

NOV 19 2013

Accepted

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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	F000	<i>This Plan of Correction is the provider's credible allegation compliance.</i>	
F 278 SS=D	No deficiencies were cited as a result of the complaint investigation survey. Event# CETO11 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. 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 and interview with staff	F278	-The MDS for resident #43 has been corrected and submitted as an accurate reflection of section K; unplanned severe weight loss. The subsequent corrected care plan was completed. -The corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice by the Interdisciplinary Team performing a scheduled review of the MDS' of residents to assess for the accuracy of Section K and to correct any information deemed inaccurate. -The measure put into place to ensure that the deficient practice will not occur is the inservicing of the Interdisciplinary Team on "The need for Accuracy on the Information Coded on Each MDS" Section K and inservicing on the "Weight Change Policy." (See Exhibits #1 & # 2) -The facility plans to monitor its performance to ensure that solutions are sustained by having the Quality Assurance Nurse or her designee monitor, through a monthly audit and record a review of the accuracy of the MDS section K. The results of the audits will be brought to the Quarterly Quality Assurance Meeting to ensure that the corrective action is achieved and sustained. The Administrator/DON is responsible for the overall compliance.	11/4/13 11/14/13 11/11/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jim Jackson* TITLE *Administrator* (X6) DATE *11-15-13*

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.

*PR
2/15/13
JFD*

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2013
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 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 278	Continued From page 1 the facility failed to code the annual (MDS) assessment for severe weight loss accurately. This was evident in 1 of 3 residents in the sample reviewed for nutrition. Resident #43 Findings included: Resident had cumulative diagnoses which included dementia. Review of the monthly weight chart form revealed the resident ' s height was 5 feet. The monthly weight chart form indicated a weight history that included in part: 07/02/13 138 pounds (lbs) 07/31/13 134 lbs (weight for August) 09/02/13 128 lbs 10/02/13 121 lbs This represented an unplanned severe weight loss of 17 lbs within 3 months. Review of the annual Minimum Data Set (MDS) dated 10/2/2013 revealed under Section K swallowing and nutrition, the weight loss column was coded 0 (zero) which indicated the resident had not experienced a weight loss of 5% or more in the last month or 10% or more in the last 6 months or the data was unknown. This coding was inaccurate and did not reflect weight loss. Interview on 10/23/13 at 4:40 pm with (NCM#1) nutrition care manager revealed " I did the wrong math " in determining the degree of weight loss. Interview on 10/23/13 at 4:50 pm with the consultant dietitian the director of food services was held. The consultant dietitian indicated the weight loss should have been assessed. Interview on 10/24/13 at 5:10 PM with director of nurses (DON) and the Administrator regarding their expectations related inaccurate assessment. The DON indicated expectations would be that the assessment wasn't missed, and we will be revising the weight policy. The DON indicated it was just a human error.	F278	<i>This Plan of Correction is the provider's credible allegation compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F279	Corrective actions for resident #63 affected by the deficient practice are a repeat serum albumin level recommended by the consultant Registered Dietitian and ordered by NP on 10/23/13. Lab results received on 10/24/13	10/23/13 10/24/13 11/13/13

