PRINTED: 07/05/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '				TE SURVEY MPLETED	
		345116	B. WING			1	C (24/2047	
NAME OF P	ROVIDER OR SUPPLIER	0.00		STRI	EET ADDRESS, CITY, STATE, ZIP CODE	1 05/	/24/2017	
					S HOLDEN ROAD			
STARMOL	INT HEALTH AND REH	AB CENTER			EENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	3	F	000				
		ation survey was conducted gh 05/12/17. Immediate ied at:						
	(J) CFR 483.35 at tag F	309 at a scope and severity 353 at a scope and severity						
	(J) CFR 483.70 at tag F (J)	490 at a scope and severity						
		began on 05/08/17 and was 7. A Partial extended survey						
	was obtained on 05/ 05/24/17. As a result 483.12 at tag F224 a was also identified.	view, additional information 18/17, and 5/22/17 through i, immediate jeopardy at CFR at a scope and severity (J) The facility provided a in 05/23/17 and it was						
	Therefore, the exit da	ate was changed to 5/24/17.						
	The tags F224 J and Substandard Quality	of Care.						
F 157 SS=D	483.10(g)(14) NOTIF (INJURY/DECLINE/F		F	157			6/27/17	
	(g)(14) Notification o	f Changes.						
	consult with the resid	nediately inform the resident; dent's physician; and notify, r her authority, the resident en there is-						
LABORATORY	 DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATUF	<u> </u> RE		TITLE		(X6) DATE	

Electronically Signed 06/09/2017

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.

	345116	B. WING		C
				05/24/2017
/IDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	1 00/24/2017
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
A) An accident involvesults in injury and hysician intervention by A significant characterioration in health attus in either life-the inical complication. C) A need to alter the need to discontinue eatment due to advormence a new for the inical complication. A) A decision to train eather the fact that is not the fact that is a section to the inical complication. A) When making not the initial pertinent information available and proving a available and proving in the fact that is a section. A) A change in rooms as specified in §483. B) A change in resident in section in §483.	living the resident which has the potential for requiring on; Inge in the resident's physical, cial status (that is, a th, mental, or psychosocial preatening conditions or s); The eatment significantly (that is, a e an existing form of or eatment); or the eatment of the eatment of the eatment of the eatment of the eather	F 157		
The state of the s	SUMMARY S (EACH DEFICIEN REGULATORY OF Ontinued From page (A) An accident involved in injury and invision intervention (B) A significant chat in ental, or psychosoteterioration in health attus in either life-th inical complication: (C) A need to alter the inical complication: (C) A need to alter the inical complication: (C) A need to alter the inical complication: (D) A decision to transident from the fact in the fact in the inical in the inical complication: (E) A decision to transident from the fact in the inical information in the inical inical in the inical inical in the inical inical in the inical i) When making notification under paragraph (g) 4)(i) of this section, the facility must ensure that I pertinent information specified in §483.15(c)(2) available and provided upon request to the hysician. i) The facility must also promptly notify the sident and the resident representative, if any,	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG TAG TAG ID PREFIX TAG PREFIX TAG F 157 A) An accident involving the resident which sults in injury and has the potential for requiring hysician intervention; B) A significant change in the resident's physical, ental, or psychosocial status (that is, a eterioration in health, mental, or psychosocial atus in either life-threatening conditions or inical complications); C) A need to alter treatment significantly (that is, need to discontinue an existing form of eatment due to adverse consequences, or to commence a new form of treatment); or D) A decision to transfer or discharge the sident from the facility as specified in 483.15(c)(1)(ii). D) When making notification under paragraph (g) 4)(i) of this section, the facility must ensure that I pertinent information specified in §483.15(c)(2) available and provided upon request to the hysician. ii) The facility must also promptly notify the sident and the resident representative, if any, hen there is- A) A change in room or roommate assignment as specified in §483.10(e)(6); or B) A change in resident rights under Federal or tate law or regulations as specified in paragraph	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILL BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Ontinued From page 1 (A) An accident involving the resident which sults in injury and has the potential for requiring hysician intervention; (B) A significant change in the resident's physical, ental, or psychosocial status (that is, a eterioration in health, mental, or psychosocial attus in either life-threatening conditions or inical complications); (C) A need to alter treatment significantly (that is, need to discontinue an existing form of eatment due to adverse consequences, or to ommence a new form of treatment); or (D) A decision to transfer or discharge the sident from the facility as specified in §483.15(c)(1)(ii). (D) When making notification under paragraph (g) 4)(i) of this section, the facility must ensure that 1 pertinent information specified in §483.15(c)(2) available and provided upon request to the hysician. (i) The facility must also promptly notify the sident and the resident representative, if any, hen there is. (ii) A change in room or roommate assignment is specified in §483.10(e)(6); or (iii) A change in resident rights under Federal or tate law or regulations as specified in paragraph

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345116	B. WING _			C 05/24/2017
NAME OF P	ROVIDER OR SUPPLIER	L	1	STREET ADDRESS, CITY, STAT	E, ZIP CODE	1 00/2 1/2011
				109 S HOLDEN ROAD		
STARMOL	JNT HEALTH AND REHA	B CENTER		GREENSBORO, NC 27407	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECT) CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA FICIENCY)	DATE
F 157	Continued From page	e 2	F 1	57		
	This REQUIREMENT by: Based on observatio interview, the facility of elevated capillary by	resident representative(s). is not met as evidenced ns, record review, staff failed to notify the physician blood glucose (CBG) levels ent brittle diabetic resident.		Resident #2 no long facility. The Director of Nursi		
	of an insulin dependent brittle diabetic resident. This was evident in 1 of 3 diabetic residents (Resident #2). Findings included:			Manager will review of identified as receiving days to ensure that p	current residents g CBG in past thirt physician orders w	
	1. Resident #2 was a 02/27/17 with diagnos	dmitted to the facility on ses including Type I //) with Chronic Kidney	followed for current residents with elevated CBG and/or physician notification if indicated per orders by 6/27/17.			
	dated 03/06/17 reveal cognitively intact. A review of the medic	Minimum Data Set (MDS) led that Resident #2 was cal records revealed the		Current facility reside receiving capillary blomonitoring will be reviewed for one month to two months to ensure were notified as state orders of elevated care	ood glucose viewed five times a then weekly times e that physicians ed in physician⊡s	
	"NovoLOG Solution 1 sliding scale: if (CBG unit; 211 - 270 = 2 un 390 = 4 units; 391 - 4 (physician) if CBG is	ed 02/28/17 at 6:32 AM read 00 UNIT/ML, inject as per) 150 - 210 = 1 (NovoLOG) its; 271 - 330 = 3 units; 331 - 50 = 5 units; notify MD greater than 450, re meals and at bedtime for	The facility licensed nurses will be provided re-education regarding notification of change, to include notification of elevated capillary blood glucose per physician orders and completed by Staff Development Coordinator by 6/27/17.			
	order dated 03/06/17 order: New SSI (sliding scal (resident) with meals units, 251-300=5 unit	151-200=2 units, 201-250=3		The Director of Nursi of audits to the Quali Process Improvementimes three. Data will analyzed for patterns Quality Assurance ar Improvement Commiresults and implement	ity Assurance and nt Committee mon- ill be reviewed and s and trends. The nd Performance ittee will evaluate t	thly

