STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345116	A. BUILDING _____ B. WING _____	C 12/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - STARMOUNT	109 S HOLDEN ROAD GREENSBORO, NC 27407

(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 201 SS=D	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT	F 201		

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

The safety of individuals in the facility is endangered;

The health of individuals in the facility would otherwise be endangered;

The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or

The facility ceases to operate.

This REQUIREMENT is not met as evidenced by:
Based on resident and staff interview and record review, the facility failed to ensure there was a clinical reason for discharge for 1 of 3 sampled residents transferred from one skilled nursing facility(SNF) to another SNF (Resident #1). The

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the 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.

F201

Resident # 1 is no longer a resident at the facility. 12/28/12

An audit of all residents who were discharged for the previous 30 days was conducted by the Social Services Director to ensure appropriate documentation and reason for discharge. No other resident was found to be affected as a result of this audit.

The facility interdisciplinary team was inserviced by the Executive Director on the appropriate reasons for discharge and on ensuring the documentation reasons are documented in the medical record.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Beth Hunter	Executive Director	12/20/12

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
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F 201	Continued From page 1 findings included 1. Resident # 1 was admitted to the facility on 07/16/12 in a certified skilled nursing facility (SNF) bed. The business office records revealed that Resident #1 was transferred/discharged to another (SNF) facility on 09/25/12. Resident #1 Minimum Data Set(MDS) dated 7/23/12, indicated that his mental status was coded as 14. Section Q of the MDS is the participation in assessment and goal setting, revealed Resident #1 expected to be discharged to the community and referrals had been made to the local contact agency. Review of the physician ' s order dated 9/20/12, revealed the discharge was to assisted living for wound care and coumadin management. The progress note dated 9/20/12, did not include that services at current facility could not be met or Resident #1 would need transfer to another skilled nursing facility(SNF). Resident was transferred to another SNF on 9/25/12. During an interview on 12/3/12 at 2:17PM, the social worker indicated that she was unaware of any clinical reason for the discharge. During an interview on 12/3/12 at 4:00PM, the director of nursing indicated that there was no clinical reason noted for the discharge documented. During an interview on 12/4/12 at 10:05AM, the administrator acknowledged there was no documentation available indicating a clinical reason for the discharge.	F 201	The interdisciplinary team will review all pending and actual transfers and discharges to ensure there is an appropriate and documented reason for transfer and/or discharge, the appropriate notice has been given in writing, that there is documentation of resident and/or family conversation, preparation, orientation, and notification of discharge plans. This audit will be conducted daily in the morning meeting five days per week for four weeks, then three days per week for four weeks, then once weekly for one month. The results of this audit will be reviewed by and brought to the Quality Assessment Performance Improvement Committee Meeting by the Social Services Director. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.	
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES	F 202		

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
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F 202	Continued From page 2	F 202	F202	

When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to document the reason for the resident ' s discharge/transfer from skilled nursing facility (SNF) bed to another (SNF) facility for 1 of 3 sampled residents(Resident #1) The findings include:

1. Resident # 1 was admitted to the facility on 07/16/12 in a certified skilled nursing facility (SNF) bed. The business office records revealed that Resident #1 was transferred/discharged to another (SNF) facility on 09/25/12. Resident #1 Minimum Data Set(MDS) dated 7/23/12, indicated that his mental status was coded as 14. Section Q of the MDS is the participation in assessment and goal setting, revealed Resident #1 expected to be discharged to the community and referrals had been made to the local contact agency.

Review of the social work assessment dated 7/20/12, revealed Resident #1 discharge plans were to return back to the community to assistive

Resident # 1 is no longer a resident at the facility. 12/28/12

An audit of all residents who were discharged for the previous 30 days was conducted by the Social Services Director to ensure appropriate documentation and reason for discharge. No other resident was found to be affected as a result of this audit.

The facility interdisciplinary team was inserviced by the Executive Director on the appropriate reasons for discharge and on ensuring the documentation reasons are documented in the medical record.