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/24/2013
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
F279	<p>Continued From page 2</p> <p>comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview with staff and record review the facility failed to develop a comprehensive care plan that addressed the low total protein and serum albumin levels. This was evident in 1 of 3 residents in the sampled reviewed for nutrition. Resident#63 Findings included:</p> <p>Resident#63 was admitted to the facility on 6/24/13 with cumulative diagnoses which included anemia and diabetes.</p> <p>Review of the Minimum Data Set dated 9/25/13 revealed resident required supervision with Activities of daily living and was cognitively intact.</p> <p>Review of the hospital laboratory studies revealed on 6/18/13 a total protein level of 4.4 grams per deciliters (g/dl) milligrams per deciliter and with a serum albumin level 2.0 g/dl. The reference range for total protein level was 6.0-8.3 g/dl. The reference range for a serum albumin level was 3.5-5.5 g/dl.</p> <p>Review of the laboratory blood studies dated 7/1/13 revealed a total protein 5.1 g/dl and serum albumin of 3.1 g/dl.</p> <p>Review of the medical record revealed no care plan to address the low protein levels.</p> <p>Interview on 10/23/13 at 1:50 PM with the consultant dietitian via the phone revealed "we (referring to the facility) failed miserably, dropped</p>	F279	<p>were 3.4g/dl. NP reviewed serum albumin level result and no new orders were received. The care plan was updated on 10/23/13 and 10/24/13 accordingly to address the serum albumin levels. The consulting Registered Dietitian reassessed resident and recommended a protein supplement on 11/13/13. NP ordered a protein supplement on 11/13/13. The resident care plan was updated on 11/13/13.</p> <p>Corrective action for all residents with the potential to be affected by the same deficient practice is that all abnormal albumin levels will be assessed and evaluated by the NP and by either the NCM or the consultant Registered Dietitian. The results of the assessment will be communicated to the MDS Coordinator via a Nutritional Communication Notebook (Notebook implemented 11/14/13) and recorded on the residents care plan.</p> <p>Measures to be put into place to ensure that the deficient practice will not occur are that abnormal albumin levels will be assessed and evaluated by the NP and by either the NCM or Consultant Registered Dietitian. The result of the assessment will be communicated to the MDS Coordinator via the Nutritional Communication Notebook and recorded on the resident care plan. In-services were conducted by the consultant Registered Dietitian for licensed Nursing staff on serum albumin and total protein and on the purpose of the Nutritional Communication Notebook. (See Exhibit #3)</p> <p>The Consultant Registered Dietitian will communicate through a monthly report to the Administrator or designee to ensure resident protein needs are addressed. The administrator will meet with the MDS Coordinators to ensure the care plans have been updated to address any abnormal serum albumin and protein levels. Any concerns will be reported to the Quarterly Quality Assurance meeting to ensure that corrective actions are achieved and sustained. The Administrator /DON are responsible for overall compliance.</p>	11/13/13

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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
F279	<p>Continued From page 3</p> <p>the ball [indicating the facility failed to address the low protein and serum levels]" We were focusing on the nurses concern of her blood sugars. "</p> <p>Interview on 10/23/13 at 4:50 pm with the consultant dietitian and the director of food services was held. The consultant dietitian indicated as the consultant she should have addressed the low albumin and total protein levels.</p> <p>Interview conducted on 10/24/13 at 5:20 PM with the director of nurses (DON) and administrator regarding the expectations related to care planning the resident ' s protein needs. The DON revealed the dietitian needs to monitor more closely. The administrator indicated he would reiterate and remind the dietitian once per month when we meet, to make sure the protein needs are addressed.</p>	F279	<p><i>This Plan of Correction is the provider's credible allegation compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
F280	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff the facility failed to update a nutritional care plan when a severe weight loss occurred. This was evident in 1 of 3 residents in the sample reviewed for nutrition. Resident #43 Findings included:</p> <p>Resident#43 had cumulative diagnoses which included dementia.</p> <p>Review of the monthly weight chart form revealed the resident ' s height was 5 feet. The monthly weight chart form indicated a weight history that</p>	F280	<p>-The MDS for resident #43 has been corrected and submitted as an accurate reflection of the Section K; unplanned severe weight loss. The subsequent corrected Care Plan was completed.</p> <p>-The corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice by the Interdisciplinary Team performing a scheduled Review of the MDS of residents to assess for the accuracy of Section K and the correction of any information deemed to be inaccurate. Any resident identified to have a weight loss of 5% or more in a month or 10% or more in the last six months will be addressed by interventions on their Care Plan. (See Exhibit #2)</p> <p>-The measure put into place to ensure that the deficient practice will not occur is the in-servicing of the Interdisciplinary Team on "Nutritional Care Planning". Utilizing the Nutritional Assessment Policy. (See Exhibit #4)</p> <p>-The facility plans to monitor its performance to ensure that solutions are sustained by having the Quality Assurance Nurse or her designee monitor, through a monthly audit, and record a review of the accuracy of Nutritional Care Plans when a severe weight loss occurs. The result of the audits will be brought to the Quarterly Quality Assurance Meeting to ensure that the corrective action is achieved and sustained. The</p>	<p>11/4/13</p> <p>11/11/13</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2013
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F280	<p>Continued From page 4</p> <p>Based on record review and interview with staff the facility failed to update a nutritional care plan when a severe weight loss occurred. This was evident in 1 of 3 residents in the sample reviewed for nutrition. Resident #43 Findings included:</p> <p>Resident#43 had cumulative diagnoses which included dementia.</p> <p>Review of the monthly weight chart form revealed the resident ' s height was 5 feet. The monthly weight chart form indicated a weight history that included in part: 07/02/13 138 pounds (lbs) 07/31/13 134 lbs 09/02/13 128 lbs 10/02/13 121 lbs This represented severe weight loss of 17 lbs within 3 months.</p> <p>Review of the annual Minimum Data Set (MDS) dated 10/2/2013 revealed under Section K swallowing and nutrition, the weight loss column was coded 0 (zero) which indicated the resident had not experienced a weight loss of 5% or more in the last month or 10% or more in the last 6 months or the data was unknown.</p> <p>Review of the careplan revised 7/9/13 addressing nutrition revealed in part the goals were met regarding being at risk for altered nutrition.</p> <p>Review of the revised care plans dated 10/17/13 revealed no written goals and approaches to address the unplanned severe weight loss.</p> <p>Interview on 10/23/13 at 4:16 pm with MDS coordinator#2 revealed the interdisciplinary team did not do a careplan regarding nutrition because it did not appear on the CAA (care area assessment) summary determine if the facility should make a decision to careplan.</p> <p>Interview on 10/23/13 at 4:40 pm with nutrition care manager (NCM#1) revealed " I did the wrong math " in determining the degree of weight loss on the Minimum Data Set (MDS) assessment form dated 10/2/13.</p> <p>Interview on 10/23/13 at 4:50 pm with the consultant dietitian and the director of food services was held. The consultant dietitian indicated the weight loss should have been assessed. The dietitian also indicated as the consultant she should have addressed the weight loss on the careplan</p>	F280	Administrator/DON is responsible for overall compliance.	