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	COMPLETED
		345116	B. WING		C 05/24/2017
	ROVIDER OR SUPPLIER JNT HEALTH AND REHA	B CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	03/24/2017
(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 SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 157	than 450 call MD. Review of the Medica (MAR) 03/06/17 throunew SSI order of 3/6/the MAR. The transowas the following: Novolog solution 100 scale: if 150-210=1 u 271-330=3 units, 331 units. Notify MD if CI subcutaneously befor DM. Order date 02/27. Review of the March following CBG readin administered to Resid MAR date 03/06/17 a "8" was written which note." No written progthe medical record. No physician was notified On 05/18/17 at 11:10 conducted with Nurse Resident #2 on 3/6/13 glucose of 508 mg/dL confirmed that the resident #2 on 3/6/13 glucose o	ation Administration Record ugh 03/31/17 revealed the 17 was not transcribed on wribed Novolog SSI order unit/ml, inject as per sliding nit, 211-270=2 units, -390=4 units, 391-450=5 aG is greater than 450, re meals and at bedtime for 7/17. 2017 MAR revealed the gs and SSI coverage dent #2: at 11:30 AM, CBG 508. Code meant "other/see progress gress note or order found in No documentation that the dd. AM, an interview was	F 157	interventions as needed to ensure continued compliance.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245446	B. WING			l	C
		345116	B. WING			05/	24/2017
	ROVIDER OR SUPPLIER	B CENTER			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	Review of the Nursing 5:37 AM revealed CB documentation of slid the physician was not the note was not available he was out of the coulinvestigation. An interview on 05/12 of Nursing (DON) and they did not know who 03/06/17 with the SSI did not get placed on expectation that every physician's order she computer and confirm. There was no indicatinotified of the elevate 483.12(b)(1)-(3) PROMISTREATMENT/NE §483.12 The resident abuse, neglect, misage	g Note dated 03/08/17 at G was 570. There was no ing scale insulin given or if ified. The nurse that wrote lable for interview because ntry at the time of 2/17 at 1:15 PM with Director d Administrator revealed that by the physician order of order and insulin changes the MAR. It was the by order was written on the et, signed off, placed in the ned on the MAR. on that the physician was d CBG as ordered.	F	157	, DEFICIENCY)	TE .	6/27/17
	subpart. This includes freedom from corpora seclusion and any ph not required to treat the 483.12(b) The facility	s but is not limited to al punishment, involuntary ysical or chemical restraint ne resident's symptoms.					
		event abuse, neglect, and nts and misappropriation of					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		345116	B. WING _			C 05/24/2017
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 224	Continued From page (b)(2) Establish policinvestigate any such (b)(3) Include training §483.95, This REQUIREMENT by: Based on observation interview, and physical neglected a resident orders for sliding scamonitoring and reass brittle diabetic reside blood glucose (CBG) (milligram/deciliter). showing signs of leth unusual bowel inconfacility failed to initiat services (EMS) for the in distress. This was residents (Resident # the hospital and short The facility neglected wound care for two dwere supposed to ha	e 5 ies and procedures to allegations, and g as required at paragraph is not met as evidenced ons, record review, staff ian interview, the facility by not following physician le insulin (SSI), by not lessing an insulin dependent ont that had a critical capillary	F 2	Nurse #2 has received education 5/12/17 from the Director of Nur Staff Development Coordinator the facility policy for identification assessment of changes in condimanagement of residents with dincluding monitoring of residents intervention, implementation, an physician notification. Nurse #2 longer an employee and will not education about initiating EMS. All residents with changes in conhave the potential to be affected alleged deficient practice. The E Nursing and Nurse Managers of an audit of current diabetic residence have had an acute change in conrelated to high blood sugar level last 30 days and reviewed their	on on esing and regarding n and lition, liabetes is following and receive endition by the Director of conducted dents who condition is in the	
	5/8/17 when Resider registered HI on the gwas more than 600 m showing signs of leth vomiting, and unusua was not immediately continue to assess the jeopardy was remove facility provided an acceptance of the second secon	for Resident #2 began on at #2 blood glucose glucometer (blood glucose ng/dL.) and the resident was argy, low blood pressure, at bowel incontinence. EMS initiated and nursing did not be resident. The immediate ed on 5/23/17 when the cceptable credible allegation acility will remain out of		corresponding documentation to that a nursing assessment has be completed and interventions we implemented according to the Physician orders and the car including emergency medical se initiated immediately as directed physician completed May 12, 20 Beginning May 12, 2017 the Direction Nursing and Nurse Managers we those residents who have exhibit	re plan, ervices by 017. ector of ill review	

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		345116	B. WING _				C 24/2017
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	,	
				10	9 S HOLDEN ROAD		
STARMOL	INT HEALTH AND REHA	B CENTER		GI	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From page		F 2	224			
F 224	compliance at a scop actual harm with the minimal harm that is the facility to complet monitoring systems p. The facility is also ou scope and severity for # 5. Findings included: 1. Resident #2 was a 02/27/17 with diagno Diabetes Mellitus (DN Disease. A review of the initial dated 03/06/17 reveat cognitively intact and the physical assistant activities of daily livin with walking and drest able to stabilize without utilized a wheelchair needed. It also reveat incontinent of bladde bowel. A review of the care president #2 had Dial interventions to include incontinent of bladde incontinent of blad	pe and severity level of D (not potential for more than not immediate jeopardy) for the staff training and to ensure out into place are effective. It of compliance at the D or Resident #4 and Resident dmitted to the facility on sees including Type I M) with Chronic Kidney Minimum Data Set (MDS) alled that Resident #2 was required supervision with the ce of one person with g (ADL), was independent sesing, was not steady but out staff assistance and as a mobility device when led that he was occasionally and was continent of the color	F 2	224	changes in condition to assure that assessments or observations of symptoms have been assessed, interventions were initiated as ordered care planned, and the attending physic was notified. The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Licensed Nurses beginning May 11, 20 regarding the facility sexisting policy to identification and assessment of change in condition, Diabetic Management including monitoring of residents follow intervention implementation, and physician notification. Education included clarification of exist policy: Beginning May 11, 2017 of the following. When a resident blood sugar read on the glucometer, Residents will be re-assessed within 30 minutes to 1 hou following insulin administration and according to the physician of sorders. -Physician of the physician of scale insulin administration and blood sugar monitoring will include parameters for physician notification. - Identification of an obvious critical acchange in condition, and appropriate	ian 117 for es ing Ing HI	
	effects and effectiven sugar as ordered by document/report prn sign/symptoms of hyl and appetite, frequer fatigue, dry skin, poo				response and physician notification. - Ensuring staff awareness that failure provide care and services, including what to initiate EMS, can constitute resident neglect. - EMS will be imitated by physician or and/or advanced directives.	nen	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345116	B. WING _				24/2017
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	24/2017
					09 S HOLDEN ROAD		
STARMOL	INT HEALTH AND RE	HAB CENTER			GREENSBORO, NC 27407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 224	Continued From pa	age 7	F 2	224			'
	labored breathing a	associated with diabetes)			Licensed nursing staff, and agency		
		breath, stupor and coma.			licensed nursing staff will not be allowed	ed	
	J.				to work until this training is complete.		
	A review of the me	dical records revealed					
		otes, CBG level order changes			The Director of Nursing, Staff	ĺ	
	and insulin regimer				Development Coordinator and Nurse		
	' '	dated 02/28/17 at 6:32 AM read		Managers have conducted training with			
I		n 100 UNIT/ML, inject as per			Certified Nursing Assistants beginning		
		3G) 150 - 210 = 1 (NovoLOG) units; 271 - 330 = 3 units; 331 -			May 11, 2017 regarding reporting an observation of a resident s change of		
		- 450 = 5 units; notify MD			condition to the Nurse immediately.		
		is greater than 450,			Nursing assistants will not be allowed	to	
		fore meals and at bedtime for			work until this training is complete.	cu to	
	DM."						
	Review of Residen	t #2 handwritten physician			The Director of Nursing, Staff Development Coordinator and Nurse		
		17 revealed the following new			Managers have conducted education v	with	
	order:	Tri Tovodiou tilo Tollovillig How			Licensed Nursing staff and nurses aide		
		cale insulin) for patient			on Abuse and Neglect Prevention on N		
		als 151-200=2 units, 201-250=3			22, 2017 including prompt response to		
	units, 251-300=5 u	nits, 301-350=7 units,			resident□s change of condition.		
	351-400=9 units, 4	01-450=11 units, if greater			Beginning May 22nd, Licensed Nursing		
	than 450 call MD.				staff, nurses□ aides and Agency Licen		
					nursing staff will not be allowed to work	(
		ication Administration Record			until the training is complete. This		
		rough 03/31/17 revealed the /6/17 was not transcribed on			education also included ensuring staff	and	
		scribed Novolog SSI order			awareness that failure to provide care services, including when to initiate EM		
	was the following:	iscribed Novolog 331 order			can constitute resident neglect.	3,	
		00unit/ml, inject as per sliding			San sonstitute resident neglect.	ĺ	
	_	unit, 211-270=2 units,			Beginning May 22, 2017 Licensed nurs	sing	
		31-390=4 units, 391-450=5			staff and Agency Licensed nursing staff	-	
	i i	CBG is greater than 450,			will not be allowed to work until the	ĺ	
		fore meals and at bedtime for			training for Abuse and Neglect Prevent		
	DM. Order date 02	/27/2017.			including prompt response to resident		
					change of condition is completed. This	ĺ	
		ch 2017 MAR revealed the			education also includes ensuring staff		
	following CBG read	dings and SSI coverage			awareness that failure to provide care		

