DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		(X3) DATE SURVEY COMPLETED			
	345116	B. WING		C	C 09/24/2015		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E			
LIVINGCENTER - STARN	IOUNT		109 S HOLDEN ROAD GREENSBORO, NC 27407				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	I SHOULD BE	(X5) COMPLETIO DATE		
483.15(h)(1) SAFE/CLEAN/COMF ENVIRONMENT	ORTABLE/HOMELIKE	F 25	52		10/22/15		
comfortable and hom the resident to use his	elike environment, allowing s or her personal belongings						
by: Based on observatio facility failed to mainta on 1 of 2 halls (100 h failed to provide a sat multi-purpose confere room by failing to clea	ns and staff interviews the ain an odor free environment allway). The facility also nitary interior in the ence room/restorative dining an the microwave oven, the		does not constitute admission agreement by the provider of the facts alleged or conclusion in the statement of deficiencie of correction is prepared and/ soley because it is required by	or the truth of ns set forth es. The plan or executed y the			
through 09/24/15, the the 100 hall and in the elevators. Observations conduc revealed there was a the entry of the facility	rough 09/24/15, there were lingering odors on e 100 hall and in the front lobby area near the evators. Deservations conducted on 09/20/15 at 9:40 PM vealed there was a very strong odor of urine at e entry of the facility directly in front of the		were deep cleaned. The entr facility directly in front of the e deep cleaned. The multi-purp conference/restorative dining deep cleaned to include the n	y of the elevators was bose room was hicrowave			
Observations conduct 104 D at 2:39 PM, 10 2:49 PM, 107 A at 2:4 113 A at 2:36 PM, and PM revealed stale uri Observations conduct	ted on 09/21/15 in rooms 5 A at 3:59 PM,106 A at 16 PM, 111 B at 3:37 PM, d 114 A and 114 B at 2:51 ne odors.		effected. All resident rooms v inspected for stale urine odors 10/15/15. No odors were pre- common areas were inspecte 10/15/15 for odors and none v present.	vere s on sent. All d on were			
	PF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER LIVINGCENTER - STARM SUMMARY ST. (EACH DEFICIENC REGULATORY OR I 483.15(h)(1) SAFE/CLEAN/COMF ENVIRONMENT The facility must prov comfortable and hom the resident to use his to the extent possible This REQUIREMENT by: Based on observatio facility failed to mainta on 1 of 2 halls (100 h failed to provide a sat multi-purpose confere room by failing to clea stove, the dishwashe Findings included: 1. During all days of t through 09/24/15, the the 100 hall and in the elevators. Observations conduc revealed there was a the entry of the facility elevators on the first field Observations conduc 104 D at 2:39 PM, 10 2:49 PM, 107 A at 2:2 113 A at 2:36 PM, and PM revealed stale uri	IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         483.15(h)(1)         SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT         The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.         This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain an odor free environment on 1 of 2 halls (100 hallway). The facility also failed to provide a sanitary interior in the multi-purpose conference room/restorative dining room by failing to clean the microwave oven, the stove, the dishwasher and the dual sinks. Findings included:         1. During all days of the survey from 09/20/15 through 09/24/15, there were lingering odors on the 100 hall and in the front lobby area near the elevators.         Observations conducted on 09/20/15 at 9:40 PM revealed there was a very strong odor of urine at the entry of the facility directly in front of the elevators on the first floor.         Observations conducted on 09/21/15 in rooms 104 D at 2:39 PM, 105 A at 3:59 PM, 106 A at 2:49 PM, 107 A at 2:46 PM, 111 B at 3:37 PM, 113 A at 2:36 PM, and 114 A and 114 B at 2:51 PM revealed stale urine odors.	OF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIF A. BUILDING         345116       B. WING	CORRECTION       DENTFICATION NUMBER:       A. BUILDING         A45116       B. WING         ROWDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP COD         LIVINGCENTER - STARMOUNT       STREET ADDRESS, CITY, STATE, ZIP COD         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION)       ID       PRECISION, NC 27407         (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)       IP       PREFIX TAG       CROSS-REFERENCED TO YOURD STATE CODE OF THE DEFICIENCY)         483.15(m)(1)       SAFE/CLEAN/COMFORTABLE/HOMELIKE       F 252       F         ENVIRONMENT       F       252         This REQUIREMENT is not met as evidenced by:       Preparation and/or execution dated to provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.       Preparation and/or execution des not constitue admission agreement by the provide or failed to provide a sanitary interior in the multi-purpose conference rom/restorative dining room by failing to clean the microwave oven, the stove, the dishwasher and the dual sinks.       Preparation and/or execution dos or periate and Sta         1. During all days of the survey from 09/20/15 through 09/21/15, the conducted on 09/20/15 at 9:40 PM revealed there was a very strong odor of urine at the entry of the facility directly in front of the elevators.       Rooms 104,105,106,107,111, wer deep cleaned. The entify-pur conference/restorative dining deep cleaned to include the m oven, the stove, the dishwash sinks.	CORRECTION       IDENTIFICATION NUMBER:       A BUILDING       CO         345116       B. WING       STREET ADDRESS, CITY, STATE, 2P CODE       109 3 HOLDEN ROAD         ROWDGER OR SUPPLIER       STREET ADDRESS, CITY, STATE, 2P CODE       109 3 HOLDEN ROAD         SUMMARY STATEMENT OF DECIDENTIES       FROMDERS IR ALW OF CORRECTION       REENSBORO, N.C. 27407         SUMMARY STATEMENT OF DECIDENTIES       FROMDERS IR ALW OF CORRECTION       REENSBORO, N.C. 27407         SAFE/CLEAN/COMFORTABLE/HOMELIKE       PROVIDERS IR ALW OF CORRECTION       CROSS REFERENCED TO THE APPROPRIATE DEFCIENCE OF THE APPROPRIATE DEFCIENCY         SAFE/CLEAN/COMFORTABLE/HOMELIKE       F 252       CROSS REFERENCED TO THE APPROPRIATE DEFCIENCE OF THE APPROPRIATE DEFCIENCY         This REQUIREMENT       The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.       F 252         This REQUIREMENT is not met as evidenced by:       Based on observations and staff interviews the facility failed to non/restorative dining room by failing to clean the microwave oven, the stove, the dishwasher and the dual sinks.       Preparation and/or execution of this plan does not constitute admission or an of ormetoin sprepared and/or executed soley because it is required by the provisions of Federal and State Law.         1. During all days of the survey from 09/20/15 through 09/24/15, there were lingering odors on the first floor.       Rooms 104,105,106,107,111,113, and 114 were deep cleaned. The entry		