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2013
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 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 325 SS=D	Continued From page 5 Interview on 10/24/13 at 5:10 PM with the director of nurses (DON) and the Administrator regarding their expectations related to the resident's weight loss being Care Plan. The DON indicated her expectations would be that it wasn't missed and it was just a human error. 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with staff, consultant dietitian, and nurse practitioner, the facility failed to assess for and provide nutritional interventions for a severe weight loss, and for low protein and serum albumin levels, for 2 of 3 sampled residents reviewed for nutrition. (Resident #43 and #63) Findings included: 1. Record review indicated Resident #43 had cumulative diagnoses which included dementia. Review of the annual Minimum Data Set (MDS) dated 10/2/2013 revealed the resident had severely impaired cognition, was totally dependent on staff for eating and had not experienced a weight loss of 5 percent (%) or more in the last month or 10 % or more in the last 6 months. Review of the care plan revised 7/9/13, which addressed nutrition, revealed in part the goals were met regarding being at risk for altered nutrition. Review of the monthly weight chart form revealed the resident's height was 5 feet. The monthly weight chart form indicated a weight history which included in part: 07/02/13 =138 pounds (lbs.) 07/31/13 =134 lbs. 09/02/13 =128 lbs. 10/02/13 = 121 lbs.	F325	<i>This Plan of Correction is the provider's credible allegation compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	10/24/13
	1) The corrective action was accomplished for resident #43 affected by the deficient practice by the re-starting of her Resource Supplement with the addition of chocolate syrup (as is her preference) administered with each medication pass. -The corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice by the Interdisciplinary Team identifying at their weekly Weight Management Meeting those residents with a severe weight loss in accordance with the parameters in the Weight Change Policy. (Exhibit #2) -The measure put into place to ensure that the deficient practice will not occur is the in-servicing of the Interdisciplinary Team on the Weight Change Policy and in-servicing of the facility staff nurses at the Monthly Nurses Meeting. (See Exhibits #2 and #5) The facility plans to monitor its performance to ensure that solutions are sustained by having the Quality Assurance Nurse or her designee monitor through a monthly audit, and record a review of the accuracy of care plan interventions related to those residents with a severe weight loss. The results of the audits will be brought to the Quarterly Quality Assurance Meeting to ensure that the corrective action is achieved and sustained. The Administrator/DON is responsible for overall compliance. 2) Corrective actions for resident #63 affected by the deficient practice are a repeat serum albumin level recommended by the consultant Registered Dietitian and ordered by NP on		11/11/13 11/13/13	