The interdisciplinary team will review all pending and actual transfers and discharges to ensure there is an appropriate and documented reason for transfer and/or discharge, the appropriate notice has been given in writing, that there is documentation of resident and/or family conversation, preparation, orientation, and notification of discharge plans. This audit will be conducted daily in the morning meeting five days per week for four weeks, then three days per week for four weeks, then once weekly for one month.

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F 202	Continued From page 3	F 202	The results of this audit will be reviewed by and brought to the Quality Assessment Performance Improvement Committee Meeting by the Social Services Director. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.	

living. Additional, review of the social work notes revealed there was no documentation of the reason for the discharge to another SNF or attempts to find desired placement to an assistive living in the community.

Review of the physician ' s order dated 9/20/12, revealed the discharge was to assisted living for wound care and coumadin management. The progress note dated 9/20/12, did not include that services at current facility could not be met or Resident #1 would need transfer to another skilled nursing facility(SNF). Resident was transferred to another SNF on 9/25/12.

Review of the nurse ' s note dated 9/25/12, revealed that Resident #1 was discharged to another SNF with main diagnosis as left foot ulcer with osteomyelitis for skill nursing care. Resident #1 was given discharge information including medication and transported to new facility. There were no concerns documented prior to discharge noted that indicated the current facility could not meet the resident needs for wound care.

During an interview on 12/3/12 at 2:17PM, the social worker indicated that upon admission Resident #1 indicated that his desire was to return to the community in an assistive living housing. SW added that a verbal discussion was held with resident regarding his discharge plans, but she did not document what the reason and the efforts were to obtain desired placement.

During an interview on 12/3/12 at 3:30PM, the admission staff indicated that upon admission

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F 202	Continued From page 4	F 202		

Resident #1 wanted to return to the community but not to previous assistive living. Admission staff indicated the SW was responsible for the development of Resident #1 discharge plans and should have documented the process in the resident record.

During an interview on 12/3/12 at 4:00PM, the director of nursing indicated that any time a resident was scheduled for discharge the plan would have been discussed in the morning meeting, doctor ' s order obtained and documented in resident record. The director of nursing indicated that the SW was responsible for initiating and implementing the discharge process and documenting the discharge plans. The director of nursing reviewed the record and acknowledged there was no documentation that indicated the reason for discharge.

During an interview on 12/4/12 at 10:05AM, the administrator indicated that documentation of resident discharge should be noted in nurse ' s note, physician note and social worker notes. The documentation should include the discussion and discharge plan with the resident/responsible person and treatment team. The information would included the reason for the discharge, summary of the discharge and an all the required paperwork necessary for safe discharge.

F 203 SS=D — 483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE — F 203

Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a

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F 203	Continued From page 5 language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents	F 203	F203 Resident # 1 is no longer a resident at the facility. An audit of all residents who were discharged for the previous 30 days was conducted by the Business Office Director to ensure there was a notice of discharge given in writing and that it was documented in the record. The Social Services Director and Business Office Director were inserviced by the Executive Director on ensuring residents who are transferring or discharging are given the appropriate discharge notice in writing and documenting delivery of the notice in the record and retaining a copy of the notice. The interdisciplinary team will review all pending and actual transfers and discharges to ensure there is an appropriate and documented reason for transfer and/or discharge, the appropriate notice has been given in writing, that there is documentation of resident and/or family conversation, preparation, orientation, and notification of discharge plans. This audit will be conducted daily in the morning meeting five days per week for four weeks, then three days per week for four weeks, then once weekly for one month.	12/28/12

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F 203	Continued From page 6	F 203		

who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

This REQUIREMENT is not met as evidenced by:
Based on record review, interview with the legal representative and staff interview, the facility failed to document and to give a notice of discharge in writing to the resident or legal representative prior to discharge from the facility for 1 of 3 sampled discharged resident(Resident#1). Findings included:

1. Resident # 1 was admitted to the facility on 07/16/12 in a certified skilled nursing facility (SNF) bed. The business office records revealed that Resident #1 was transferred/discharged to another (SNF) facility on 09/25/12.