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		345116	B. WING _				C 24/2017
NAME OF PR	ROVIDER OR SUPPLIER		I I	S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
				10	09 S HOLDEN ROAD		
STARMOU	INT HEALTH AND REHA	B CENTER		G	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From page	e 8	F 2	224			
	MAR date 03/06/17 at MAR date 03/06/17 at MAR date 03/06/17 at "8" was written which note." No written proof the medical record. On 05/18/17 at 11:10 conducted with Nurse Resident #2 on 3/6/1 glucose of 508 mg/dl confirmed that the resident #2 in the resident was supported by the manual proof that the resident was supported by the manual proof that the resident was supported by the manual proof that the resident was supported by the manual proof that the resident was supported by the manual proof that the resident was supported by the manual proof that the manual proof the manu	at 6:30 AM, CBG 71. at 11:30 AM, CBG 508. Code a meant "other/see progress gress note or order found in AM, an interview was at #8 who worked with and documented the blood at 11:30 AM. The nurse sident blood glucose was			can constitute resident neglect. License nursing staff will be provided this education at least annually via the Director of Nursing or Resident Care Management Director. This education be included in the facility s new hire orientation and newly hired licensed nursing staff will not be permitted to assume their floor responsibilities until they have completed this education.		
	20 units one time from that she knew to place medical records for in	eceived an order for Novolog in physician #1. She stated be a progress note in the interventions related to high v orders, but, she did not do			Resident #4 attending physician and responsible party were notified on 5/10 of two questionable missed treatments Resident #5 attending physician and responsible party were notified on 5/10 of two questionable missed treatments	ified on 5/10/17 d treatments. sician and ified on 5/10/17 d treatments. eted of ysician orders sure that wound d for the past /27/17 by the lurse Manager. eted by a nistration team ation record for es a week for	
	given instead of 5 un MAR date 03/06/17 a given instead of 3 un MAR date 03/07/17 a MAR date 03/07/17 a given instead of 2 un MAR date 03/07/17 a given instead of 2 un MAR date 03/07/17 a given instead of 2 un MAR date 03/08/17 a given instead of 2 un MAR date 03/08/17 a "8" was written which	at 4:30 PM, CBG 271, 3 units its as ordered on 03/06/17 at 9:00 PM, CBG 220, 2 units its as ordered on 03/06/17 at 6:30 AM, CBG 83. at 11:30 AM, CBG 180, 1 unit its as ordered on 03/06/17 at 4:30 PM, CBG 206, 1 unit its as ordered on 03/06/17 at 9:00 PM, CBG 209, 1 unit its as ordered on 03/06/17 at 9:00 PM, CBG 570, Code meant "other/see progress gress note or order found in			Facility audit will be completed of residents identified with physician orde for daily wound care to ensure that wortestments were completed for the pasthirty days per orders by 6/27/17 by the Director of Nursing and / Nurse Manage Facility audit will be completed by a member of the nurse administration tea of the treatment administration record for wound care orders five times a week for one month then weekly times two months.		
	the medical record. Review of the Nursin 5:37AM revealed CB documentation of slic the physician was no	g Note dated 03/08/17 at G was 570. There was no ling scale insulin given or if tified. The nurse that wrote ilable for interview because			Visual validation that daily wound care treatments occur will be conducted randomly three times a week to ensure completion of physician order. Facility audit will be completed of residents identified with physician orde for sliding scale insulin to ensure that a	rs	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			, 50.25.	_		(C
		345116	B. WING			05/	24/2017
	ROVIDER OR SUPPLIER JNT HEALTH AND REHA	AB CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 09 S HOLDEN ROAD GREENSBORO, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	given instead of 2 un MAR date 03/09/17 a given instead of 11 u MAR date 03/09/17 a given instead of 11 u MAR date 03/10/17 a units given instead of 03/06/17 MAR date 03/10/17 a given instead of 7 un MAR date 03/10/17 a given instead of 2 un MAR date 03/11/17 a units given instead of 2 un MAR date 03/11/17 a units given instead of 7 un MAR date 03/11/17 a given instead of 7 un MAR date 03/11/17 a given instead of 7 un MAR date 03/11/17 a given instead of 2 un MAR date 03/12/17 a given instead of 3 un MAR date 03/12/17 a given instead of 3 un MAR date 03/12/17 a given instead of 1 un MAR date 03/13/17 a given instead of 1 un MAR date 03/13/17 a given instead of 11 un MAR date 03/13/17 a given instead of 11 un MAR date 03/13/17 a given instead of 103/06/17.	at 11:30 AM, CBG 168, 1 unit its as ordered on 03/06/17 at 4:30 PM, CBG 414, 5 units nits as ordered on 03/06/17 at 9:00 PM, CBG 431, 5 units nits as ordered on 03/06/17	F	2224	readings above 600 (HI) have physician notification, reassessment and monitor five times a week for one month and weekly times two months. Residents who require EMS transport fremergencies will be audited to ensure there was not a delay in initiating service five times a week for one month and weekly times two months. The facility licensed nurses will be provided re-education regarding follow physician sorders regarding wound catreatment by the Staff Development Coordinator to be completed by 6/27/17. The Director of Nursing will report finding audits to the Quality Assurance and Performance Improvement Committee monthly times three. Data will be reviewed and analyzed for patterns and trends. The Quality Assurance and Performance Improvement Committee evaluate the results and implement additional interventions as needed to ensure continued compliance.	ing for ces ring are 7 ngs	