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2013
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F325	<p>Continued From page 6</p> <p>The seventeen pound weight loss experienced by Resident #43 from 07/02/13 to 10/02/13 equates to a 12.32 % percent severe weight loss during this three month period.</p> <p>Review of the revised care plan dated 10/17/13 revealed no written goals and approaches to address the unplanned weight loss.</p> <p>Review of Resident #43 ' s the October 2013 physician orders for October 2013 revealed orders for a regular diet and an order for a chocolate liquid supplement of 120 milliliters twice a day since 10/30/2012.</p> <p>Review of the intake monitoring sheets from July 2013 through October 23, 2013 revealed the resident ' s food and fluid intake varied from 50 % to 100 % at different meals.</p> <p>Review of Resident #43 ' s physician orders revealed a 10/10/13 to receive 120 milliliters of a nutritional supplement which provided two calories per milliliter. This order was discontinued on 10/14/13, despite the resident consuming 100%. Review of the medical record revealed no documentation to determine why this liquid supplement was discontinued nor that other dietary interventions were implemented.</p> <p>Nurse#7 who discontinued the supplement on 10/14/13 was not available at the time of the survey for an interview</p> <p>Interview on 10/23/13 at 3:08 PM with Nurse# 2 revealed he provided a carton of chocolate liquid supplement with a straw to the resident and she consumed all of it. Nurse#2 indicated sometimes he gave her more when he administered her medications.</p> <p>Interview on 10/23/13 at 4:01 PM with nursing assistant (NA) #3 revealed, " The resident eats almost anything. " NA #3 indicated she had not had a problem feeding the resident.</p> <p>Observation of breakfast on 10/22/13 at 8:30 AM revealed the resident consumed 100 % of the eggs and hot cereal with the assistance of staff.</p> <p>Observation of lunch on 10/23/13 at 12:20 PM revealed the resident was being fed and consumed 75 % of her meal.</p> <p>Interview on 10/23/13 at 4:50 PM with the facility ' s consultant dietitian and the director of food services was held regarding Resident #43 ' s severe weight loss. The dietitian stated, " The</p>	F325	<p>10/23/13. Lab results received on 10/24/13 were 3.4g/dl. NP reviewed serum albumin level result and no new orders were received. The care plan was updated on 10/23/13 and 10/24/13 accordingly to address the serum albumin levels. The consulting Registered Dietitian reassessed resident and recommended a protein supplement on 11/13/13. NP ordered a protein supplement on 11/13/13. The resident care plan was updated on 11/13/13.</p> <p>Corrective action for all residents with the potential to be affected by the same deficient practice is that all abnormal albumin levels will be assessed and evaluated by the NP and by either the NCM or the consultant Registered Dietitian. The results of the assessment will be communicated to the MDS Coordinator via a Nutritional Communication Notebook and recorded on the residents care plan.</p> <p>Measures to be put into place to ensure that the deficient practice will not occur are that abnormal albumin levels will be assessed and evaluated by the NP and by either the NCM or Consultant Registered Dietitian. The result of the assessment will be communicated to the MDS Coordinator via the Nutritional Communication Notebook and recorded on the resident care plan. In-services were conducted by the consultant Registered Dietitian for licensed Nursing staff on serum albumin and total protein and on the purpose of the Nutritional Communication Notebook. (See Exhibit #3)</p> <p>The Consultant Registered Dietitian will communicate through a monthly report to the Administrator or designee to ensure resident protein needs are addressed. The administrator will meet with the MDS Coordinators to ensure the care plans have been updated to address any abnormal serum albumin and protein levels. Any concerns will be reported to the Quarterly Quality Assurance meeting to ensure that corrective actions are achieved and sustained. The Administrator /DON are responsible for overall compliance.</p>	<p>10/23/13 10/24/13</p> <p>11/13/13</p> <p>11/13/13</p>

