff with all transfers for safety. Review of physician orders and progress notes revealed there were no concerns identified with falls or the need for geo mattress or bed bolster on bed. There was no medical justification or therapy screen for the use of the devices. During an observation on 12/4/13 at 8:10AM, Resident #66 was lying in bed with the geo mattress, bed bolsters in place and 1/4 rails at top of bed. Resident looked stuffed in a tight place and drawn closely to the bolsters with no leg room. The bed was in low position and beige floor mat in place. There was no physical movement in any direction.	F 221	accomplished for those residents having the potential to be affected by the same deficient practice: □All current residents with geomat with wings and/or bed bolsters have been re-assessed for least restrictive device by DON or designee, and whether meets the definition of restraint per RAI. MDS modifications made if indicated. Completion 1/2/2014. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Any resident with a geomat with wings, bed bolsters or both, will be assessed for least restrictive device and whether meets the definition of restraint per RAI. Quarterly and weekly by Committee (DON, RN Unit Manager, Rehab Director) in Quality Assurance Risk meeting X 3 months and Quarterly Quality Assurance meeting x 1 for further resolution is needed. Completion 1/2/2014. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Any resident with a geomat with wings, bed bolsters or both, will be assessed for least restrictive device and whether meets the definition of restraint per RAI quarterly, weekly by Committee (DON, RN Unit Manager, Rehab Director) in Quality Assurance Risk meeting X 3 months and Quarterly Quality Assurance meeting x 1 for further resolution is needed. Completion 1/2/2014.	

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	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 2 During an observation and interview on 12/4/13 at 9:30AM, Resident #66 was seated in his wheelchair room looking out the window. He indicated that he had not fallen out of bed. He did say that he was transferring himself from a chair to wheelchair and missed the chair about a month ago. His bed has blue bed bolster and geo mattress. He indicated that the bed bolster was put on his bed because "they said I use to roll out of bed." He indicated that he didn't think he needed it because he did not roll out of bed. He used the call light and he was able to walk the short distance to the bathroom. He further stated it stopped him from getting up when he wanted to go to the bathroom or get in his chair. The chair was located next to bed in corner. He stated that they keep telling him they didn't want him to fall, "I haven't fallen out of bed in years, I just want go to bathroom or get something to eat." During an interview on 12/4/13 at 9:40AM, Nurse#2 indicated that Resident #66 was able to verbalize his needs and use the call light. Nurse#1 further stated the geo mattress and bed bolster was in place because Resident #66 was a high risk for falls and to prevent him from falling and for safety. Nurse #1 indicated that she was unaware of how long the resident had the bed bolster or geo mattress. During an observation on 12/4/13 at 9:50AM, Resident #66 was seated in his wheelchair with no positioning concerns or repetitive movement. During an interview on 12/4/13 at 11:30AM, physical therapist #1 indicated that she was unaware of Resident #66 being assessed by	F 221		

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	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 3 therapy for bed positioning and she was unaware that Resident #66 had the geo mattress/bed bolster. She added that the resident was being seen for ambulation/transfer and unaware of the assessment process for bed positioning devices. During a follow-up interview on 12/4/13 at 11:47AM, Resident #66 stated again that he did not fall out of bed and the stuff in the bed got in his way of getting to his chair or the bathroom. During an interview on 12/4/13 at 12:00PM, Nurse #3 indicated that the geo mattress and bed bolsters had been in place since 5/2/12 to prevent resident falls and for safety. Review of the medical record revealed that Resident #66 did not have any falls from the bed for the past year and half. Nurse indicated there were no concerns noted in the nurse's notes to indicate or reflect Resident #66 attempts to get out of bed or any falls, nor was there a medical reason for the use of the geo mattress or bed bolster since the resident did not have any falls. The team discussed options for referral to therapy and elected not to refer to therapy since the devices were not considered a restraint and it was for resident safety. During an interview on 12/4/13 at 12:05PM, the Nurse Consultant indicated that the geo mattress and bed bolster was used to prevent Resident #66 from falls and safety. The devices were not coded as a restraint because the resident could still get out of bed. Review of the record revealed the devices were in place since 5/2/12. Resident #66 did not have any positioning concerns in the bed and the resident did not have any falls from bed or chair in more than a year. In addition, the nursing notes did not have any documentation	F 221		

