

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

PRINTED: 03/27/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345460</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GUILFORD HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2041 WILLOW ROAD GREENSBORO, NC 27406</b>	
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K 000	INITIAL COMMENTS  A Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. In the exit conference all deficiencies noted were discussed with administration.  Stories: 1 Construction Type V (111) Constructed: 5/24/1994 Fully Sprinkled - Yes At time of survey the: Certified Beds: Medicare/Medicaid - 110 Census - 94 Certified Beds: Medicaid only - 0 Census - 0	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025		3/7/15

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

TITLE

(X6) DATE

Electronically Signed

02/13/2015

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

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K 025	Continued From page 1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a)  Based on observations, on January 29, 2015 at approximately 9:00 AM onward, the following deficiencies were noted: 1) The smoke walls located on the 100 attic area and the smoke wall between the kitchen and dining room in the attic area have holes and/or penetrations that were not sealed in order to maintain the fire resistance rating of the wall. PVC Pipe penetrations in smoke wall will need to be protected with approved UL rate fire assemblies. NFPA 101, 19.3.7.3 NFPA 101, 8.3.6.1 This deficiency affected 5 of 8 smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 025	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.  K025 Penetrations, including PVC Pipe penetrations in smoke walls, will be repaired by 02/20/15.  All walls and firewalls have been inspected for openings and repairs, if any, will be made by 02/24/15.  Maintenance Director or designee will inspect for penetrations or 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 03/7/2015.		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system required for life safety is installed, tested, and maintained in accordance	K 052		3/7/15	

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K 052	<p>Continued From page 2</p> <p>with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: 42 CFR 483.70 (a)</p> <p>Based on observations, on January 29, 2015 at approximately 9:00 AM onward, the following deficiencies were noted:</p> <p>1) The two HVAC units located, one above each nurse station did not shutdown upon activation of fire alarm. This deficiency affected six of approximately eight smoke compartments.</p> <p>2) The strobe lights located on 200 hall were not synchronized upon activation of fire alarm. This deficiency affected one of approximately eight smoke compartments.</p> <p>Ref: 1999 NFPA 72; A-4-4.4.2.2 2000 NFPA 101, 9.6.1.4. NFPA 90A, 4-2 Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.</p>	K 052	<p>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.</p> <p>K052 After a phone conference with the DHHS Construction Section Inspection supervisor on 2/12/2015, we believe we are in compliance with this regulation, and that the facility's fire protective system is working as designed, and as approved, for construction. Based on guidance received by the supervisor during this telephone conference, we contacted the Greensboro Fire Department Inspector</p>		

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K 052	Continued From page 3	K 052	who has responsibilities for our facility's routine inspections. Again, using the supervisor's guidance, we asked for the records concerning our initial GFD compliance inspection, which was required before the issuance of a Certificate of Occupancy These records will address air handler compliance requirements then in existence, as well as compliance with strobe light synchronization requirements. We expect this documentation to be forthcoming from GFP on or about 2/18/2015 and will forward to the Construction Section immediately upon receipt. Completion 03/07/2015.		
K 056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: 42 CFR 483.70 (a)</p>	K 056	The statements included are not an admission and do not constitute	3/7/15	

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K 056	Continued From page 4 Based on observations, on January 29, 2015 at approximately 9:00 AM onward, the following deficiencies were noted: 1) The 4 exit exterior roofs on the resident halls were not protected with sprinkler coverage. (Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in depth. 2) The closet located in resident room 105 was not protected with sprinkler coverage. Ref: 2000 NFPA 101 Section 19.3.5 1999 NFPA 13 Section 5-13.8.1 CMS S&C 13-55-LSC This deficiency affected four of seven exits and one of approximately 60 resident rooms. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 056	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.  K056 Sprinkler heads will be installed by 03/02/2015 on four exit patios and in the closet of Room 105.  The Maintenance Director inspected the entire facility on 02/12/2015 to ensure there were no other areas requiring additional sprinkler heads.  Maintenance Director or designee will once per month x 2 months for compliance.  Results will be reported to the Quality Assurance Risk meeting for further resolution is needed. Completion 03/07/2015.		
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		3/7/15	

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K 067	Continued From page 5  This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on January 29, 2015 at approximately 8:00 AM onward, the following deficiencies were noted: 1) The emergency HVAC shut down switch located at 100 hall nurse station did not operate when tested. NFPA 90A, 4-2  This deficiency affected three of approximately 8 smoke compartments Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 067	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.  K067 The emergency HVAC switch for the HVAC UNIT ON 100 Hall was repaired on 02/12/2015.  All other emergency HVAC Switches will be inspected by 02/16/2015 to ensure compliance and repairs made, if necessary.  Maintenance Director or designee will inspect four switches 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 03/07/2015.		

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K 104 K 104 SS=F	Continued From page 6 NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.  This STANDARD is not met as evidenced by: 42 CFR 483.70 (a)  Based on observations, on January 29, 2015 at approximately 9:00 AM onward, the following deficiencies were noted: 1) The smoke damper located in the smoke wall on 100/200 hall did not close upon activation of the fire alarm system. NFPA 72, National Fire Alarm Code. ref: 2000 NFPA 101: 8.2.4.4.3 This deficiency affected two out of two smoke dampers inspected. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 104 K 104	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.  K104 After a phone conference with the DHHS Construction Section Inspection supervisor on 2/12/2015, we believe we are in compliance with this regulation, and that the facility's fire protective system is working as designed, and as approved, for construction. Based on guidance received by the supervisor during this telephone conference, we contacted the Greensboro Fire Department Inspector who has responsibilities for our facility's routine inspections. Again, using the supervisor's guidance, we asked for the	3/7/15	

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K 104	Continued From page 7	K 104	records concerning our initial GFD compliance inspection, which was required before the issuance of a Certificate of Occupancy These records will address air handler and damper compliance requirements then in existence. We expect this documentation to be forthcoming from GFP on or about 2/18/2015 and will forward to the Construction Section immediately upon receipt. Completion 03/07/2015		