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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
F325	<p>Continued From page 7</p> <p>weight loss should have been assessed, and as the consultant, I should have addressed the weight loss. "</p> <p>On 10/24/13 at 5:10 PM an interview with the Director of Nurses (DON) and the administrator was held regarding their expectations related to the resident ' s weight loss The DON indicated her expectations would be that it (referring to the weight loss) was ' t missed and the facility would be revising the weight loss policy.</p> <p>2. Resident#63 had cumulative diagnoses which included anemia and diabetes. Review of the Minimum Data Set dated 9/25/13 revealed resident required supervision with activities of daily living and was cognitively intact.</p> <p>Review of the medical record revealed no careplan to address the low protein levels.</p> <p>Review of the resident ' s hospital laboratory studies revealed on 6/18/13 a total protein level of 4.4 grams per deciliter (g/dl) and a serum albumin level 2.0 g/dl. The reference range for total protein level was 6.0-8.3 g/dl. The reference range for a serum albumin level was 3.5-5.5 g/dl.</p> <p>Review of the laboratory blood studies dated 7/1/13 revealed a total protein 5.1 g/dl and serum albumin of 3.1 g/dl.</p> <p>Review of the admitting nutritional assessment form dated 6/24/13 and authored by nutrition care manager (NCM#1) revealed a notation indicating a total protein level 5.1 g/dl and 3.1 g/dl serum albumin level. There was no assessment of the resident's estimated protein needs or recommendations to address the low protein markers.</p> <p>Interview on 10/23/13 at 10:21 AM with NCM#1 revealed the low albumin levels were not brought to her attention. NCM #1 revealed she was unaware of Resident #63 ' s low protein and albumin levels of 06/24/13, so she had not made any recommendations to address these abnormal laboratory results.</p> <p>Review of the 7/25/13 nutrition assessment form authored by NCM#2 revealed no indication of the low protein levels. Nor were the resident ' s low protein needs addressed.</p> <p>Interview on 10/23/13 at 11:30 AM via the phone with NCM#2 revealed she did not address the resident ' s low protein and albumin levels on the</p>	F325		

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/24/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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
F325	<p>Continued From page 8</p> <p>07/25/13 nutritional assessment.</p> <p>Continued review of the nutritional assessment progress notes dated 9/25/13 and 10/4/13 revealed the facility still did not address the low protein levels or conducted an assessment of the resident's estimated protein needs.</p> <p>Interview on 10/23/13 at 1:50 PM with the consultant dietitian via the phone revealed a confirmation that the facility failed to address Resident #63 ' s low protein and albumin levels. An interview on 10/23/13 at 4:50PM with the consultant dietitian and the director of food services was held. The consultant dietitian specified she should have addressed the low albumin and total protein levels and should have assessed the resident ' s estimated daily protein needs.</p> <p>An interview was conducted on 10/24/13 at 5:20 PM with the director of nurses (DON) and the administrator regarding the expectations related to the assessment of the resident ' s protein needs. The DON revealed she would have expected the facility to implement measures to address Resident #63 ' s low albumin and total protein levels.</p> <p>Interview on 10/24/13 at 5:15PM with the Nurse Practitioner (NP) was conducted. The NP indicated she was unaware that a nutritional assessment had not been completed to address the low albumin levels.</p>	F325	<p><i>This Plan of Correction is the provider's credible allegation compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
F431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature</p>	F431	<p>1) For resident #29 found to have been affected by the deficient practice of expired medication, the corrective action was to return the expired medication to the pharmacy and new supply of medication was ordered and received from the pharmacy.</p> <p>The corrective action for those residents having potential to be affected by the same deficient practice is to educate all licensed nursing staff on medication storage and expiration dates per the pharmacy policy of medication storage and expiration dates. (See Exhibit #6)</p> <p>Measures to be put into place to ensure that the deficient practice will not occur will be weekly audits of medication storage and expiration dates to be conducted by licensed nurses on the 11pm-7am shift as part of the Medication Cart and Medication Room Weekly Audit.</p>	<p>10/23/13</p> <p>11/13/13</p>