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	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 4 that the resident had any falls from bed or had been screen or a physician order for the use of the devices. During an interview on 12/4/13 at 2:10PM, physical therapist #2 indicated that he was unaware of the type of devices on Resident #66 bed. He added that resident was seen in therapy for restorative ambulation only. He added that nursing staff was responsible for determining the positioning devices used for bed and that therapy had not seen the resident for an assessment for the geo mattress/bed bolsters. He indicated that the resident only required 1 person assistance. Resident #66 was able to walk short distance with staff assistance. He was not aware of a medical concern for the use of the bed devices. 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. During an interview on 12/4/13 at 2:50PM, NA#1 indicated that she had worked with Resident #66 on numerous occasions and on different shifts. She indicated that she was unaware of why the geo mattress or bed bolster were in place other than it was for safety to prevent the resident from falling. She indicated that when the bed bolsters were in place and the resident wanted to get out	F 221		

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	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 5 of bed Resident #66 would scoot to the end of the bed. He generally either wanted something to eat or go sit in the chair. She indicated that he required 1 person assistance. Resident did not have many repetitive movements or falls that she was aware of and he was able to let staff know when he needed to go to the bathroom or wanted something to eat. During an interview on 12/4/13 at 2:55PM, NA #2 indicated that she had worked with Resident #66 for a number of years. She indicated that the resident generally would attempt to get out of bed early in the morning between 2 and 5AM so that he could get in his chair or he wanted something to eat. She indicated that Resident #66 would scoot to the end of the bed in order to get out of the bed. She indicated that the resident did not have any falls that she was aware of or he would throw his legs over the bolster trying to get what he needed. She indicated that she was told the bolsters were to prevent the resident from falling out of bed. He was able to verbalize his basic needs and that Resident #66 did not have a lot of movements in the bed. During an observation on 12/5/13 at 8:00AM, resident lying in bed in fetal position without the bed bolsters in place. There were no physical movements.	F 221		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272		1/2/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 6 A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to assess for the least restrictive device before utilizing geo mattress and bed bolsters for 1 of 3 sampled	F 272	This POC F272 The statements included are not an admission and do not constitute agreement with the alleged deficiencies	

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	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 7 residents (Resident #66) with restraints. Findings include: Resident #66 was readmitted to the facility on 1/19/12. The cumulative diagnoses included hypertension, diabetes coronary artery disease, degenerative joint disease, congestive heart failure and dementia. The quarterly Minimum Data Set (MDS) dated 10/16/13, indicated that Resident #66 required extensive to total dependence with all activities of daily living. The MDS coded Resident #66 as 1 person assistance with transfers and 1 person assistance with mobility. The MDS did not code Resident #66 with any ambulation concerns or falls during the assessment period. The facility did not assess for any negative consequence of restraint, the underlying need for the restraint, any other least restrictive devices or determine what medical symptom the geo mattress/bed bolsters was treating. Review of the care plan dated 10/22/13, identified Resident #66 was at increased risk for falls related decreased cognition, decreased mobility. The goals included resident will not sustain any injury from a fall resulting in hospitalization through next review. The approaches included usage of rails on bed to assist with bed mobility, keep call bell in place, keep wheels on bed locked, pressure pad alarm, fall mat beside bed, ask/encourage/assist resident to toilet, low bed positioned to aid in preventions of falls, bolsters place on bed to define perimeters of the bed, reeducated resident about calling staff with all transfers for safety.	F 272	herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F272 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #66 bed bolsters were discontinued on 12/4/13. Geo mat with wings was discontinued on 12/20/13. New Device/Restraint assessment completed on 12/11/13 and 12/20/13 to reflect current status. Fall Care Plan updated 12/11/13 and 12/20/13 to reflect current status. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: □All current residents with geomat with wings and/or bed bolsters have been re-assessed for least restrictive device by DON or designee. Completion 1/2/2014. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Any resident with a geomat with wings, bed bolsters or both, will be assessed for least restrictive device Quarterly and weekly by Committee	

