\$EC 2 8 2012

PRINTED: 12/12/2012 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SUF COMPLET	ED
		345116	8. WING			C 4/2012
	OVIDER OR SUPPLIER	OUNT	109	ET ADDRESS, CITY, STATE, ZIP CODE S HOLDEN ROAD EENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (CROSS-REFERENCE)	0 BE	(X5) COMPLETION DATE
F 201 SS=D	the facility, and not to resident from the faci discharge is necessa		F 201	Preparation and/or execution of this correction does not constitute admiss agreement by the provider of the trut alleged or the conclusions set forth is statement of deficiencies. The plan of correction is prepared and/or execut because it is required by the provision federal and state law.	sion or th of facts in the of ed solely	
	the resident's health	ransfer or discharge is appropriate because sident's health has improved sufficiently so sident no longer needs the services led by the facility;		F201 Resident # 1 is no longer a resider facility.	at at the	12/28/12
	The resident has faile appropriate notice, to under Medicare or M For a resident who be after admission to a refacility may charge a charges under Medicare	uals in the facility would bered; ed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. ecomes eligible for Medicaid nursing facility, the nursing resident only allowable eald; or		An audit of all residents who were discharged for the previous 30 day conducted by the Social Services I to ensure appropriate documentati reason for discharge. No other resi was found to be affected as a resul audit. The facility interdisciplinary team inserviced by the Executive Direct the appropriate reasons for dischar on ensuring the documentation readocumented in the medical record.	ys was Director ion and ident It of this was tor on rge and asons are	
	by: Based on resident a review, the facility fai clinical reason for disresidents transferred	o operate. It is not met as evidenced and staff interview and record led to ensure there was a scharge for 1 of 3 sampled from one skilled nursing her SNF (Resident #1). The				

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

Executive Director

(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.

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		ALEDIOAID CEDVICES				OMB N	O. 0938-0391
		MEDICAID SERVICES	·			(X3) DATE SI	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	COMPLETED	
		345116	B. WIN	G		120	C 04/2012
		343110		 -		121	04/2012
NAME OF PR	OVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
GOLDENI	IVINGCENTER - STAR	MOUNT			9 S HOLDEN ROAD		
				GF	REENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 201	Continued From pag	e 1	F	, 201			•
	findings included				The later Mark 12 and 4 and 11		
					The interdisciplinary team will re pending and actual transfers and	view all	
	1. Resident # 1 was	admitted to the facility on			discharges to ensure there is an		
		d skilled nursing facility			appropriate and documented reas	on for	
		iness office records revealed			transfer and/or discharge, the app		
		s transferred/discharged to			notice has been given in writing,		
		y on 09/25/12. Resident #1			is documentation of resident and/		
		MDS) dated 7/23/12, indicated swas coded as 14. Section			conversation, preparation, orienta	ition, and	
		participation in assessment			notification of discharge plans. T	his audit	:
		ealed Resident #1 expected			will be conducted daily in the mo		•
		the community and referrals			meeting five days per week for for		
		ne local contact agency.		:	weeks, then three days per week		
	iliaa baari iliaaa ta il	,		t	weeks, then once weekly for one	month.	
	Review of the physic	cian ' s order dated 9/20/12,		:	The results of this audit will be re		
		ge was to assisted living for	٠		by and brought to the Quality Ass		
		madin management. The			Performance Improvement Comm		
		9/20/12, did not include that			Meeting by the Social Services D		
		acility could not be met or			Any issues or trends identified wi		
		need transfer to another			addressed by the Quality Assuran		
		y(SNF). Resident was			Performance Improvement Comm		
	transferred to anothe	9/ SINF ON 9/25/12.			they arise and the plan will be rev		
	During an intention	on 12/3/12 at 2:17PM, the			needed to ensure continued comp		
		ted that she was unaware of					
	any clinical reason f						
	•	on 12/3/12 at 4:00PM, the					
		idicated that there was no					
	clinical reason noted documented.	a for the discharge					
	administrator acknow	on 12/4/12 at 10:05AM, the weedged there was no lable indicating a clinical					
	reason for the disch	arge.					