PRINTED: 07/05/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345116	B. WING				24/2017
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 09 S HOLDEN ROAD GREENSBORO, NC 27407	1 03/	24/2017
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F 224	they did not know wh 03/06/17 with the SSI did not get placed on expectation that every physician's order she computer and confirm. Review of the current date of 3/21/17 revea NovoLOG Solution 10 sliding scale: If CBG 150 - 200 = 2 201 - 250 = 3 units; 251 - 300 = 5 units; 301 - 350 = 7 units; 301 - 350 = 7 units; 301 - 400 = 11 units, notify MD if CBG is grave subcutaneously befor DM. On 5/10/17 at 4:55 Pl were interviewed. Numanager/administrati a MDS nurse. Nurse 5/8/17, three nurses of shift. The facility called come in and work on Resident #2 resided. AM and worked from Nurse #1 and Nurse	d Administrator revealed that by the physician order of order and insulin changes the MAR. It was the yorder was written on the et, signed off, placed in the ned on the MAR. It physician orders of start led the following: OUNIT/ML, inject as per It units; Treater than 450, re meals and at bedtime for M, Nurse #1 and Nurse #3 was #1 was a unit we nurse and Nurse #3 was #1 and Nurse #3 said on called in sick on the first red Nurse #1 and Nurse #3 to the 100 hall, where They both came around 8 around 8 AM to 3 PM. #3 manned the carts on 100 is doing okay on their shift.	F	224			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
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F 224	during the last two n 5/8/17, he shaved a felt like a "million bu wheeled himself in that morning and he A review of the Nursdated 5/8/17 at 9:25 5/8/17, Nurse #2 wa and noticed that the "properly." His skin who blood glucose was do (a machine used to (a type of sugar) is it registered "HI" (the gwhen blood glucose Vital signs were che low. Nurse #2 called an order to give 17 to Zofran every 8 hours #2 checked the reside and the glucometer called Physician #2 order to give 14 unit resident's status did the hospital. Reside He was incontinent or remained lethargic. notified of the reside send him to the hosp resident complained Resident was sent to were as follows: temblood pressure was respiration 20, O2 services with the services of the Emergian Review of the Emergian R	al self except he slept in nornings. On the morning of and showered and he said he cks" after that. He usually he wheelchair. He ate well ate well for lunch. ing Note, written by Nurse #2, PM, revealed at 4 PM on lked in Resident #2's room resident was not responding was cool and clammy. His checked using a glucometer measure how much glucose in the blood). The glucometer glucometer registered "HI" was more than 600 mg/dL.) cked and blood pressure was dephysician #1 and she gave units of Novolog and 4 mg of a for nausea. At 7 PM, Nurse dent's blood glucose again registered "HI." Nurse #2 and she received a verbal so of Novolog and if the not get better then to send to not's condition did not improve. Of bowel and bladder and The resident's family was ent's status and agreed to poital. 911 was called. The of an ache in his abdomen. On the hospital. Vital signs apperature 98.3 Fahrenheit, 98/46, heart beat 82/minute,	F 2	24		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	ZIP CODE	03/24/2017
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STARMOL	INT HEALTH AND REHA	B CENTER		GREENSBORO, NC 27407		
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F 224	Continued From page	e 12	F 2	224		
F 224	5/8/17. The EMS per blood glucose and it is glucometer. The resisurrounding but was a person, time, and ever resident's pupils were to light. Multiple attensuccess to administe. A telephone interview #2 on 5/11/17 at 11:1 usually worked from 5/8/17, the facility cal work from 3 PM to 7 lbusy. At around 4 Phroom. The resident wunusual for him. He was slurred and he had face and in the trash what was wrong, he twell. She checked hip pressure was low and high on the glucomet #1 and notified him or including the "HI" bloom nausea, slurred spee and unresponsivenes give the resident 17 unausea. The resident Zofran pill and she gather the resident until 15 rechecked the blood gluth. She called physically surrounded the resident until 15 rechecked the blood gluth. She called physically surrounded the resident until 15 rechecked the blood gluth. She called physically surrounded the resident until 15 rechecked the blood gluth.	registered "HI" on their dent was not alert to alert to verbal stimuli to ent. It was also noticed the pin point and not reactive apts were made without intravenous (IV) fluids. To was conducted with Nurse 9 AM. Nurse #2 said she 7 PM to 7 AM. But on led her and asked her to PM on the 100 Hall. It was was lethargic. His speech and vomitus dried up on his can. The nurse asked him old her he was not feeling is vital signs. His blood of his blood sugar registered er so she called physician of the resident's condition, and glucose, lethargy, ch, unusual incontinence, is. The physician told her to anits of insulin and Zofran for it was able to swallow the ave him the insulin injection. In the time the insulin injection in the resident's period of the condition of the sale to swallow the ave him the insulin injection. In the time the insulin injection in the physician of the resident's condition, and glucose and it still registered cian #2 (On call) and the more units of sliding scale		224		
		n to the hospital if not came back to check on movement on himself which				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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STARWOO	JNT HEALTH AND REH	AB CENTER		GREENSBORO, NC 27407			
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F 224	Continued From pag	e 13	F 2	224			
F 224	was unusual for him him up. Nurse #2 sa complete her tasks it ordinary. She said sto take care of the reprevented her from a she gave him insulin was trying to get a classification taking over me hall, had to get Zofra in residents' medical employed at the faci she did not know hor for Zofran. So she in said there was no exhelp when something. An interview with NA revealed she usually She stated, on averawhich was a managed different with a lot of a lot of staff assignm started that day and where they worked, and the other nurse residents on the hall work with the resider He was in bed and he eating and he would 6:30 PM. She repornot eat. The nurse so	She sent the aide to clean aid usually she was able to a nothing came up out of the she did not have enough time esident. When asked what checking on the resident after around 4 PM, she said she hange of shift report, stock check on tube feeding, talk edication cart of the other an and needed to document record. She had been lity for only three months and w to put in a physician order leeded help with that. She stra administrative staff to g unexpected came up. A #4 on 5/12/17 at 12:35 PM worked from 3 PM -11 PM. age, she had 12-14 residents eable load. On 5/8/17, it was things going on. There were leent changes. New staff they were confused about There were one new nurse was not familiar with the . NA #4 stated she did not not eat. It was around 6 or ted to the nurse that he would		224			
	had a history of bein because of high bloc	g found unconscious od glucose. He was a brittle experiences frequent,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345116	B. WING			C 05/24/2017	
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F 224	resident wanted to a shown the 5/8/17 N #2 regarding the resident on 5/8/17 about remember giving insulin. The physical she said if they call resident had vomiting and blood glucose in have sent the resident because the nursing resident in that conditions the statement more physician said "no with patient without intrasid she reviewed to and his blood glucohospital and he died. Review of the hospital and he died. Review of the hospital statement (ED) datest results from the collected on 5/8/17 Resident's urine glumg/dL (reference resident in the resident in t	dolood glucose levels). The go home. The physician was ursing Note written by Nurse sident's change in condition. It do she did not remember being but this resident and she did go the order for 17 units of an said "I was never called." led her and told her the eng, slurred speech, lethargic registering "HI", she would gent right away to the hospital go home could not manage the dition. The physician repeated than one time. The evay I would have kept the venous fluids." The physician he resident's hospital record se was 1123 mg/dL at the dof myocardial infarction. Ital emergency room the 5/8/17 revealed laboratory eresident's urine sample at 10:44 PM were as follows: loose was more than 1000	F 2				
	on 5/8/17 at 11:43 F Blood glucose was The resident died o The administrator w jeopardy on 5/22/17	est results of blood collected PM were as follows: 1123 mg/dL, n 5/8/17 at 12:55 AM.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION		PLETED	
		345116	B. WING _				C 24/2017	
	ROVIDER OR SUPPLIER	AB CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407			•	
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F 224	Continued From page	e 15	F 2	224				
	allegation of compliant PM.	nce effective 5/23/17 at 2:47						
	Residents identified t deficient practice.	o be affected by the alleged						
	responding as usual. clammy. His Blood gread "HI" with no value manufacturer insert for that a reading of "HI" value of greater than was notified and order administer 17 units of Zofran 4 mg every 6. At approximately 4:30 check on Resident #2 with no new changes At approximately 6-6 Resident #2 his dinner he was not feeling go NA#4 stated this was Resident #2 remaine set up. At 7:00 PM, Nurse #2 blood sugar and it ag notified the Physician administer 14 units of transport to the hosp status did not improverse.	d noticed that he was not His skin was cool and plucose was checked and ue on the monitor. The or this glucometer stated indicated a blood glucose 600 mg/dL. The Physician ers were received to f Novolog one time and hours for nausea. 0 PM NA#3 entered room to 2 who was resting in bed						
	Resident complained Family was notified of called at 8:25 PM, and hospital at 9:26 PM. The nurse reported s	I of an ache in his abdomen. If resident status, 911 was add resident arrived at the he was too busy to check on quently to reassess following						

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			1	C 24/2017
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F 224	reading with nausea and that she did not manager that she waresident. Nurse #2 has receive the Director of Nursic Coordinator regarding identification and assecondition, managem including monitoring intervention implement notification. Nurse # and will not receive exemple.	and a low blood sugar and a low blood pressure communicate with a as not able to recheck on the ed education on 5/12/17 from an and Staff Development go the facility policy for sessment of changes in ent of residents with diabetes of residents following entation, and physician 2 is no longer an employee education about initiating	F:	2224			
	potential to be affect practice. On 5/12/17 Nurse Managers cordiabetic residents whin condition related to the last 30 days and documentation to values assessment has been interventions were in Physician's Orders are mergency medical as directed by physician's. Systemic Measures						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	JILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407		03/24/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 224	who have exhibited a assure that assessm symptoms have beer were initiated as order attending physician variety attending physician variety attending physician variety and physician was beginning May 11, 20 existing policy for ide of changes in condition including monitoring intervention implementification. Education included of Beginning May 11, 20 when a resident's beglucometer, Residen 30 minutes to 1 hour administration and accorders. -Physician's Orders from a definition of an change in condition, and physician notification of an change in condition, and physician notification. - Ensuring staff away provide care and serioritiate EMS, can correctly advanced directives. Licensed nursing staff will not be training is complete.	will review those residents acute changes in condition to ents or observations of a assessed, interventions ered or care planned, and the was notified. Ing. Staff Development see Managers have ith Licensed Nurses of regarding the facility's ntification and assessment on, Diabetic Management of residents following ntation, and physician Color of the following: Color of the following: Color of the following: Color of the physician's Cor sliding scale insulin cood sugar monitoring will or physician notification. Cobvious critical acute and appropriate response	F 2	24			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	•	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 224	Continued From pag	e 18	F	224		
	reporting an observa condition to the Nurs assistants will not be training is complete.	ith Certified Nursing May 11, 2017 regarding tion of a resident's change of e immediately. Nursing allowed to work until this				
	Coordinator and Nur conducted education and nurses aides on Prevention on May 2 response to resident Beginning May 22nd nurses' aides and Ag will not be allowed to complete. This educ staff awareness that	with Licensed Nursing staff Abuse and Neglect 2, 2017 including prompt 's change of condition. , Licensed Nursing staff, ency Licensed nursing staff work until the training is cation also included ensuring failure to provide care and hen to initiate EMS, can				
	and Agency Licensed allowed to work until Neglect Prevention, resident's change of education also include that failure to provide when to initiate EMS neglect. Licensed nuthis education at least Nursing or Resident This education will be hire orientation and restaff will not be perm	017 Licensed nursing staff d nursing staff will not be the training for Abuse and including prompt response to condition is completed. This les ensuring staff awareness a care and services, including a can constitute resident rsing staff will be provided at annually via the Director of Care Management Director. The included in the facility's new newly hired licensed nursing itted to assume their floor they have completed this				