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.

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	COMPLETED
					С
		345116	B. WING		09/24/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO		PCODE
GOLDEN	GOLDEN LIVINGCENTER - STARMOUNT			109 S HOLDEN ROAD GREENSBORO, 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 ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
F 252	Continued From page	e 1	F 2	52	
	not determine where from. An interview conduct Director on 09/24/15 expectations for elim expect the housekee odors are coming fro rooms. We also use a Each housekeeper h clean everyday unles cleaned. Each morning the rooms, and I iden cleaning. I text it to m of it, I just keep it on Housekeeping Direct other form of docume to show which rooms when the rooms were 2. Observations cond conference /restoratin at 9:30 PM, 09/21/15 on 09/22/15 at 7:40 A	for indicated there was no entation for use by the facility had been deep cleaned and		multi-purpose conference room 5 times a week for address a sanitary interior resident/common areas of The housekeeping staff of by the Environment Servidentifying and addressin cleaning of resident room cleaning of the multi-purp room/restorative dining room/restorative	4 weeks to or and odors in all of the facility. will be inserviced vices Director on ng odors, deep ns, and deep pose conference oom. be reported to ly in the Stand Up ne audits will be Assurance and ent Meeting Additional g will be initiated
	turntable was covere compartment sink wa inside the drain cove inside upper door led observed with accum The inside door ledge with black accumulat Interview conducted Director on 09/24/15	with the Food Service at 12:10 PM indicated it ity of the Housekeeping staff			

CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES			FORM AP OMB NO. 09	38-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345116	B. WING		C 09/24/2	2015
NAME OF PF	ROVIDER OR SUPPLIER	•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN I	IVINGCENTER - STARM	IOUNT		99 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE CO	(X5) MPLETIO DATE
F 252	(including the stove a	e 2 ng room area and equipment and dishwasher) clean." ducted on 09/24/15 at 12:20	F 252			
	PM with the Houseke are responsible for cl	eeping Aide indicated, "We eaning the sinks and the le multi-purpose conference				
E 278	12:30 PM. When ask equipment in the mul room/restorative dinin the director stated, "T was cleaned was Sat was unable to provide when the equipment/ asked what his expect Housekeeping staff re Environmental Service expect the equipment daily. "	tess Director on 09/24/15 at ed when the last time the ti-purpose conference ing room had been cleaned, The last time the equipment turday 09/19/15. The director e documentation related to area was cleaned. When ctations was of the elated to the concern, the tess Director indicated, "I t and the area to be cleaned	F 278		10/	22/15
F 278 SS=D		DINATION/CERTIFIED	F 278		10/.	22/15
	A registered nurse m each assessment wit participation of health					
	A registered nurse m assessment is compl	ust sign and certify that the eted.				
		completes a portion of the n and certify the accuracy of				

Facility ID: 953473

If continuation sheet Page 3 of 11

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345116	B. WING		09/24/2015
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
GOLDEN	LIVINGCENTER - STARN	IOUNT		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 278	that portion of the ass Under Medicare and I willfully and knowingly false statement in a re subject to a civil mone \$1,000 for each asses willfully and knowingly to certify a material and resident assessment penalty of not more the assessment. Clinical disagreement material and false state This REQUIREMENT by: Based on record revif facility failed to accura Data Set (MDS) asse (Preadmission Screet level 2 (two) for 1 of 1 reviewed for PASRR. Findings included: Resident #68 was add cumulative diagnoses anxiety and bipolar di Review of PASRR (Pi Resident Review) De revealed that Resider a PASRR level II sinc date. Review of the Signific Set (MDS) assessme Section A of the MDS PASRR determination	Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual hd false statement in a is subject to a civil money han \$5,000 for each to does not constitute a tement. T is not met as evidenced ew and staff interviews, the ately code on the Minimum ssment to reflect PASRR hing and Resident Review) resident in the sample (Resident #68) mitted on 06/20/15 with to which included depression, sorder. readmission Screening and termination notification form ht #68 was determined to be e 6/23/14 with no expiration tant Change Minimum Data nt dated 1/12/15 revealed was not coded to reflect	F 278	The Minimum Data Set (MDS) for Resident #68 was corrected on 10/15/ to reflect the correct PASRR determination. All residents have the potential to be affected. All current Minimum Data So were audited to ensure Section A of th MDS is coded to reflect the PASRR determination of the resident. No othe incorrect coding of PASRR determinative were found. Social Services Director will audit Sec A of the MDS to ensure the correct PASRR determination is coded for the resident. Social Services Director will audit the Comprehensive MDS prior to their completion date times 4 weeks.	ets le ions tion

Facility ID: 953473

If continuation sheet Page 4 of 11

TATEMENT (	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	ECONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	C		
		345116	B. WING		09/24/2015	
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	GOLDEN LIVINGCENTER - STARMOUNT			109 S HOLDEN ROAD GREENSBORO, 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE	
F 278	Continued From page	e 4	F 278			
F 279	9:53 AM who stated is responsible for comp the MDS assessmen The Social Worker w at 9:37 AM who state admitted on 6/23/14 the B code. Continue worker revealed the Is permanent PASRR II The Social Worker w 09/24/15 at 09:57 AM responsible for codin MDS and that it was coded on the MDS S Assessment. The Administrator was 11:56 AM who stated should be accurate a status. 483.20(d), 483.20(k)	that the Social Worker was leting the PASRR section on t. as interviewed on 09/24/15 ed that the resident was with a level II PASRR with ed interview with the social B code indicated a as interviewed again on A and indicated she was g the PASRR section of the an oversight that it was not ignificant Change as interviewed on 09/24/15 at that the MDS assessment nd reflect the resident (1) DEVELOP	F 279	Social Services Director inserviced to Executive Director to ensure that ear resident PASRR determination is co accurately on Section A of the MDS. Results of the audits will be reported the Executive Director daily in the Si Up Meeting. Results from the audits be discussed at the Quality Assuran and Performance Improvement Meet monthly times 3 months. Additional education and monitoring will be init for any identified concerns.	ch ded to tand s will ce ting	
SS=D	to develop, review ar comprehensive plan The facility must deve plan for each residen objectives and timeta medical, nursing, and	e results of the assessment nd revise the resident's				
	to be furnished to atta highest practicable p psychosocial well-be	lescribe the services that are ain or maintain the resident's hysical, mental, and ing as required under rvices that would otherwise				