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2013
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F431	<p>Continued From page 9</p> <p>controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to discard an expired medication as specified by the drug manufacturer in 1 of 4 medication carts (Oaks); and failed to securely store medications in 3 of 4 wound care treatment carts (Maples, Oaks, and Cedars).</p> <p>The findings included: 1) An observation of the Oaks medication cart on 10/23/13 at 4:13 PM revealed an opened bottle of calcitonin-salmon spray 200 Units per actuation (an intranasal spray used for the treatment of osteoporosis) in the medication cart drawer for Resident #29. The bottle was labeled as opened on 9/4/13 and an expiration date of 10/4/13 was hand-written on the label. A review of Resident #29 's October 2013 Physicians Orders revealed there was a current order for the calcitonin-salmon spray dispensed as generic for Miacalcin in a 30-dose bottle delivering 200 Units per dose to be given as one spray in alternating nostrils every day.</p> <p>The manufacturer ' s product information indicated a bottle of calcitonin-salmon spray may be stored at room temperature for up to 35 days. Opened or unopened bottles left at room temperature for more than 35 days must be discarded. Additional information from the manufacturer indicated that more than 30 doses should not be used from one bottle. After 30 doses, the pump may not deliver the correct amount of medication with each spray.</p> <p>An interview was conducted with the nurse assigned to the Oaks medication cart (Nurse #1) on 10/23/13 at 4:13 PM. Upon inquiry, Nurse #1 stated, " If I had seen that (the expiration date) I would have re-ordered it. The nurse noted she did not see another bottle of calcitonin-salmon on the medication cart and subsequently reported none was found in the medication store room refrigerator.</p>	F431	<p>The facility's plan is to monitor its performance and ensure that solutions are sustained through implementing a Weekly Medication Storage and Expiration Audit.</p> <p>The audit will be given to the Quality Assurance Nurse for review and will be reported to the Quarterly Quality Assurance Committee to ensure that the corrective action is achieved and sustained. The Administrator/DON is responsible for overall compliance.</p>	

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2013
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F431	<p>Continued From page 10</p> <p>An interview was conducted with the Staff Development Coordinator (SDC) on 10/23/13 at 4:25 PM. The SDC reported that calcitonin-salmon spray should be labeled with the date the medication was opened and the date it expired. She also indicated it should be pulled from the medication cart upon expiration. When Nurse #1 inquired as to what to do with the expired calcitonin-salmon spray, the SDC instructed her to take it off of the medication cart as it could no longer be used.</p> <p>During an interview with the DON on 10/24/13 at 9:46 AM, the DON stated she was aware that expired calcitonin-salmon spray had been found on the Oaks medication cart and that this situation had been resolved. The DON indicated her expectation would be for an expired bottle of calcitonin-salmon spray to be promptly removed from the medication cart.</p> <p>2a) A review of the facility 's Policy entitled, " Storage and Expiration of Medications, Biologicals, Syringes and Needles, " dated 1/1/13 included the following statement: " Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. "</p> <p>The initial tour of the facility was conducted on 10/21/2013 at 10:45 AM. During this tour, the door to room D111 (a clean utility room) on the Maples hall was observed to be open. A wound care treatment cart was observed in the room with the cart's locking mechanism in the out/unlocked position. There was no nurse or other staff member near the room or utilizing the cart. During the continued tour of the Maples hall from 10:45 AM to 11:00 AM, the door to room D111 remained open and the cart remained unlocked. Residents, visitors, and staff were observed to pass the open room containing the unlocked cart. Another observation was made on 10/21/13 at 12:10 PM which revealed the door to room D111 was open and the wound care treatment cart inside the room was unlocked. There was no nurse or staff member near the room or utilizing the cart. At 12:55 PM Nurse #6 was observed leaving room D111. Upon her exit, both the door to the room and the treatment cart inside were observed to be unlocked.</p> <p>An observation of the Maples treatment cart on</p>	F431	<p>2A-2C) No residents were reported to be directly affected by this practice.</p> <p>The corrective action for those residents having the potential to be affected by the same deficient practice will be accomplished by ensuring that all items, per facility policy for "storage and expiration of medications, biological, syringes and needles" including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.</p> <p>The measures put into place to ensure that the deficient practice will not occur will be to educate all licensed nursing staff on medication storage per our facility policy. The key to each treatment cart will remain in the possession of the charge nurse on each assigned hall. The charge nurse will sign a log to verify that the treatment cart will remain locked. (See Exhibits #6 and #7)</p> <p>The sustained solution to monitor the facility's performance will be through random weekly cart audits to ensure storage is achieved per our facility policy. The results of the audits will be reviewed and reported to the Quarterly Quality Assurance Committee by the Quality Assurance Nurse. The Administrator/DON will be responsible for overall compliance.</p>	11/13/13

