STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345148	A. BUILDING _____ B. WING _____	06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS HOMES AT GUILFORD	925 NEW GARDEN RD GREENSBORO, NC 27410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the Recertification Survey Event ID NXG211.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

PRINTED: 07/19/2011
FORM APPROVED
OMB NO. 0938-0391

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
	345148	A. BUILDING 02 - MAIN BUILDING B. WING _____	07/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS HOMES AT GUILFORD	925 NEW GARDEN RD GREENSBORO, NC 27410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 07/13/2011 the door to storage room #C-143 and the door to the laundry chute in room #D-121 did not close and latch. 42 CFR 483.70 (a)	K 029	We will correct the issue with the door To Storage Room #C-143 and the door to the laundry chute in Room #D-121 to assure they will close and latch. The Maintenance Director or designee of The Maintenance Staff will make monthly inspections to prevent this issue. If an issue is identified, the Maintenance Department, working with the Director of Nursing and her/his staff, will take corrective action and will report such actions at the Quarterly Quality Assurance Meeting.	08/27/11
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 07/13/2011 the staff interviewed did not not know about the master door release switch located at the nurses station in the secured unit. 42 CFR 483.70 (a)	K 038	To correct the deficient practice of staff not knowing location of master door release switch located at the nurses station in the secured unit: 1. A large print laminated sign was placed at the master door release switch location. 07/13/11 2. Staff member immediately in-serviced on location and use of the master door release switch. 07/13/11 To identify other safety issues having the Potential to affect residents by the same deficient practice and corrective actions:	
K 061 SS=D	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	K 061	1. Large print laminated signs will be posted at each Staff Work room and the emergency door release switch in the Administrative Work room.	08/01/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Tim Jackson | ADMINISTRATOR | 7-29-11

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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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345148	A. BUILDING 02 - MAIN BUILDING B. WING _____	07/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS HOMES AT GUILFORD	925 NEW GARDEN RD GREENSBORO, NC 27410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 061	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 07/13/2011 the sprinkler exhausters (2) located in small room on the first floor had valves that were not supervised and one of the valves was in the closed position,which took that exhauster out of the system. 42 CFr 483.70 (a)	K 061	Response to K 038 continued: To insure this deficient practice does not Recur: 1. Current Nursing Staff will be in-serviced by 08/26/11 on location and use of the master door release switch for the secured unit. 2. Newly employed Nursing Staff will be in-serviced during orientation. Information will be added to the Orientation Packet. Monitoring to ensure the deficient practice will not recur: 1. Quality Assurance Monthly Audit Will include checking for signage in place. 2. Monthly Fire Drill Reports will include insuring locking doors for the secured unit have been released. Response to K 061 We will work with our sprinkler service company and our fire alarm system service company to correct this deficiency to comply With NFPA 101 Safety Code Standard. The Maintenance Director or designee of the Maintenance Staff will make monthly inspections to prevent this issue. If an issue is identified, the Maintenance Department, working with the Director of Nursing and her/his staff, will take corrective action and will report such actions at the Quarterly Quality Assurance Meeting.	08/26/11 08/26/11 08/26/11 08/26/11 08/27/11