If continuation sheet Page 5 of 11

345116				OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
040110	B. WING			C 09/24/2015		
			REET ADDRESS, CITY, STATE, ZIP CODE	09/	/24/2015	
NAME OF PROVIDER OR SUPPLIER			9 S HOLDEN ROAD			
NT						
JST BE PRECEDED BY FULL					(X5) COMPLETION DATE	
rcise of rights under ght to refuse treatment not met as evidenced record review and aff, the facility failed to for activities of daily for a dependent for activities of upled residents. dy Wash directions on h or add small amount to eanse patient's face. . Rinse thoroughly and red to the facility 6/30/09. Alzheimer's Disease. lated 4/1/15 revealed that stance with activities of ncourage self care to changes. Placement was h. st recent quarterly 19/8/15 revealed that the ith short and long term	F	279	All residents have the potential to be affected. Resident #66 Care Plan was updated on 9/24/15 to reflect total assistance with one person assist for dressing, personal hygiene, and bathin CNA #2 inserviced on Body Wash directions and completed Bath Competency. Registered Nurse Assessment Coordinator (RNAC) audited all reside care plans to ensure it reflects the appropriate plan of care related to Activities of Daily Living. No other residents were affected. RNACs to audit any newly completed/updated Care Plans to ensu an Activities of Daily Living plan of care correct and included times 4 weeks. Unit Coordinators will observe baths o residents 5 times a week times 4 week to ensure appropriate bathing procedu is followed. Certified Nursing Assistants will be	ng. nt ure e is f 2 ks ire		
	INT VENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION) 25 but are not provided rcise of rights under ght to refuse treatment not met as evidenced record review and aff, the facility failed to for activities of daily for a dependent for activities of aldependent for activities of apled residents. dy Wash directions on th or add small amount to eanse patient's face. . Rinse thoroughly and ted to the facility 6/30/09. Alzheimer's Disease. dated 4/1/15 revealed that stance with activities of neourage self care to changes. Placement was h. st recent quarterly 19/8/15 revealed that the ith short and long term vas coded that she with one person physical poal hygiene and bathing.	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION) F 25 but are not provided rcise of rights under ght to refuse treatment not met as evidenced record review and aff, the facility failed to for activities of daily for a dependent for activities of adependent for activities of apled residents. dy Wash directions on th or add small amount to eanse patient's face. . Rinse thoroughly and ted to the facility 6/30/09. Alzheimer's Disease. lated 4/1/15 revealed that stance with activities of noourage self care to changes. Placement was h. st recent quarterly 19/8/15 revealed that the ith short and long term vas coded that she with one person physical	INT       ID         WENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)       ID         PREFIX TAG       PREFIX TAG         PREFIX TAG       F 279         25 but are not provided rcise of rights under ght to refuse treatment       F 279         not met as evidenced       record review and aff, the facility failed to for activities of daily for a dependent for activities of mpled residents.         dy Wash directions on th or add small amount to eanse patient's face. . Rinse thoroughly and         ted to the facility 6/30/09. Alzheimer's Disease.         lated 4/1/15 revealed that stance with activities of noourage self care to changes. Placement was n.         st recent quarterly 19/8/15 revealed that the ith short and long term vas coded that she with one person physical	INT         GREENSBORO, NC 27407           WENT OF DEFICIENCIES UST BE PRECEDED BY FULL DENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)           25 but are not provided roise of rights under ght to refuse treatment         F 279           All residents have the potential to be affected. Resident #66 Care Plan was updated on 9/24/15 to reflect total assistance with one person assist for dressing, personal hygiene, and bathir Competency.           dy Wash directions on th or add small amount to eanse patient's face. . Rinse thoroughly and Alzheimer's Disease.         CNA #2 inserviced on Body Wash directions and completed Bath Competency.           Registered Nurse Assessment Coordinator (RNAC) audited all reside care plans to ensure it reflects the appropriate plan of care related to Activities of Daily Living, No other residents 5 times a week times 4 weeks.           NACS to audit any newly completed/updated Care Plans to ensure an Activities of Daily Living plan of care correct and included times 4 weeks.           Unit Coordinators will observe baths o residents 5 times a week times 4 week to ensure appropriate bathing procedu is followed.           St recent quarterly 19/8/15 revealed that ths hort and long term vas coded that she with one person physical         Certified Nursing Assistants will be inserviced regarding proper bathing of resident witb Body Wash.	INT         GREENSBORO, NC 27407           WENT OF DEFICIENCIES UST BE PRECEDED BY FULL DENTIFYING INFORMATION)         PREFIX TAG         PREVIDENS PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)           225 but are not provided roise of rights under ght to refuse treatment         F 279         All residents have the potential to be affected. Resident #66 Care Plan was updated on 9/24/15 to reflect total assistance with one person assist for dressing, personal hygiene, and bathing.           dependent for activities of pipeld residents.         CNA #2 inserviced on Body Wash directions and completed Bath Competency.           dy Wash directions on h or add small amount to ranse patient's face. . Rinse thoroughly and Alzenimer's Disease.         Registered Nurse Assessment Coordinator (RNAC) audited all resident care plans to ensure it reflects the appropriate plan of care related to Activities of Daily Living. No other residents were affected.           RNACs to audit any newly completed/updated Care Plans to ensure an Activities of neurage self care to changes. Placement was t.         RNACs to audit any newly completed/updated Care Plans to ensure an Activities of Daily Living plan of care is correct and included times 4 weeks.           st recent quarterly 19/8/15 revealed that ths hort and long term vas coded that she with one person physical         Unit Coordinators will beserve baths of 2 resident with Body Wash.	