Review of the physician ' s order dated 9/20/12, revealed the discharge was to assisted living for wound care and coumadin management. The progress note dated 9/20/12, did not include that services at current facility could not be met or Resident #1 would need transfer to another skilled nursing facility(SNF). Resident was transferred to another SNF on 9/25/12

Review of the medical records including the discharge summary revealed no documentation as to why the resident was discharged to another nursing facility. There was no discharge summary available to summarize the discharge plan/process.

The results of this audit will be reviewed by and brought to the Quality Assessment Performance Improvement Committee Meeting by the Social Services Director. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.

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F 203	Continued From page 7	F 203		

During an interview on 12/3/12 at 5:00PM, the social worker indicated that she had not given the resident a 30 day written notice and generally it would be the administrator that gave the resident or legal representative the notice. Social worker indicated that she would not have given the resident the notice since he wanted to go to the other facility for more smoking privileges. She acknowledged there was no documentation available regarding the discussion as for the reason for the discharge and/or confirmation of the resident ' s acceptance of the discharge.

During an interview on 12/4/12 at 9:32AM, Resident #1 indicated that when he was admitted to the facility he wanted to return to the community. He indicated that he was told on 9/18/12 that he was being transferred to another facility because he smoked on facility property and they were a smoke free facility. He further stated that when he wanted to smoke he would sign himself out and go down the street. He added that he was never offered any assistance to quit smoking. He further stated he did not want to leave the facility and could not understand why he was asked to leave for smoking when he did not smoke on the property. He stated the social worker handed him a book of names of place and told him he needed to start calling these places and she told him about his current facility that had liberal smoking privileges. He stated that he felt rushed out of the facility without clear understanding and expectation to find his own place. He added that he thought the facility staff would " help me find housing in the community not put me in another nursing home. " " I was not given a 30 day notice or time to even look at

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F 203	Continued From page 8	F 203		

other places to decide where I wanted to go " . He added that on 9/20/12 the social worker told him she had found his current facility and would be moving in a few days. " I had no place to go so I just got in the car and went where they sent me. "

Review of the responsibility for leave of absence revealed that Resident #1 did sign himself in/out of the facility several times a day. Additional review of the record revealed there were no incidences of a concern regarding the resident smoking on facility property. Review of the facility smoking policy/procedures and assessment revealed that Resident #1 was not offered participation in the smoking sensation program or assistance for quitting smoking. There was no 30 day notice form/document available or presented by facility staff.

During an interview on 12/4/12 at 9:46AM, the director of nursing indicated that discharge plans were typically discussed in the morning meeting and Resident #1 was discussed in that the resident wanted to go to another place in the community and assistive living was discussed, however there was an issue with the payor source. Director of nursing indicated that she did not give the resident a 30 day written notice and there was no clinical reason for the discharge to another SNF since Resident#1 desire was for assistive living. Reviewed the physician ' s order which indicated the discharge was for assistive living. She acknowledged there was no supporting evidence of why the resident ' s desired placement was not obtained. In addition, there was no documented concern that a problem existing with the resident regarding smoking noted or discussed.