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345116	B. WING _			C 05/24/2017
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F 224	On 5/24/17 at 1:27 F compliance was valimplemented their control immediate jeopa evidence of an audit insulin dependent discompliance.	PM, the credible allegation of dated to ensure the facility prective actions to remove rdy. The facility provided , on 5/12/17, of current abetic residents who have	F2	224		
	blood glucose levels facility reviewed thei documentation to va assessment has bee interventions were in of diabetic residents they received care to ordered by the physical evidence of inservice how to manage diab	lidate that a nursing				
	assistants were inter knowledge of negled. One of the nurses w and nursing assistar received inservices r in condition in the last were all able to ident and what to do wher condition. 2. Record review sh re-entered the facility diagnoses included of Dementia, Mood Dis Accident, Hyperlipide	PM, 4 nurses and 4 nursing viewed regarding their st and change of condition. as an agency nurse. Nurses ats confirmed that they regarding neglect and change st few two days and they tify what constituted neglect in a resident has a change in sowed that resident #4 y on 01/3/17. Current Cerebral Infarction, order, Cerebral Vascular emia, Alcohol Abuse with od Disorder, Hypertension,				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		345116	B. WING _			C 05/24/2017
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F 224	Continued From pag	e 20	F 2	224		
	Cardiac Arrest, Resis Vitamin B12 Deficien Infection, Wound Bot Dysphagia and Epile	eripheral Vascular Disease, stance to Vancomycin, icy Anemia, Urinary Tract tulism, Pressure Ulcer (Hip), psy. ecent care plan on 05/10/17				
	area to her right hip a Interventions include orders, complete lab- assist to turn and rep provide supplements	resident had a pressure and her right heel. d to apply dressings per s as ordered, monitor intake, position on rounds and prn, as ordered, and see the s scheduled. The most				
	recent MDS dated 4/ had (2) facility acquir pressure reducing de and nutrition and hyd	10/17 indicated the resident red Stage 4 pressure ulcers, evices for her chair and bed,				
	The most recent phy related to skin integri	sician orders on 05/10/17 ty included:				
	to moist dressing twi 2. Apply Santyl Oir every day shift 3. Multivitamin one 4. House Shakes 4 5. Pro Stat Liquid 3	tab daily to ounces at lunch and dinner months of the state of the sta				
	progress notes dated there was no change for either wound on t	ecent wound care specialist d 05/05/17 documented that in wound healing progress hat date. Further review bunds are smaller in size and				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 224	05/10/17 at 2:40 PM Nurse #6. Proper h donning was observused. It was observe removed from the S was dated 05/07/17 malodorous with a lexudate present. The wound was reddened with gauze soaked in covered with a dry cophysician. Nurse #6 dressing from the resulcer on her right he dated 05/07/17. It was amount of brown ex the wound was whit applied to the wound applied. The used coproperly. In an interview with PM she revealed the 05/08/17 and 05/09/01/19/19/19/19/19/19/19/19/19/19/19/19/19	dent #4 was observed on I. Care was provided by and washing and glove ed. Clean technique was ed that the old dressing tage 4 right hip pressure ulcer	F	224		
	wounds were not tre 05/09/17. In an interview with PM she stated that son 05/09/17 during the day had been very	ere not changed and the sated on 05/08/17 and Nurse #7 on 05/11/17 at 2:30 she had care for resident #4 he day shift. She said that ery busy. She stated that her eep the residents safe and				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345116	B. WING		05/24/2017	
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F 224	had looked at the d sure everything was to do the treatments revealed that it was treatments but that during the day shift 3. Record review share-entered the facilid diagnoses included Hyperglycemia, Ans Major Depressive Elements of Diabetic Foot Ulcon Review of the most MDS) Assessment that the resident had diabetic foot ulcers as intact. He was emobility, personal he totally dependent for assessment indicate plan interventions of dressings per order monitor intake, assirounds and prn, pro and see the wound	nes. She revealed that she ressings on wounds to make intact but did not have time is on her assignment. She is her intention to do the there was too much going on to get everything done. nows that resident #5 if yon 05/14/16. Current intention Type 2 Diabetes Mellitus with exiety Disorder, Mood Disorder, Disorder, Essential insufficiency Chronic Spasms and Personal History	F 224			
	with setting locked	tress is functioning properly				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	` '	OATE SURVEY OMPLETED
		345116	B. WING _			C 05/24/2017
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 109 S HOLDEN ROAD GREENSBORO, NC 27407	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 224	dry, apply Silver Sulvarap with Kerlix dai 5. Apply Santyl O LLE topically every 6. Apply Mupirocii topically every day 5. Apply Hydrocol venous wound ever Review of the most progress notes date there was no chang progress for the (2) wounds on that date that the measuremeremained the same An observation on O that the dressing on extremity of Resider The surveyor was unbecause the resider was medicated for pure In an interview with PM she revealed the 05/08/17 and 05/09, nurses working the doing the dressing of agreed that the dressing of the	left foot with Normal Saline, fa Cream 1%, apply 4 x 4, y normal 250 unit/gm to outer day no Ointment 2% to left great toe shift for skin alteration loid to left heel Stage 2 y 3 days recent wound care specialist d 04/28/17 documented that e in the wound healing arterial and (1) venous e. Further review revealed ents for all wounds have	F2	224		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345116	B. WING				C / 24/2017
	ROVIDER OR SUPPLIER	B CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 09 S HOLDEN ROAD REENSBORO, NC 27407		= W=V
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282 SS=E	11:20 AM she revealeresident #5 on 05/08/PM. She stated that coming on shift. She treatments on her shimuch to do. She said caring for forty-two reshe was relieved by a ln an interview with the 05/12/17 at 5:00 PM state treatments to be ophysician. 483.21(b)(3)(ii) SERV PERSONS/PER CAR (b)(3) Comprehensive The services provided as outlined by the commust- (ii) Be provided by quaccordance with each care. This REQUIREMENT by: Based on observation interview, the facility oplan for a sliding scal was evident in 1 of 3 #2). The facility failed provide wound care for residents who were significant in the said of th	urse #2 on 05/11//17 at an add that she had cared for 17 from 3:00 PM to 11:00 she did not get report when said she did not do the fit because she had too did for part of the shift she was sidents until 11:00 PM when an Agency Nurse. The Director of Nursing on she stated that she expected done as ordered by the PLAN The Care Plans did or arranged by the facility, imprehensive care plan, The is not met as evidenced in a record review, and staff failed to implement the care in sulin (SSI) order. This diabetic residents (Resident did to follow the care plans to		2224	Resident #2 no longer resides in the facility. Resident #4 attending physician and responsible party were notified on 5/10 of two questionable missed treatments. Resident #5 attending physician and responsible party were notified on 5/10		6/27/17