Facility ID: 953473

If continuation sheet Page 6 of 11

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345116	B. WING		C 09/24/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - STARMOUNT			STREET ADDRESS, CITY, STATE, ZIP CODE 09 S HOLDEN ROAD		
GOLDEN		NOONT	(	SREENSBORO, NC 27407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC
F 279	living. Observation on 9/24, providing a bed bath that NA #2 applied set 's legs and the period She dried the resider continued and washe the resident 's right's rinsing off the soap be NA #2 did not wash to back and the back of Interview on 9/24/15	lan for activities of daily /15 at 9:30 AM of NA #2 to Resident #66 revealed oap to the top of the resident area but did not rinse soap. ht with a towel. NA #2 ed Resident #66's back on side with soap, without before she dried the resident. he resident's left side of her	F 279	Director of Nursing services will ins RNACs regarding completion of Ca Plan to reflect that each resident ha completed and accurate Activites of Living plan of care. Results of the audits will be reported the Executive Director daily in the S Up Meeting. Results from the audit be discussed at the Quality Assurated and Performance Improvement Me monthly times 3 months. Additional education and monitoring will be interformed to the formation of the security of	are as a f Daily ed to Stand ts will nce eting I
F 312 SS=E	the bed bath. Interview on 9/24/15 Director of Nursing rewas that the resident Interview on 09/24/2 Director of Nursing reactivities of daily livir been completed. Sh 9/24/15. 483.25(a)(3) ADL CA DEPENDENT RESID A resident who is una daily living receives the statement of the s	015 at 12:53 PM with the evealed that the care plan for ig for Resident #66 had just e continued that it was dated ARE PROVIDED FOR	F 312		10/22/15

Facility ID: 953473

If continuation sheet Page 7 of 11

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345116	B. WING			C 09/24/2015		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
				1	09 S HOLDEN ROAD			
GOLDEN	LIVINGCENTER - STARM	IOUNT		G	REENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 312	Continued From page	7	F	312				
	by: Based on observation interviews with reside facility failed to provid for 5 hours and 10 mi provide proper technic care for 1 of 2 reside care. (Resident #80) the soap off the reside bath. This was eviden residents, dependent #66) The findings included 1. Resident #80 was 9/24/13 with diagnose urine and unspecified Care Plan dated 4/9/1 Focus: Potential for actual urinary tract inf urinary retention, urin	nts and facility staff, the e urinary incontinent care nutes on 9/24/15 and que for urinary incontinent nts dependent on staff for The facility failed to rinse ent's body during a bed nt in 1 of 2 sampled on staff for care. (Resident : admitted to the facility on es of dementia, retention of urinary incontinence.			Resident #80 has BIMS score of 12. Resident is care planned to frequently refuse care. No other residents were affected by this practice. CNA #2 inserviced on Body Wash directions and completed Bath Competency. CNA #1 inserviced regarding timely incontinent care and to complete round at the beginning of the shift on all assigned residents. Unit Coordinators will observe baths of residents 5 times a week times 4 week to ensure appropriate bathing procedur is followed. Director of Staff Education to audit 2 residents 5 times a week to ensure timeliness of incontinent care. Director of Staff education will inserviced	2 s re		
	Interventions: Assist care as needed. Encourage fluids unle Observe and report si	gns of urinary tract			Certified Nursing Assistants regarding proper bathing of resident and Body W directions. Director of Staff Education will inservice	ash		
	urine, dysuria, frequen The most recent annu 6/18/15 coded Reside assistance with one p	al Minimum Data Set dated			Certified Nursing Assistants regarding timeliness of incontinent care and completion of rounds at the beginning of the shift on all assigned residents. Results of the audits will be reported to the Executive Director daily in the Stan	)		