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	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 8 Review of physician orders and progress notes revealed there were no concerns identified with falls or the need for the geo mattress or bed bolsters. There was no medical justification or therapy screen for the use of the devices. During an observation on 12/4/13 at 8:10AM, Resident #66 lying in bed with the geo mattress, bed bolsters in place and 1/4 rails at top of bed. Resident looked stuffed in a tight place and drawn closely to the bolsters with no leg room. The bed was in low position and beige floor mat in place. There was no physical movement in any direction. During an observation and interview on 12/4/13 at 9:30AM, Resident #66 was seated in his wheelchair room looking out the window. He indicated that he had not fallen out of bed. He did say that he was transferring himself from a chair to wheelchair and missed the chair about a month ago. His bed has blue bed bolster and geo mattress. He indicated that the bed bolster was put on his bed because "they said I use to roll out of bed." He indicated that he didn't think he needed it because he did not roll out of bed. He used the call light and he was able to walk the short distance to the bathroom. He further stated it stopped him from getting up when he wanted to go to the bathroom or get in his chair. The chair was located next to bed in corner. He stated that they keep telling him they didn't want him to fall, "I haven't fallen out of bed in years; I just want go to bathroom or get something to eat." During an interview on 12/5/13 at 9:00AM, the Minimum Data Set (MDS) coordinator confirmed the most recent quarterly MDS dated 10/9/13, did not coded the geo mattress/bed bolster as	F 272	(DON, RN Unit Manager, Rehab Director) in Quality Assurance Risk meeting X 3 months and Quarterly Quality Assurance meeting x 1 for further resolution is needed. Completion 1/2/2014. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Any resident with a geomat with wings, bed bolsters or both, will be assessed for least restrictive device Quarterly, weekly by Committee (DON, RN Unit Manager, Rehab Director) in Quality Assurance Risk meeting X 3 months and Quarterly Quality Assurance meeting x 1 for further resolution is needed. Completion 1/2/2014.	

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	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 9 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.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED 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.	F 278		1/2/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 10 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, resident observations and staff interviews, the facility failed to code the Minimum Data Set (MDS) accurately to reflect the use of physical restraints for 1 of 3(Resident #66). The findings included: Resident #66 was readmitted to the facility on 1/19/12. The cumulative diagnoses included hypertension, diabetes coronary artery disease, degenerative joint disease, congestive heart failure and dementia. The quarterly Minimum Data Set (MDS) dated 10/16/13, indicated that Resident #66 required extensive to total dependence with all activities of daily living. The MDS coded Resident #66 as 1 person assistance with transfers and 1 person assistance with mobility. The MDS did not code Resident #66 with any ambulation concerns or falls during the assessment period. The geo mattress and bed bolster had been in place since 5/2/12 and identified as defining the parameters of the bed. There were no physician orders for either device.	F 278	This POC F278 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F278 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #66 bed bolsters were discontinued on 12/4/13. Geo mat with wings was discontinued on 12/20/13.	

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	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 11 Review of physician orders and progress notes revealed there were no concerns identified with falls or the need for geo mattress or bed bolsters. There was no medical justification or therapy screen for the use of the devices. During an observation on 12/4/13 at 8:10AM, Resident #66 lying in bed with the geo mattress, bed bolsters in place and 1/4 rails at top of bed. Resident looked stuffed in a tight place and drawn closely to the bolsters with no leg room. The bed was in low position and beige floor mat in place. There was no physical movement in any direction. During an interview on 12/5/13 at 9:00AM, the Minimum Data Set (MDS) coordinator confirmed the most recent quarterly MDS dated 10/9/13 did not coded the geo mattress/bed bolster as 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	F 278	New Device/Restraint assessment completed on 12/11/13 and 12/20/13 to reflect current status. Fall care plan updated 12/11/13 and 12/20/13 to reflect current status. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: □All current residents with geomat with wings and/or bed bolsters have been re-assessed for least restrictive device by DON or designee, and whether meets the definition of restraint per RAI. MDS modifications made if indicated. Completion 1/2/2014. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Any resident with a geomat with wings, bed bolsters or both, will be assessed for least restrictive device and whether meets the definition of restraint per RAI. Quarterly and weekly by Committee (DON, RN Unit Manager, Rehab Director) in Quality Assurance Risk meeting X 3 months and Quarterly Quality Assurance meeting x 1 for further resolution is needed. Completion 1/2/2014. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Any resident with a geomat with wings, bed bolsters or both, will be assessed for least restrictive device and whether meets the definition of restraint per RAI quarterly, weekly by Committee (DON, RN Unit Manager, Rehab Director)	