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345116	B. WING				C	
NAME OF D	ROVIDER OR SUPPLIER	040110		et.	REET ADDRESS, CITY, STATE, ZIP CODE	05/	24/2017	
NAIVIE OF FI	NOVIDER OR SUFFLIER							
STARMOL	INT HEALTH AND REHA	B CENTER			S HOLDEN ROAD			
				GR	REENSBORO, 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 282	Continued From page	e 25	F 2	82				
	Findings included:				of two questionable missed treatments			
	1. Resident #2 was a 02/27/17 with diagnost Diabetes Mellitus (DM Disease. A review of the initial dated 03/06/17 reveat cognitively intact. A review of the Care in revealed Resident #2 interventions to include resident/family's current about the disease propass ordered by doctor, effects and effectiven sugar as ordered by document/report printer.	Minimum Data Set (MDS) led that Resident #2 was Plan dated 05/03/17 had Diabetes Mellitus with de: observe/document the ent level of understanding ocess, diabetes medication observe/document for side ess, Fasting Serum Blood doctor, observe/			A member of nurse administration team (Staff Development Coordinator, Assis Director of Nursing and /or Director of Nursing) will review physician orders for past thirty days of residents receiving sliding scales by 6/27/17 to validate correct sliding scale usage. Facility audit will be completed of residents identified with physician order for daily wound care to ensure that wound treatments were completed for past thirty days per orders by 6/27/17 to the Director of Nursing and / Nurse Manager. A member of nurse administration team (Staff Development Coordinator, Assis Director of Nursing and /or Director of Nursing) will review new insulin sliding	tant or rs the by		
	and appetite, frequen fatigue, dry skin, poor cramps, abdominal pa labored breathing ass	t urination, weight loss, wound healing, muscle ain, Kussmaul (deep and sociated with diabetes)			scale physician orders from previous d to ensure that order transcribed correct for five times a week for one month and weekly times two months.	tly		
	<u> </u>	eath, stupor and coma.			Facility audit will be completed by a member of the nurse administration tea of the treatment administration record f wound care orders five times a week for	or		
	"NovoLOG Solution 1 sliding scale: if (CBG unit; 211 - 270 = 2 un 390 = 4 units; 391 - 4 (physician) if CBG is	ed 02/28/17 at 6:32 AM read 00 UNIT/ML, inject as per) 150 - 210 = 1 (NovoLOG) its; 271 - 330 = 3 units; 331 - 50 = 5 units; notify MD greater than 450, re meals and at bedtime for			one month then weekly times two monivisual validation that daily wound care treatments occur will be conducted randomly three times a week to ensure completion of physician order. The facility licensed nurses will be provided re- education regarding process.	•		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		345116	B. WING_		C 05/24/2017
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP	
				109 S HOLDEN ROAD	
STARMO	UNT HEALTH AND REH	AB CENTER		GREENSBORO, 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 C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION OF THE APPROPRIATE COMPLETION DATE
F 282	Review of Resident: order dated 03/06/17 order: New SSI (sliding sca (resident) with meals units, 251-300=5 uni 351-400=9 units, 40° than 450 call MD. Review of the Medic (MAR) 03/06/17 thronew SSI order of 3/6 the MAR. The transwas the following: Novolog solution 100 scale: if 150-210=1 u 271-330=3 units, 33 units. Notify MD if C subcutaneously befor DM. Order date 02/2 Review of the March following CBG readin administered to Resimal MAR date 03/06/17 at 30% was written which note." No written prothe medical record. On 05/18/17 at 11:10 conducted with Nurse Resident #2 on 3/6/10 glucose of 508 mg/d confirmed that the resident stated she in the state	#2 handwritten physician 7 revealed the following new le insulin) for patient 5 151-200=2 units, 201-250=3 1ts, 301-350=7 units, 1-450=11 units, if greater ation Administration Record ugh 03/31/17 revealed the 1/17 was not transcribed on cribed Novolog SSI order Dunit/ml, inject as per sliding unit, 211-270=2 units, 1-390=4 units, 391-450=5 1/18 BG is greater than 450, ore meals and at bedtime for 1/1/17.	F 2		orders, following ders by the Staff r by 6/27/17 vill report findings esurance and nt Committee a will be or patterns and rance and nt Committee will mplement s needed to

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345116	B. WING _				C 24/2017
	ROVIDER OR SUPPLIER JNT HEALTH AND REHA	AB CENTER		STREET ADDRESS, C 109 S HOLDEN ROA GREENSBORO, N		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	or low CBGs and new it that day. MAR date 03/06/17 a given instead of 5 un MAR date 03/07/17 a given instead of 3 un MAR date 03/07/17 a given instead of 2 un MAR date 03/07/17 a given instead of 2 un MAR date 03/07/17 a given instead of 2 un MAR date 03/07/17 a given instead of 2 un MAR date 03/08/17 a given instead of 2 un MAR date 03/08/17 a "8" was written which note." No written properties where we was record. Review of the Nursin 5:37 AM revealed CE documentation of slice the physician was not availed the physician was not availed the was out of the continuestigation. MAR date 03/09/17 a given instead of 11 un MAR date 03/09/17 a given instead of 11 un MAR date 03/10/17 a given instead of 11 un	at 4:30 PM, CBG 271, 3 units its as ordered on 03/06/17 at 9:00 PM, CBG 83. at 11:30 AM, CBG 180, 1 unit its as ordered on 03/06/17 at 9:00 PM, CBG 206, 1 unit its as ordered on 03/06/17 at 4:30 PM, CBG 206, 1 unit its as ordered on 03/06/17 at 4:30 PM, CBG 209, 1 unit its as ordered on 03/06/17 at 9:00 PM, CBG 209, 1 unit its as ordered on 03/06/17 at 6:30 AM, CBG 570, Code in meant "other/see progress gress note or order found in g Note dated 03/08/17 at 8G was 570. There was no ding scale insulin given or if tiffied. The nurse that wrote ilable for interview because untry at the time of at 11:30 AM, CBG 168, 1 unit its as ordered on 03/06/17 at 4:30 PM, CBG 414, 5 units inits as ordered on 03/06/17 at 9:00 PM, CBG 431, 5 units inits as ordered on 03/06/17 at 9:00 PM, CBG 431, 5 units inits as ordered on 03/06/17	F2	82			