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F 203	Continued From page 9 During an interview on 12/4/12 at 10:05AM, the administrator indicated that when she was hired at the facility the discharge process was in progress and she did not give the 30 day notice as required.	F 203		
F 204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to provide sufficient preparation and orientation to the family/resident prior to discharge for one 1 of 3 residents (Resident # 1) The findings included; 1. Resident # 1 was admitted to the facility on 07/16/12 in a certified skilled nursing facility (SNF) bed. The business office records revealed that Resident #1 was transferred/discharged to another (SNF) facility on 09/25/12. Resident #1 Minimum Data Set(MDS) dated 7/23/12, indicated that his mental status was coded as 14. Section Q of the MDS is the participation in assessment and goal setting, revealed Resident #1 expected to be discharged to the community and referrals had been made to the local contact agency. Review of the social work assessment dated 7/20/12, revealed Resident #1 discharge plans	F 204	F204 Resident # 1 is no longer a resident at the facility. An audit of all residents who were discharged for the previous 30 days was conducted by the Social Services Director to ensure appropriate documentation, reason for discharge; family and resident involvement, notification, and agreement. No other resident was found to be affected as a result of this audit. The Social Services Director, Business Office Director and licensed nurses will be inserviced by the Executive Director, Director of Nursing Services and Director of Clinical Education on documentation requirements for the resident who is transferring or discharging with specific emphasis on documenting resident and family conversation, preparation, orientation, and notification of discharge plans prior to and upon discharge.	12/28/12

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F 204	Continued From page 10	F 204	The interdisciplinary team will review all pending and actual transfers and discharges to ensure there is an appropriate and documented reason for transfer and/or discharge, the appropriate notice has been given in writing, that there is documentation of resident and/or family conversation, preparation, orientation, and notification of discharge plans. This audit will be conducted daily in the morning meeting five days per week for four weeks, then three days per week for four weeks, then once weekly for one month. The results of this audit will be reviewed by and brought to the Quality Assessment Performance Improvement Committee Meeting by the Social Services Director. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.	

were to return back to the community to assistive living. Additional, review of the social work notes revealed there was no documentation of the reason for the discharge to another SNF or attempts to find desired placement to an assistive living in the community.

Review of the physician ' s order dated 9/20/12, revealed the discharge was to assisted living for wound care and coumadin management. The progress note dated 9/20/12, did not include that services at current facility could not be met or Resident #1 would need transfer to another skilled nursing facility(SNF). Resident was transferred to another SNF on 9/25/12.

Review of the closed medical record revealed that the resident was discharged to SNF on 9/25/12. Continued review of the medical record revealed no documentation that the Resident #1 was provided sufficient preparation and orientation before the discharge.

During an interview on 12/4/12 at 9:32AM, Resident #1 indicated that when he was admitted to the facility he wanted to return to the community. He indicated that he was told on 9/18/12 that he was being transferred to another facility because he smoked on facility property and they were a smoke free facility. He further stated that when he wanted to smoke he would sign himself out and go down the street. He added that he was never offered any assistance to quit smoking. He further stated he did not want to leave the facility and could not understand why he was asked to leave for smoking when he did not smoke on the property. He stated the social worker handed him a book of names of place and

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told him he needed to start calling these places and she told him about his current facility that had liberal smoking privileges. He stated that he felt rushed out of the facility without clear understanding and expectation to find his own place. He added that he thought the facility staff would " help me find housing in the community not put me in another nursing home. " " I was not given a 30 day notice or time to even look at other places to decide where I wanted to go " . He added that on 9/20/12 the social worker told him she had found his current facility and would be moving in a few days. " I had no place to go so I just got in the car and went where they sent me. "

During a follow-up interview on 12/4/12 at 11:30AM, the social worker was unable to provide any information that was given to the resident for sufficient preparation and orientation prior to discharge. SW did provide the faxed document to the receiving facility dated 9/21/12 indicated that placement was due to resident wanting/desire to smoke and current facility was smoke free campus. She added that there was no documented evidence there was a problem with the resident smoking on facility grounds. In addition, there had not been any trial arrangements made for Resident #1 to new locations and there was no information available for attempts made to seek assistive living in the community.

During a follow-up interview on 12/4/12 at 1:30PM, the director of nursing indicated the expectation would have been the treatment team meet with resident/responsible person and develop a care plan/discharge plan in which all persons were clear of the discharge plans and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345116	A. BUILDING _____ B. WING _____	C 12/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - STARMOUNT	109 S HOLDEN ROAD GREENSBORO, NC 27407

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location. The alert and oriented resident would be actively involved and encouraged to have input in searches/referrals with the assistance of the social worker.