Facility ID: 953473

If continuation sheet Page 8 of 11

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/26/2015 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345116	B. WING				C / <b>24/2015</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
GOLDEN	LIVINGCENTER - STARM	IOUNT			09 S HOLDEN ROAD		
				G	REENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From page	8	F	312			
_	was always incontine			012	Up Meeting. Results from the audits	will	
	Record review of the dated 7/6/15 revealed extensive to depende	Care Area Assessment I that Resident #80 required nt assistance with toilet use. risk for complications such			be discussed at the Quality Assurance and Performance Improvement Meeti monthly times 3 months. Additional education and monitoring will be initia for any identified concerns.	e ng	
		at 12:23 PM with Nurse #1 at #80 was considered to be					
	#80's bath was perfor #1)NA#1 took the was between both sides o then came back to the swipe from front to ba cloth. Resident #80 v Her night gown was s back, the incontinent	/15 at 10:55 AM of Resident med by nurse aid #1 (NA sh cloth and then wiped f the skin between her legs e peri area and made one lock, without rinsing the wash vas then turned on her side. loaked with urine up her brief was saturated and the circle of about 30 inches of					
	revealed that this was	with NA #1 at 11:05 AM a late for her to get up. nt #80 on 9/24/15 at 11:08					
		was last changed at 5:00					
	revealed she did not of shift began because h she was in the dining	with NA #1 at 11:10 AM do morning rounds when her preakfast came early and room. She had not gotten her incontinent rounds.					
	Interview on 9/24/15 a	at 12:30 PM with the					

Facility ID: 953473

If continuation sheet Page 9 of 11

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE		
			A. BUILDI	NG.			C	
		345116	B. WING			09/24/2015		
NAME OF PROVIDER OR SUPPLIER				;	STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - STARN	IOUNT			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 312	Director of Nursing rewas to be done in the arrived, after meals a should provide care to clean/rinsed wash cloop 2. Record review of t the container revealed Either apply to damp basin of warm water. Continue down the bore pat dry. Resident #66 was add Her diagnoses include Care Area Assessment staff was to provide a daily living as needed abilities and monitor f Record review of the Minimum Data Set daresident had problems memory, Resident #66 required total assistar assist for personal hy There was no care plativing. Observation 9/24/15 a providing a bed bath that NA #2 applied so 's legs and the peri a from her skin. She dr towel. NA #2 continue 's back on the resident 's back on the reside	evealed that incontinent care morning when the NA nd as needed. The NA o the perineal area with a th. he Body Wash directions on d, cloth or add small amount to Cleanse patient ' s face. ody. Rinse thoroughly and mitted to the facility 6/30/09. ed Alzheimer's Disease. In the dated 4/1/15 revealed that ssistance with activities of l, encourage self care to or changes. most recent quarterly ted 9/8/15 revealed that the s with short and long term 6 was coded that she nee with one person physical giene and bathing. an for activities of daily	F	312	2			

Facility ID: 953473

If continuation sheet Page 10 of 11

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/26/2015 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345116	B. WING				C 24/2015
NAME OF P	ROVIDER OR SUPPLIER	I	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
GOLDEN	LIVINGCENTER - STARM	IOUNT			09 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 312	she dried the resident resident ' s left side o her legs. Interview on 9/24/15 a Director of Nursing re was that the resident Interview on 9/24/15 a	t. NA #2 did not wash the f her back and the back of at 12:30 PM with the evealed that her expectation was to be rinsed off. at 12:35 PM with NA #2 when asked why she did	F	312			

Facility ID: 953473

If continuation sheet Page 11 of 11