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2013
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F431	<p>Continued From page 11</p> <p>10/22/13 at 2:16 PM revealed the treatment cart was stored in Room D111. The door to the room was ajar (not latched). The room was unlocked and the treatment cart was noted to be unlocked and unattended. Prescription topical medications stored in the second drawer of the unlocked treatment cart included the following: 4 tubes of nystatin-triamcinolone cream (a prescription antifungal-steroidal cream); one bottle of ketoconazole shampoo (an anti-fungal agent); one tube of silver sulfadiazene cream (an antiseptic typically used for the treatment of burns); 2 tubes of mupirocin ointment (an antibiotic medication); 1 tube of ketoprofen gel (a nonsteroidal anti-inflammatory medication); and one vial of NyStop powder (an anti-fungal agent). Two tubes of over-the-counter (OTC) creams were also stored in the second drawer of the treatment cart.</p> <p>On 10/23/2013 at 10:02 AM, the facility's Assistant Director of Nursing (ADON) was observed storing the unlocked wound care treatment cart in room D111 on the Maples hall. Room D111 was left unlocked. Residents, staff, and visitors were observed passing the unlocked room storing the unlocked wound care treatment cart.</p> <p>An observation of the Maples treatment cart on 10/24/13 at 9:25 AM revealed the treatment cart was stored in Room D111. The room was unlocked. The treatment cart was unlocked and unattended. Topical prescription medications were stored in the second drawer of the cart.</p> <p>An interview was conducted with Nurse #3 on 10/24/13 at 9:30 AM. Nurse #3 was the staff nurse on duty for the Maples neighborhood. Nurse #3 stated all staff nurses used the treatment cart. She indicated the treatment cart was kept in the clean utility room with the doors closed. She also stated that staff using the cart needed to make sure it was locked.</p> <p>During an interview with the DON (Director of Nursing) on 10/24/13 at 9:46 AM, the DON indicated that her expectation would be for the treatment carts to be kept in the clean utility room and locked unless it was in use.</p> <p>2b) A review of the facility 's Policy entitled, " Storage and Expiration of Medications, Biologicals, Syringes and Needles, " dated 1/1/13 included the following statement: " Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents</p>	F431		

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2013
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F431	<p>Continued From page 12</p> <p>and visitors. "</p> <p>An observation of the Oaks treatment cart on 10/22/13 at 2:01 PM revealed the treatment cart was stored in Room B111 (a clean utility room). The room was unlocked. The treatment cart was unlocked and unattended. Two 60-gram tubes of nystatin-triamcinolone cream (a prescription antifungal-steroidal cream) were sitting on top of the treatment cart. Prescription topical medications stored in the second drawer of the unlocked treatment cart included the following: 1 tube of Nizoral cream (an anti-fungal agent); 2 tubes of nystatin-triamcinolone cream; one tube of a compounded prescription cream (a medication compounded by the pharmacy which contained 6 prescription ingredients formulated in accordance with a prescriber ' s specifications); one tube of Prudoxin (a topical cream typically used for nerve pain); and one tube of Voltaren gel (a nonsteroidal anti-inflammatory medication). Four tubes of over-the-counter (OTC) creams were also stored in the second drawer of the treatment cart and additional over-the-counter topical products were stored in the third drawer of the cart.</p> <p>An observation of the Oaks treatment cart on 10/23/13 at 9:50 AM revealed the treatment cart was stored in Room B111. The room was unlocked. The treatment cart was unlocked and unattended. Topical prescription medications were stored in the second drawer of the cart.</p> <p>An observation of the Oaks treatment cart on 10/24/13 at 9:25 AM revealed the treatment cart was stored in Room B111. The room was unlocked. The treatment cart was unlocked and unattended. Topical prescription medications were stored in the second drawer of the cart.</p> <p>An interview was conducted with Nurse #2 on 10/24/13 at 9:35 AM. Nurse #2 was the staff nurse on duty for the Oaks neighborhood. Nurse #2 stated the treatment cart was kept in the clean utility room. Upon entry into the utility room, the treatment cart was unlocked. Upon inquiry, Nurse #2 indicated the treatment cart should be locked but stated he had just used it. He locked the treatment cart prior to leaving the room.</p> <p>During an interview with the DON (Director of Nursing) on 10/24/13 at 9:46 AM, the DON indicated that her expectation would be for the treatment carts to be kept in the clean utility room and locked unless it was in use.</p> <p>2c) A review of the facility ' s Policy entitled, "</p>	F431		