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	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 12 falls from the bed or any other location. The new screen/evaluation should have been done.	F 278	in Quality Assurance Risk meeting X 3 months and Quarterly Quality Assurance meeting x 1 for further resolution is needed. Completion 1/2/2014.	1/2/14
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441		

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	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 13 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and policy review the facility failed to follow infection control policy and wash hands before and after wound care for 1 of 2 sampled residents (#157) Findings Included: The facility provided the infection control policy dated 6/1/13, "all staff are trained in proper technique and are monitored for proper handwashing practices. Employees will wash hands at appropriate times to reduce the risk of transmission and acquisition of infections." During an observation on 12/4/13 at 9:47 AM , Nurse #1 was observed pushing the wound cart down the hall. She moved the linen and trash bin, and then moved a resident in a wheelchair. She stopped outside of Resident #157 room and opened the wound cart gathered her supplies, opened the door. No hand sanitizer was observed on the wound cart. No handwashing or had sanitizer was used prior to gathering the supplies out of the wound cart. Resident #157 was bathing herself, using a wash basin on the bedside table. Nurse #1 placed her supplies on the bedside table next to the wash basin. She gloved and removed the sacral (a large, triangular bone at the base of the spine, at the top of the buttocks)	F 441	This POC F441 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F441 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Nurse #1 has been educated by Staff Development Coordinator Policy #401 Handwashing requirements. Nurse #1 has received treatment observation for Non-Sterile Treatment Technique by Staff Development Coordinator X 1. Completion January 2, 2014. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current Licensed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 14 dressing from Residents #157 wound and discarded the dressing into the trash can. The nurse picked up the wound cleanser bottle sprayed the sacral area and cleaned it with gauze and tossed each gauze into the trash. She then opened the skin prep and wiped around the wound discarding the used pads into the trash. Nurse #1 then applied the dressing to the wound area, pulled her pen out of her pocket and wrote the date and initials on the dressing. The nurse then attempted to remove some tape that was tattered at the right nephrostomy site, (a surgical site at the lower back with a catheter coming directly from the kidney draining into a bag). Nurse #1 removed her gloves and tossed them into the trash and tied the bag. Then left the room and dropped the trash into the hall trash bin, passing 2 sanitizer stations on the hall. She continued down the hall to the front of the nursing station past a bathroom on the right side of the hall. During interview Nurse #1 was asked when she was going to wash her hands and she indicated she was going into the clean utility room to wash them. She usually washed her hands in the resident's room, and couldn't say why she didn't this time. During an interview on 12/5/13 at 3:46 PM, the Director of Nursing indicated staff was expected to wash their hands each time they do patient care. The hand sanitizers were everywhere and there was no excuse not to use them. The observation of the dressing change was shared and she said, "It was not acceptable."	F 441	Nursing Staff will have Handwashing education including treatment technique using Policy #401. Completion 1/2/2014. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Treatment Observation will be done on 2 Licensed nurses weekly X 4 weeks, 2 Licensed Nurses X 2 weeks for one month, and 2 Licensed nurses monthly X 3 months by DON or designee. 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 will not re-occur: Treatment Observation will be done on 2 Licensed nurses weekly X 4 weeks, 2 Licensed Nurses X 2 weeks for 1 month, and 2 Licensed nurses monthly X 3 months by DON or designee. All New hire Licensed Nurse□s 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 in Quarterly Quality Assurance Meeting X 2 quarters for further resolution if needed. Completion 1/2/2014	