` ,		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345116	B. WING				C 24/2017
	ROVIDER OR SUPPLIER JNT HEALTH AND REHA	B CENTER		109	REET ADDRESS, CITY, STATE, ZIP CODE 9 S HOLDEN ROAD REENSBORO, NC 27407	1 00.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	MAR date 03/10/17 a given instead of 2 un MAR date 03/11/17 a units given instead of 03/06/17 MAR date 03/11/17 a given instead of 7 un MAR date 03/11/17 a given instead of 2 un MAR date 03/12/17 a MAR date 03/12/17 a given instead of 3 un MAR date 03/12/17 a given instead of 2 un MAR date 03/12/17 a given instead of 2 un MAR date 03/13/17 a given instead of 1 un MAR date 03/13/17 a given instead of 11 un	ts as ordered on 03/06/17 t 9:00 PM, CBG 176, 1 unit ts as ordered on 03/06/17 t 6:30 AM, CBG 123. t 11:30 AM, CBG 440, 5 11 units as ordered on t 4:30 PM, CBG 335, 4 units ts as ordered on 03/06/17 t 9:00 PM, CBG 154, 1 unit ts as ordered on 03/06/17 t 6:30 AM, CBG 143.	F	282			
	O3/06/17. An interview on 05/12 of Nursing (DON) and they did not know wh 03/06/17 with the SS did not get placed on expectation that ever physician's order she computer and confirm 2. Record review she re-entered the facility diagnoses included Thyperglycemia, Venc Peripheral, and Persoulcer.	y order was written on the et, signed off, placed in the ned on the MAR.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345116	B. WING			C)5/24/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407		13/24/2017	
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 282	that the resident had diabetic foot ulcers. as intact. He needed bed mobility, personal the assessment indices as intact. He needed bed mobility, personal the assessment indices as plant intervet to apply dressings personal to apply dressings personal to apply dressings personal to apply dressing or apply Silver Sulf wrap with Kerlix daily 2. Apply Santyl Oir LLE topically every day so apply Hydrocollic topically every day so apply Hydrocollic venous wound every an observation on observation on observation on observation on extremity of Residen The surveyor was urbecause the resident was medicated for personal topically and obsologically and o	dated 03/06/17 documented venous, arterial, and Cognition was documented dextensive assistance for all hygiene and toilet use. icated that he did not walk. The entions on 05/10/17 included er orders, complete labs as ake, assist to turn and and as needed, provide ered, and see the wound care of the wound care of the ention was a seed of the wound care of the ention of the entire the entire that the e	F 2	82			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(>	(X3) DATE SURVEY COMPLETED		
		345116	B. WING _			C 05/24/2017	
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE 109 S HOLDEN ROAD GREENSBORO, NC 27407		00/24/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 30 agreed that the dressings had not been changed		F	282			
		sings had not been changed e not treated on 05/08/17 and					
	05/10/17 at 5:15 PM worked together on shift. They both state	Nurse #1 and Nurse #3 on I they stated that they had the 100 Hall on 05/08/17 day ted that they did not have time and had passed the duty on urse.					
	11:20 AM she revea resident #5 on 05/08 PM. She stated that coming on shift. Sh- treatments on her sh much to do. She sa	Nurse #2 on 05/11//17 at led that she had cared for 8/17 from 3:00 PM to 11:00 t she did not get report when e said she did not do the nift because she had too id for part of the shift she was esidents until 11:00 PM when an Agency Nurse.					
	05/12/17 at 5:00 PM	the Director of Nursing on she stated that she expected done as ordered by the					
	re-entered the facilit diagnoses included Peripheral Vascular Vancomycin, Vitamii	owed that resident #4 y on 01/3/17. Current Cerebral Vascular Accident, Disease, Resistance to n B12 Deficiency Anemia, essure Ulcer (Hip), and					
	that the resident had hip and her right hee apply dressings per	olan on 05/10/17 documented d a pressure area to her right el. Interventions included to orders, complete labs as ake, assist to turn and					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345116	B. WING				24/2017
	ROVIDER OR SUPPLIER	B CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 09 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 282	The most recent Mini 4/10/17 indicated the acquired Stage 4 prereducing devices for nutrition and hydratio skin problems. Cogn Physician orders on Cintegrity included: 1. Apply to right hip to moist dressing twice 2. Apply Santyl Oin every day shift Wound care for reside 05/10/17 at 2:40 PM. Nurse #6. It was obsermoved from the Stawas dated 05/07/17. malodorous with a lare exudate present. The wound was reddened with gauze soaked in covered with a dry drephysician. Nurse #6 dressing from the resulcer on her right heed dated 05/07/17. It was amount of brown exuthe wound was white applied to the wound applied.	and prn (as needed), as ordered, and see the s scheduled. mum Data Set (MDS) dated resident had (2) facility ssure ulcers, pressure her chair and bed, and n intervention to manage ition was intact. 05/10/17 related to skin Dakins Solution 0.25% wet be daily thent to right heel topically thent to right heel topically erved that the old dressing age 4 right hip pressure ulcer. The dressing was rige amount of brown eskin surrounding the days ordered by the	F	282			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	, ,	DATE SURVEY COMPLETED	
		345116	B. WING _			C 05/24/2017
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 109 S HOLDEN ROAD GREENSBORO, NC 27407	DE	00/2-4/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE
F 282	PM she revealed that	she had called out on	F 2	282		
	nurses working the hadoing the dressing chagreed that the dress and the wounds were 05/09/17. Nurse #1 v	7. She stated that the all were responsible for an anges in her absence. She sings had not been changed a not treated on 05/08/17 and was also present and agreed are not changed and the ated on 05/08/17 and				
	PM she stated that shon 05/09/17 during the the day had been verifirst priority was to ke give out the medicine had looked at the dresure everything was it to do the treatments or revealed that it was heterother than the treatments but that the	lurse #7 on 05/11/17 at 2:30 ne had care for resident #4 ne day shift. She said that ny busy. She stated that her neep the residents safe and ness. She revealed that she nessings on wounds to make ntact but did not have time non her assignment. She ner intention to do the nere was too much going on no get everything done.				
F 309 SS=J	05/12/17 at 5:00 PM the treatments to be ophysician.	ne Director of Nursing on she stated that she expected done as ordered by the PROVIDE CARE/SERVICES L BEING	F3	309		6/27/17
	applies to all care and residents. Each residents facility must provide the services to attain or necessity.	damental principle that d services provided to facility dent must receive and the he necessary care and naintain the highest mental, and psychosocial				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345116	B. WING		05/24/2017		
	ROVIDER OR SUPPLIER JNT HEALTH AND REH	AB CENTER	.	STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	, 002.22		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 309	483.25 Quality of car Quality of care is a fapplies to all treatmore facility residents. Bath assessment of a residents received accordance with propractice, the compressive plan, and the rebut not limited to the limited to the limited to resident consistent with profest the comprehensive and the residents' go (I) Dialysis. The fact residents who requires services, consistent of practice, the composite plan, and the repreferences. This REQUIREMENT by: Based on observation interview, physician interview, physician orders for monitor and reassest diabetic resident that glucose (CBG) above (milligram/deciliter).	re undamental principle that ent and care provided to sed on the comprehensive ident, the facility must ensure the treatment and care in infessional standards of chensive person-centered esidents' choices, including the following: Int. Bure that pain management is selected with professional standards of practice, person-centered care plan, the policy person-centered care plan, the dialysis receive such with professional standards of practice, with professional standards prehensive person-centered care plan, with professional standards prehensive person-centered esidents' goals and T is not met as evidenced T is not met as evidenced	F 309	Nurse #2 has received education 5/12 from the Director of Nursing and Staff Development Coordinator regarding the facility policy for identification and assessment of changes in condition, management of residents with diabeted including monitoring of residents followintervention implementation, and physician notification. All residents with the statement of the	ne es ving		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLI	IMBED:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE S	
							c	;
		34511	6	B. WING _			05/2	24/2017
NAME OF P	ROVIDER OR SUPPLIER		•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
					10	9 S HOLDEN ROAD		
STARMOL	INT HEALTH AND REHA	B CENTER			G	REENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCE Y MUST BE PRECEDED B LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	e 34		F 3	309			
F 309	Continued From page facility failed to initiate services (EMS) for the in distress. This was residents (Resident # the hospital and short The facility failed to p days for Resident #5 daily treatments as or of 1 sampled resident Immediate jeopardy for 5/8/17 when Resident registered HI on the gwas more than 600 m showing signs of lether vomiting, and unusual was not immediately continue to assess the jeopardy was remove facility provided an active of compliance. The factom compliance at a scop actual harm with the pminimal harm that is not the facility to complete monitoring systems possible the facility is also out scope and severity for Findings included: 1. Resident #2 was active of the facility of the facility was generalized anxiety of respiratory disease and facility was generalized anxiety of respiratory disease and facility disease and facility disease and facility was generalized anxiety of respiratory disease and facility disease and facility disease and facility disease and facility was generalized anxiety of respiratory disease and facility facility was generalized anxiety of respiratory disease and facility facility was generalized anxiety of respiratory disease and facility f	e emergency medical eresident when he evident in 1 of 3 dia 2). The resident was ally died of a heart at rovide wound care for who was supposed dered by the physical swith wounds. The resident #2 begand the supposed of the supposed dered by the physical swith wounds. The resident #2 begand the resident #2 blood glucose glucometer (blood glucometer (blood glucometer (blood glucometer) and the resident. The important of the supposed for the sup	became libetic lis sent to tack. for two to have lian for 1 an on ucose lent was essure, le. EMS lidid not limediate the llegation of D (not an lidy) for o ensure lective. lie D y on ey ementia, tructive	F3	309	be affected by the alleged deficient practice. The Director of Nursing and Nurse Managers conducted an audit of current diabetic residents who have har an acute change in condition related to high blood sugar levels in the last 30 da and reviewed their corresponding documentation to validate that a nursin assessment has been completed and interventions were implemented accord to the Physician of Orders and the care plan, including emergency medical services initiated immediately as direct by physician completed May 12, 2017. Beginning May 12, 2017 the Director of Nursing and Nurse Managers will reviet those residents who have exhibited acchanges in condition to assure that assessments or observations of symptoms have been assessed, interventions were initiated as ordered care planned, and the attending physic was notified. The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Licensed Nurses beginning May 11, 20 regarding the facility sexisting policy fidentification and assessment of changin condition, Diabetic Management including monitoring of residents follow intervention implementation, and physician notification. Education included clarification of exist policy:	d ays g ling e ed f w ute or ian	
	A review of the initial					Beginning May 11, 2017 of the following - When a resident solood sugar read		
ORM CMS-256	7(02-99) Previous Versions Obs	olete	Event ID: Y3J211		Fac	ility ID: 953473 If continu	ation sheet	Page 35 of 81