F 202 483.12(a)(3) DOCUMENTATION FOR

SS=D TRANSFER/DISCHARGE OF RES

F 202

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		CONSTRUCTION	(X3) DATE SU COMPLE	TED
		345116	B. WING	i			C)4/2012
NAME OF PR	OVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN I	IVINGCENTER - STAR	MOUNT			SHOLDEN ROAD ENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 8E	(X5) COMPLETION DATE
F 202	Continued From pag	ge 2	F 2		F202		
	resident under any of in paragraph (a)(2)(in the resident's clinical documented. The documented by the resident's phydischarge is necess or paragraph (a)(2)(physician when transparagraph)	nsfers or discharges a of the circumstances specified) through (v) of this section, il record must be ocumentation must be made ysician when transfer or ary under paragraph (a)(2)(i) ii) of this section; and a sfer or discharge is necessary o(2)(iv) of this section.		:	Resident # 1 is no longer a resider facility. An audit of all residents who were discharged for the previous 30 day conducted by the Social Services to ensure appropriate documentation reason for discharge. No other resident was found to be affected as a result audit.	e ys was Director ion and ident	12/28/12
	by: Based on record refacility failed to docuresident's discharg facility (SNF) bed to 3 sampled residents include: 1. Resident # 1 was 07/16/12 in a certific (SNF) bed. The but that Resident #1 was another (SNF) facili Minimum Data Set(Ithat his mental statut Q of the MDS is the and goal setting, ret to be discharged to	view and staff interview, the ament the reason for the selfransfer from skilled nursing another (SNF) facility for 1 of s(Resident #1). The findings admitted to the facility on ed skilled nursing facility siness office records revealed as transferred/discharged to ty on 09/25/12. Resident #1 MDS) dated 7/23/12, indicated as was coded as 14. Section participation in assessment yealed Resident #1 expected the community and referrals			The facility interdisciplinary team inserviced by the Executive Direct the appropriate reasons for discharce on ensuring the documentation readocumented in the medical record. The interdisciplinary team will repending and actual transfers and discharges to ensure there is an appropriate and documented reasot transfer and/or discharge, the appropriate has been given in writing, the is documentation of resident and/or conversation, preparation, orientation of discharge plans. The will be conducted daily in the more meeting five days per week for for weeks, then once weekly for one in the supplementation of the conducted days per week for the weeks, then once weekly for one in the supplementation of the conducted days per week for the weeks, then once weekly for one in the supplementation of the conducted days per week for the weeks, then once weekly for one in the supplementation of the conducted days per week for the weeks, then once weekly for one in the supplementation of the conducted days per week for the weeks, then once weekly for one in the supplementation of the conducted days per week for the weeks, then once weekly for one in the supplementation of the conducted days per week for the weeks, then once weekly for one in the supplementation of the conducted days per week for the weeks, then once weekly for one in the supplementation of the conducted days per week for the weeks, then once weekly for one in the conducted days per week for the	tor on rge and asons are l. view all on for ropriate hat there or family tion, and his audit ming ur	
	Review of the socia	he local contact agency. I work assessment dated tesident #1 discharge plans					

Facility ID: 953473

were to return back to the community to assistive

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES		· · · · · · · · · · · · · · · · · · ·	OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345116	B. WING		C 12/04/2012
NAME OF PR	OVIDER OR SUPPLIER	,	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	LIVINGCENTER - STAR!	TOUNT		9 S HOLDEN ROAD REENSBORO, NC 27407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 202	revealed there was reason for the discharattempts to find desire living in the commun. Review of the physic revealed the discharwound care and couprogress note dated services at current far Resident #1 would not skilled nursing facility transferred to another. Review of the nurse revealed that Reside another SNF with may with osteomyelitis for #1 was given discharmedication and transwere no concerns do noted that indicated meet the resident new the resident new the resident #1 indicate return to the community housing. SW added held with resident rebut she did not docut the efforts were to old the sident were to old the sident were to old the sident were to old the efforts were to old the sident were to old the efforts were to old the sident were to old the efforts were to old the sident were to old the efforts were the efforts were the efforts were the efforts were the efforts we	iew of the social work notes to documentation of the arge to another SNF or red placement to an assistive lity. ian's order dated 9/20/12, and a sessisted living for sead in management. The 9/20/12, did not include that recility could not be met or seed transfer to another (SNF). Resident was ar SNF on 9/25/12. I's note dated 9/25/12, and #1 was discharged to alin diagnosis as left foot ulcer ar skill nursing care. Resident rege information including aported to new facility. There incumented prior to discharge the current facility could not	F 202	The results of this audit will by and brought to the Qualit Performance Improvement of Meeting by the Social Servi Any issues or trends identified addressed by the Quality As Performance Improvement they arise and the plan will needed to ensure continued	ty Assessment Committee ices Director. ied will be ssurance Committee as be revised as
		ated that upon admission			