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

JAN 21 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a) using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is type V construction , one story with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliance, specific findings include: 1. unsealed openings around sprinkler heads in soiled utility room on 100 hall. 2. unsealed openings in clean utility room 200 hall, 3, unsealed opening in wall behind dryer in laundry room. 4. sprinkler pipe penetrating the 1 hour fire/smoke wall in attic at rehab. access, is not seal to maintain rating of wall.	K 012	K012 Unsealed openings around sprinkler heads were corrected on 12/30/13. Unsealed openings in clean utility room and laundry rooms were repaired 1/18/15. Sprinkler main penetration in firewall was sealed on 12/30/13. All walls and firewalls have been inspected for openings and repairs, if any, made on 1/17/14. Maintenance Director or designee will inspect for openings weekly x 4 weeks, then monthly x 2 months for compliance. Results will be reported to the Quality Assurance Risk meeting for further resolution is needed. Completion 1/28/2014.	1/28/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lynn A. Lancaster	Administrator	19JAN14

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.

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	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 012	Continued From page 1 42 CFR 483.70(a)	K 012		1/28/14
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K018 Doors to rooms 110, 117 and storage room have been adjusted to close and latch. All other doors have been inspected to ensure they close and latch, and adjustments, if any, made to ensure latching. Maintenance Director or designee will inspect 12 doors for latching weekly x 4 weeks, then monthly x 2 months for compliance. Results will be reported to the Quality Assurance Risk meeting for further resolution is needed. Completion 1/28/2014.	
	This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliance, specific findings include: 1. residents room doors 110 & 117 did not close and latch for smoke tight seal. 2. storage room door not latching.			
K 050 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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

JAN 2 1 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 2 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliance, specific findings include: at time of survey, staff that was interview did not know how to set off fire alarm system(pull station device).	K 050	K050 Individual staff member was re-inserviced on fire drills on 1/10/14. Staff members were re-inserviced on fire drills during the period 1/18/14 to 2/3/14. Maintenance Director or designee will conduct one fire drill per shift monthly for 3 months. Results will be reported to the Quality Assurance Risk meeting for further resolution is needed. Completion 2/3/2014.	2/3/14
K 061 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 9:30 am onward, the following Items were noncompliance, specific findings	K 061	K061 Tamper switch and accelerator at riser 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 be in compliance. Maintenance Director or designee will test system weekly x 4 weeks, then monthly x 2 months for compliance. Results will be reported to the Quality Assurance Risk meeting for further resolution is needed. Completion 2/7//2014.	2/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 061	Continued From page 3 include: 1. tamper switch in riser room not working. 2. accelerator valve and high and low pressure switch are not supervised. 42 CFR 483.70(a)	K 061	K062 Sprinkler heads in laundry were cleaned on 12/27/14. All other sprinkler heads were inspected for compliance. Spare sprinkler head box near riser now includes proper required sprinkler heads. Maintenance Director or designee will inspect spare sprinkler head box monthly for 3 months for compliance. Housekeeping director will inspect all sprinkler heads weekly x 4 weeks, then monthly x 2 months for compliance. Results will be reported to the Quality Assurance Risk meeting for further resolution is needed. Completion 1/28/2014.	1/28/14
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliance, specific findings include 1. sprinkler heads in back and front of dryer have excess lent on bulb, 2. sprinkler heads in spare box in riser room are not of same temp. type in building.	K 062		
K 066 SS=E	42 CRT 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.	K 066	K066 Proper ash trays and a metal self closing container have been placed at the designated resident smoking area. There is only one smoking area on the premises. Maintenance Director or designee will audit for ashtray use and presence 3x week x 2 weeks, then 1x week x 2 months for compliance. Results will be reported to the Quality Assurance Risk meeting for further resolution is needed. Completion 1/28/2014.	1/28/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____	12/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 066	Continued From page 4 (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliance, specific findings include: at time of survey facility did not have proper ash trays and a metal self closing container in smoking area. 42 CFR 483.70(a)	K 066		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	K072 Blood pressure machine was moved on 12/27/13. Staff have been inserviced on proper storage of equipment and that hallways must remain clear. Maintenance Director or designee will inspect hallways twice daily 5 times per week for 2 weeks, then once daily 5 times per week for 2 weeks, then weekly for 8 weeks for compliance. Results will be reported to the Quality Assurance Risk meeting for further resolution is needed. Completion 2/7/2014.	2/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliance, specific findings include: B/P machine was not moved on 200 hall during survey. 42 CFR 483.70(a)	K 072		