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2013
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F431	<p>Continued From page 13</p> <p>Storage and Expiration of Medications, Biologicals, Syringes and Needles, " dated 1/1/13 included the following statement: " Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. "</p> <p>An observation of the Cedars treatment cart on 10/22/13 at 2:10 PM revealed the treatment cart was stored in Room A135 (a clean utility room). The room was unlocked. The treatment cart was unlocked and unattended. Prescription topical medications stored in the second drawer of the unlocked treatment cart included the following: 8 tubes of nystatin-triamcinolone cream (a prescription antifungal-steroidal cream); two tubes of mupiricin ointment (an antibiotic medication); and one tube of hydrocortisone cream (a steroidal cream).</p> <p>An observation of the Cedars treatment cart on 10/23/13 at 9:35 AM revealed the treatment cart was stored in Room A135. The room was unlocked. The treatment cart was unlocked and unattended. Topical prescription medications were stored in the second drawer of the cart.</p> <p>An observation of the Cedars treatment cart on 10/24/13 at 9:25 AM revealed the treatment cart was stored in Room A135. The room was unlocked. The treatment cart was unlocked and unattended. Topical prescription medications were stored in the second drawer of the cart.</p> <p>An interview was conducted with Nurse #4 on 10/24/13 at 9:32 AM. Nurse #4 was the staff nurse on duty for the Cedars neighborhood. Nurse #4 stated each pod had a treatment cart and that cart was kept in the clean utility room. Upon entry into the clean utility room, the treatment cart was unlocked. Upon inquiry, Nurse #4 stated the treatment cart should be locked and she subsequently locked it.</p> <p>During an interview with the DON (Director of Nursing) on 10/24/13 at 9:46 AM, the DON indicated that her expectation would be for the treatment carts to be kept in the clean utility room and locked unless it was in use.</p>	F431		

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 New Health Care section of the LSC and its referenced publications. This building is Type 1II(111) construction, fire retardant treated wood trusses, one story, with a complete automatic sprinkler system.	K 000		
K 029 SS=D	There were no deficiencies noted during survey. 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	K 029	The door latch on the soiled linen room at the laundry (B129) which did not latch will be corrected to assure the door will close and latch. The Maintenance Director or his/her designee will make monthly inspections to prevent this issue. If an issue is identified, the Maintenance Department working with the Director of Nursing and his/her staff, will take corrective action and report such actions at the Quarterly Quality Assurance Committee Meeting.	12/30/2013
K 051 SS=D	This STANDARD is not met as evidenced by: A. Based on observation on 11/21/2013 the door to the soiled linen at the laundry failed to latch when closed. 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: A. Based on observation on 11/21/2013 the valves on the accelerators were not electrically	K 051	We will work with our Sprinkler Service Company and Fire Alarm Systems Service Company to correct this deficiency to comply with NFPA 101 Safety Code Standard. The Maintenance Director or his/her designee will make monthly inspections to prevent this issue. If an issue is identified the Maintenance Director working with the Director of Nursing and his/her staff will take corrective action and report such actions to the Quarterly Quality Assurance Committee Meeting	12/16/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Tim Jackson* TITLE Administrator (X6) DATE 12-13-13

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 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 supervised.. 42 CFR 483.70 (a)	K 061			

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD			STREET ADDRESS, CITY, STATE ZIP CODE 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 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 New Health Care section of the LSC and its referenced publications. This building is Type III(111) construction, fire retardant treated wood trusses, one story, with a complete automatic sprinkler system.	K 000		
K 029 SS=D	There were no deficiencies noted during survey: 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	K 029	The door latch on the soiled linen room at the laundry (B129) which did not latch will be corrected to assure the door will close and latch. The Maintenance Director or his/her designee will make monthly inspections to prevent this issue. If an issue is identified, the Maintenance Department working with the Director of Nursing and his/her staff, will take corrective action and report such actions at the Quarterly Quality Assurance Committee Meeting.	12/30/2013
K 081 SS=D	This STANDARD is not met as evidenced by: A. Based on observation on 11/21/2013 the door to the soiled linen at the laundry failed to latch when closed. 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: A. Based on observation on 11/21/2013 the valves on the accelerators were not electrically	K 081	We will work with our Sprinkler Service Company and Fire Alarm Systems Service Company to correct this deficiency to comply with NFPA 101 Safety Code Standard. The Maintenance Director or his/her designee will make monthly inspections to prevent this issue. If an issue is identified the Maintenance Director working with the Director of Nursing and his/her staff will take corrective action and report such actions to the Quarterly Quality Assurance Committee Meeting	12/16/2013

COPY
DEC 18 2013
CONSTRUCTION SECTION

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.

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345148	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER FRIENDS HOMES AT GUILFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 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 supervised.. 42 CFR 483.70 (a)	K 061			