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CENTERS	FOR MEDICARE &	MEDICAID SERVICES					<u>3 NO. 0938-0391</u>
STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	ULTIPLE CO	ONSTRUCTION		SURVEY PLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BU	LDING		COM	
		345116	8. WI	1G	· · · · · · · · · · · · · · · · · · ·	,	C 12/04/2012
NAME OF PRO	OVIDER OR SUPPLIER		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE		
		POUNT		I	HOLDEN ROAD		
GOLDEN	IVINGCENTER - STAR	100N1		GREE	NSBORO, NC 27407		
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F 202	Continued From page	e 4	F	202			
1 202		to return to the community	•	202			
		ssistive living. Admission					
		V was responsible for the					
		dent #1 discharge plans and					
	resident record.	nted the process in the		:			
							_
	•	on 12/3/12 at 4:00PM, the					•
		dicated that any time a led for discharge the plan					
		cussed in the morning					
	meeting, doctor's or	rder obtained and					
		ent record. The director of					
		t the SW was responsible for					
		enting the discharge process addischarge plans. The					
		viewed the record and		i			
		was no documentation that					
	indicated the reason						
	During an interview	on 12/4/12 at 10:05AM, the					
		ed that documentation of					
		hould be noted in nurse 's					
		and social worker notes. The					
		ld include the discussion and					
		the resident/responsible at team. The information					
		eason for the discharge,					
		harge and an all the required					
	paperwork necessar						
F 203 SS=D	483.12(a)(4)-(6) NO BEFORE TRANSFE	TICE REQUIREMENTS R/DISCHARGE	F	203			
	Before a facility trans	sfers or discharges a					
		must notify the resident and,					
		ember or legal representative					
	of the resident of the	transfer or discharge and					
	the reasons for the r	nove in writing and in a					

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		ND HUMAN SERVICES			·.		M APPROVED <u>O. 093</u> 8-0391_
		MEDICAID SERVICES				1	
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		E CONSTRUCTION	(X3) DATE SU COMPLE	TED
		345116	B. WIN	IG		12/	C 04/2 012
NAME OF PR	OVIDER OR SUPPLIER	<u> </u>		etor.	ET ADDRESS, CITY, STATE, ZIP CODE		
	OVIDER OR OUT LIER			1	9 S HOLDEN ROAD		
GOLDEN I	LIVINGCENTER - STAR	MOUNT			REENSBORO, NC 27407		
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E 202	On-House Same			000	-		
F 203	Continued From page		F	203	F203		
		r they understand; record			1203		
		sident's clinical record; and the items described in			Resident # 1 is no longer a reside	ent at the	12/28/12
	paragraph (a)(6) of the	nis section.			facility.		
	Except when specifie	ed in paragraph (a)(5)(ii) of			An audit of all residents who we	re	
		e of transfer or discharge		1	discharged for the previous 30 da	ays was	
	required under parag	raph (a)(4) of this section			conducted by the Business Office	e Director	
		facility at least 30 days			to ensure there was a notice of di	scharge	:
	before the resident is	stransferred or discharged.			given in writing and that it was documented in the record.	1	
	Notice may be made	as soon as practicable					
		charge when the health of		,	The Social Services Director and	Business	
		ility would be endangered		;	Office Director were inserviced I		
		s section; the resident's			Executive Director on ensuring r		
		ciently to allow a more		i	who are transferring or dischargi		
		r discharge, under paragraph		į	given the appropriate discharge r		
		n; an immediate transfer or		:	writing and documenting deliver		
		by the resident's urgent		1	notice in the record and retaining of the notice.	a copy	
		r paragraph (a)(2)(ii) of this			of the hotice.		1
	facility for 30 days.	t has not resided in the			The interdisciplinary team will re	wiew all	
	lacility for 50 days.			:	pending and actual transfers and	THOM UII	
	The written notice sp	ecified in paragraph (a)(4) of			discharges to ensure there is an		
		ude the reason for transfer			appropriate and documented reas	on for	
		ective date of transfer or			transfer and/or discharge, the app		
		on to which the resident is			notice has been given in writing,	that there	
	transferred or discha	rged; a statement that the			is documentation of resident and/		
		t to appeal the action to the			conversation, preparation, orienta		
		lress and telephone number			notification of discharge plans. T		
	_	n care ombudsman; for			will be conducted daily in the mo		
		ents with developmental			meeting five days per week for fo		
		ng address and telephone			weeks, then three days per week		
	number of the agenc				weeks, then once weekly for one	month.	
		acy of developmentally established under Part C of					
	- visavieu iliulviuuais (ratabilatien nithet Egit C Of					

the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents

		D HUMAN SERVICES MEDICAID SERVICES		÷	FO	ED: 12/12/2012 RM APPROVED NO: 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S COMPL	ETED
		345116	B. WING		12	C /04/2012
	OVIDER OR SUPPLIER	OUNT	Ş	STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 203	telephone number of the protection and ad individuals established Advocacy for Mentall. This REQUIREMENT by: Based on record reverepresentative and stailed to document are discharge in writing to representative prior to for 1 of 3 sampled discresident(Resident#1) 1. Resident # 1 was a 07/16/12 in a certified (SNF) bed. The busing that Resident #1 was another (SNF) facility. Review of the physic revealed the discharge wound care and cour progress note dated services at current faresident #1 would not the protection of the physic revealed the discharge wound care and cour progress note dated services at current faresident #1 would not the protection of the physic revealed the discharge wound care and cour progress note dated services at current faresident #1 would not the protection of the physic revealed the discharge would care and cour progress note dated services at current faresident #1 would not the protection of the physic revealed the discharge would not the physic revealed the physic revealed the discharge would not the physic revealed the phys	the mailing address and the agency responsible for vocacy of mentally ill d under the Protection and y Ill Individuals Act. is not met as evidenced liew, interview with the legal aff interview, the facility and to give a notice of the resident or legal to discharge from the facility scharged. Findings included: admitted to the facility on the skilled nursing facility iness office records revealed to transferred/discharged to	F 2	The results of this audit will by and brought to the Qualit Performance Improvement of Meeting by the Social Service Any issues or trends identificated addressed by the Quality As Performance Improvement of they arise and the plan will be needed to ensure continued of	y Assessment Committee ces Director. ed will be surance Committee as be revised as	

plan/process.

transferred to another SNF on 9/25/12

available to summarize the discharge

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

		ND HUMAN SERVICES MEDICAID SERVICES	٠.	·.		FOR	ED: 12/12/2012 RM APPROVED O. 0938-0391
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	OVIDER OR SUPPLIER LIVINGCENTER - STARI	MOUNT		109 S I	ADDRESS, CITY, STATE, ZIP CODE HOLDEN ROAD ENSBORO, NC 27407		
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F 203	Continued From pag	e 7	F	203			
	social worker indicate resident a 30 day wr would be the adminior legal representative indicated that she were resident the notice so other facility for more acknowledged there available regarding the resident 's acce. During an interview Resident #1 indicate to the facility he war community. He indicated to the facility because he sand they were a sme stated that when he sign himself out and	en 12/3/12 at 5:00PM, the ed that she had not given the litten notice and generally it strator that gave the resident we the notice. Social worker ould not have given the ince he wanted to go to the e smoking privileges. She was no documentation the discussion as for the large and/or confirmation of ptance of the discharge. In 12/4/12 at 9:32AM, and that when he was admitted atted to return to the lated that he was told on being transferred to another smoked on facility property loke free facility. He further wanted to smoke he would ligo down the street. He					

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		MEDICAID SERVICES					NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	CONSTRUCTION	· ·	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUII		,5,10,1,100,101,101,101,101,101,101,101,		PLETED
							С
		345116	8. WIN	G		1	2/04/2012
NAME OF PR	OVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
				1	HOLDEN ROAD		
GOLDEN	IVINGCENTER - STARM	NOUNI		GRE	ENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 203	Continued From page	o 8		203			
. 1 200	· -		r	203			
		e where I wanted to go " . He 2 the social worker told him					
		rrent facility and would be					
		. * I had no place to go so I					
		d went where they sent me. "					
	•						
	•	sibility for leave of absence					
		nt #1 did sign himself in/out			•		
	•	times a day. Additional revealed there were no					1
		ern regarding the resident			-		
		roperty. Review of the facility					
	smoking policy/proce	dures and assessment					
	revealed that Reside						
		noking sensation program or					
	•	g smoking. There was no 30 iment available or presented					
	by facility staff.	intent available of presented					
	During an interview of	on 12/4/12 at 9:46AM, the					
		dicated that discharge plans	1				
	were typically discus	sed in the morning meeting					
		discussed in that the					
		o to another place in the					
		stive living was discussed,					
		n issue with the payor ursing indicated that she did					
		a 30 day written notice and					
		reason for the discharge to					
		tesident#1 desire was for					
		ewed the physician 's order					
		lischarge was for assistive					
	living. She acknowled	-					
		of why the resident 's					
		as not obtained. In addition, ented concern that a problem					
		dent regarding smoking					
	•						

noted or discussed.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					IO. 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(ULTIPL ILDING	E CONSTRUCTION ((X3) DATE SU COMPLE	URVEY ETED
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GOLDEN	LIVINGCENTER - STARM	TOUNT	ļ	109	9 S HOLDEN ROAD REENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 203	Continued From page	e 9	F	203		- · · · · · ·	
SS=D	administrator indicate at the facility the disciprogress and she did as required. 483.12(a)(7) PREPAR SAFE/ORDERLY TRANSAFE/ORDERLY TRANSAFE/ORDERLY TRANSAFE/ORDERLY TRANSAFE OR DERLY TRANSAFE OR DERLY TRANSAFE OR DERLY TRANSAFE OR DESCRIPTION OF TRANSAFE OR DESCRIPTION OR DESCRIPTION OF TRANSAFE OR DESCRIPTION OF T	RATION FOR ANSFER/DISCHRG e sufficient preparation and its to ensure safe and orderly from the facility. T is not met as evidenced cord review and staff ailed to provide sufficient itation to the family/resident one 1 of 3 residents it dmitted to the facility on skilled nursing facility ness office records revealed transferred/discharged to on 09/25/12. Resident #1 DS) dated 7/23/12, indicated was coded as 14. Section	F	204	Resident # 1 is no longer a resident facility. An audit of all residents who were discharged for the previous 30 days conducted by the Social Services Di to ensure appropriate documentation reason for discharge; family and resinvolvement, notification, and agree No other resident was found to be at as a result of this audit. The Social Services Director, Busine Office Director and licensed nurses be inserviced by the Executive Director of Nursing Services and Director of Clinical Education on documentate requirements for the resident who is transferring or discharging with specemphasis on documenting resident and serviced to the serviced of the services and Director of Nursing Services and Director of Clinical Education on documentate requirements for the resident who is transferring or discharging with specemphasis on documenting resident and services are serviced to the services and Director of Nursing Serv	was irector n, ident ement. ffected ess will ctor, rector tion	12/28/12
	and goal setting, revea	articipation in assessment aled Resident #1 expected e community and referrals local contact agency.			family conversation, preparation, orientation, and notification of discharge plans prior to and upon discharge.	arge	j

Review of the social work assessment dated 7/20/12, revealed Resident #1 discharge plans

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. 8UR	ULTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED C 12/04/2012	
		345116	B. WIN	G		
	IDER OR SUPPLIER	RMOUNT		STREET ADDRESS, CITY, STATE, ZIP CO 109 S HOLDEN ROAD GREENSBORO, NC 27407	DE	
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F 204 Continued From page 10

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

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.

PRINTED: 12/12/2012

		ND HUMAN SERVICES MEDICAID SERVICES					DRM APPROVED NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		DNSTRUCTION	(X3) DATE	
		345116	B. WIN	G		1	C 2/04/2012
NAME OF PR	OVIDER OR SUPPLIER		•	1	ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	IVINGCENTER - STAR	MOUNT		1	HOLDEN ROAD NSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 204	and she told him ab- liberal smoking privi rushed out of the fac- understanding and of place. He added that would "help me fine- not put me in another not given a 30 day r other places to deci- added that on 9/20/ she had found his comoving in a few day just got in the car ar During a follow-up in 11:30AM, the social any information that sufficient preparatio discharge. SW did p the receiving facility placement was due smoke and current of campus. She added documented eviden the resident smokin addition, there had a	to start calling these places out his current facility that had leges. He stated that he felt cility without clear expectation to find his own at he thought the facility staff d housing in the community er nursing home. " "I was notice or time to even look at de where I wanted to go ". He 12 the social worker told him current facility and would be s. "I had no place to go so I ad went where they sent me." Interview on 12/4/12 at worker was unable to provide was given to the resident for and orientation prior to provide the faxed document to dated 9/21/12 indicated that to resident wanting/desire to facility was smoke free I that there was no ce there was a problem with g on facility grounds. In	F	204			
	for attempts made to community. During a follow-up in 1:30PM, the directo expectation would homeet with resident/r	was no information available o seek assistive living in the interview on 12/4/12 at r of nursing indicated the lave been the treatment team esponsible person and discharge plan in which all					

persons were clear of the discharge plans and

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345116	B. WING			C 12/04/2012	
NAME OF PROVIDER OR SUPPLIER			· · · · · · · · · · · · · · · · · · ·	STREET	ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - STARMOUNT				l .	HOLDEN ROAD :NSBORO, NC 27407		
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F 204	Continued From page 12		F 204				
	location. The alert an actively involved and	d oriented resident would be encouraged to have input in the assistance of the					
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