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l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDII				С	
		345116	B. WING_			٠,	5/24/2017	
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	0/24/2017	
	1011211 011 001 1 21211				09 S HOLDEN ROAD			
STARMOU	INT HEALTH AND R	EHAB CENTER			REENSBORO, NC 27407			
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(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	Continued From p	page 35	f (309				
	·	evealed that Resident #2 was			on the glucometer, Residents will be			
		and required supervision with			re-assessed within 30 minutes to 1 ho	our		
		stance of one person with			following insulin administration and			
		iving (ADL), was independent			according to the physician □s orders.			
		dressing, was not steady but			-Physician □s Orders for sliding scale			
	_	vithout staff assistance and			insulin administration and blood suga			
	utilized a wheelch	air as a mobility device when			monitoring will include parameters for	•		
	needed. It also re	vealed that he was occasionally			physician notification.			
	incontinent of blad	dder and was continent of			- Identification of an obvious critical a	cute		
	bowel.				change in condition, and appropriate			
		dical Orders for Scope of			response and physician notification.			
	,	Γ) dated 3/18/17 revealed the			- Ensuring staff awareness that failu			
		anted the resident to be DNR			provide care and services, including v			
		suscitation), and comfort			to initiate EMS, can constitute resider	nt		
		ep clean and dry, do not transfer			neglect.	ordor		
	met in current loc	less comfort needs cannot be			 EMS will be imitated by physician and/or advanced directives. 	order		
		ation).			Licensed nursing staff, and agency			
	Δ review of the ca	are plan dated 05/03/17 revealed			licensed nursing staff will not be allow	red		
		Diabetes Mellitus with			to work until this training is complete.	cu		
		clude: observe/document the			to work arial and daming to complete.			
		current level of understanding			The Director of Nursing, Staff			
	· ·	process, diabetes medication			Development Coordinator and Nurse			
		ctor, observe/document for side			Managers have conducted training wi	th		
	effects and effecti	veness, Fasting Serum Blood			Certified Nursing Assistants beginning	9		
	sugar as ordered	by doctor, observe/			May 11, 2017 regarding reporting an			
		orn (as needed) any			observation of a resident□s change o	of		
		hyperglycemia; increased thirst			condition to the Nurse immediately.			
		uent urination, weight loss,			Nursing assistants will not be allowed	to		
		poor wound healing, muscle			work until this training is complete.			
		al pain, Kussmaul (deep and			TI D: ((N : 0: "			
	_	associated with diabetes)			The Director of Nursing, Staff			
	preatning, aceton	e breath, stupor and coma.			Development Coordinator and Nurse	with		
	A rovious of the	adical records rovested the			Managers have conducted education			
		edical records revealed the			Licensed Nursing staff and nurses aid on Abuse and Neglect Prevention on			
	following: A physician order	dated 02/28/17 at 6:32 AM read			22, 2017 including prompt response t			
		on 100 UNIT/ML, inject as per			resident⊟s change of condition.	•		
		BG) 150 - 210 = 1 (NovoLOG)			Beginning May 22nd, Licensed Nursi	าต		

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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 5/24/2017	
NAME OF P	ROVIDER OR SUPPLIER	0.0	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COL	•	5/24/2017	
TVAINE OF T	TO VIDER OR OUT FEET			109 S HOLDEN ROAD	<i>,</i> _		
STARMOL	INT HEALTH AND REHA	AB CENTER		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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 309	Continued From pag	e 36	F 30	09			
	390 = 4 units; 391 - 4 (physician) if CBG is subcutaneously befor DM." A physician order da "NovoLOGPen Fill S UNIT/ML, inject 4 un meals for DM." A physician order da read "ToujeoSolo Sta UNIT/ML, inject 12 u a day for DM." A Nursing Note dates	nits; 271 - 330 = 3 units; 331 - 450 = 5 units; notify MD greater than 450, are meals and at bedtime for ted 02/28/17 at 6:33 AM read olution Cartridge 100 its subcutaneously with ted 03/01/17 at 12:19 AM ar Solution Pen-injector 300 nit subcutaneously two times d 03/02/17 at 2:48 PM read M, insulin given per MD		staff, Certified Nursing Assist Agency Licensed nursing sta allowed to work until the train complete. This education al ensuring staff awareness tha provide care and services, in to initiate EMS, can constitute neglect. Beginning May 22, 2017 Lice staff and Agency Licensed nu will not be allowed to work ur training for Abuse and Negle including prompt response to change of condition is comple education also includes ensu awareness that failure to pro- services, including when to in	iff will not be ning is so included it failure to cluding when e resident ensed nursing ursing staff ntil the ct Prevention, o resident □s eted. This uring staff vide care and nitiate EMS,		
	A Nursing Note dated revealed CBG was 7 A Nursing Note dated revealed CBG was 7 was low for him. Review of Resident and order dated 03/06/17 order: 1. "Start Toujeo 24 u "Do not give 03/07/1	d 03/06/17 at 7:37 AM 11. d 03/06/17 at 8:16 AM 14. The resident stated that #2 handwritten physician 7 revealed the following new nits at bedtime on 03/07/16". 6 AM dose of 12 units. scale insulin) for patient		can constitute resident negle Licensed nursing staff will be education at least annually vide Director of Nursing or Reside Management Director. This is be included in the facility sration orientation and newly hired linursing staff will not be permassume their floor responsibilithey have completed this education. Resident #5 attending physic responsible party were notified of two questionable missed to	e provided this ia the ent Care education will new hire censed itted to dilities until ucation.		
	(resident) with meals units, 251-300=5 uni 351-400=9 units, 40 than 450 call MD.	151-200=2 units, 201-250=3		A member of nurse administr (Staff Development Coordina Director of Nursing and /or D Nursing) will review physiciar past thirty days of residents r	ration team ator, Assistant irector of n orders for		

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVI COMPLETED					
		345116	B. WING				24/2017
NAME OF PI	ROVIDER OR SUPPLIER	l	_	S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2-1/2011
				10	09 S HOLDEN ROAD		
STARMOL	INT HEALTH AND REHA	B CENTER	GREENSBORO, NC 27407				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	e 37) F	309			
	(MAR) 03/06/17 throu new SSI order of 3/6/	ngh 03/31/17 revealed the 17 was not transcribed on ribed Novolog SSI order			sliding scales per physician orders by 6/27/17 to validate correct sliding scale usage.	:	
	Novolog solution 100 scale: if 150-210=1 u 271-330=3 units, 331 units. Notify MD if CE	-390=4 units, 391-450=5 3G is greater than 450, re meals and at bedtime for			Facility audit will be completed of residents identified with physician orde for daily wound care to ensure that wound treatments were completed for past thirty days per orders by 6/27/17 the Director of Nursing and / Nurse Manager.	the	
	following CBG readin administered to Resid MAR date 03/06/17 a MAR date 03/06/17 a "8" was written which	dent #2:			Facility audit will be completed of treatment administration record for work care orders five times a week for one month then weekly times two months. Visual validation that daily wound care treatments occur will be conducted randomly three times a week to ensure completion of physician order.		
	conducted with Nurse Resident #2 on 3/6/11 glucose of 508 mg/dL confirmed that the res 508 and stated she re 20 units one time fror that she knew to plac medical records for in	7 and documented the blood . at 11:30 AM. The nurse sident blood glucose was eceived an order for Novolog in physician #1. She stated e a progress note in the atterventions related to high			Facility audit will be completed of residents identified with physician orde for sliding scale insulin to ensure that a readings above 600 (Hi) have physicial notification, reassessment and monitor five times a week for one month and weekly times two months. The facility licensed nurses will be	iny n	
	it that day. MAR date 03/06/17 a given instead of 5 uni MAR date 03/06/17 a given instead of 3 uni MAR date 03/07/17 a MAR date 03/07/17 a	t 4:30 PM, CBG 271, 3 units ts as ordered on 03/06/17 t 9:00 PM, CBG 220, 2 units ts as ordered on 03/06/17 t 6:30 AM, CBG 83. t 11:30 AM, CBG 180, 1 unit ts as ordered on 03/06/17			rne facility licensed nurses will be provided re-education regarding follow physician sorders regarding wound contreatment by the Staff Development Coordinator by 6/27/17 The Director of Nursing will report finding for audits to the Quality Assurance and Performance Improvement Committee monthly times three. Data will be	are	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	\ , ,	(X3) DATE SURVEY COMPLETED	
		345116	B. WING _			C 5/24/2017	
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP C 109 S HOLDEN ROAD GREENSBORO, NC 27407		<i>5/24/2511</i>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 309	given instead of 2 ur MAR date 03/07/17 given instead of 2 ur MAR date 03/08/17 "8" was written which note." No written prothe medical record. Review of the Nursin 5:37 AM revealed C documentation of slithe physician was not the note was not availed by the mass out of the convestigation. MAR date 03/09/17 given instead of 11 ur MAR date 03/10/17 given instead of 11 ur MAR date 03/10/17 units given instead of 7 ur MAR date 03/10/17 given instead of 7 ur MAR date 03/11/17 given instead of 2 ur MAR date 03/11/17 given instead of 2 ur MAR date 03/11/17 given instead of 7 ur MAR date 03/11/17 given instead of 2 ur MAR date 03/11/17 given instead of 7 ur MAR date 03/11/17	at 4:30 PM, CBG 206, 1 unit nits as ordered on 03/06/17 at 9:00 PM, CBG 209, 1 unit nits as ordered on 03/06/17 at 6:30 AM, CBG 570, Code n meant "other/see progress ogress note or order found in a Note dated 03/08/17 at BG was 570. There was no ding scale insulin given or if otified. The nurse that wrote hallable for interview because	F3	reviewed and analyzed for trends. The Quality Assura Performance Improvement evaluate the results and im additional interventions as ensure continued complian	ance and Committee will plement needed to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345116	B. WING		05/24/2017
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	1 00/2-72011
(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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION
F 309	MAR date 03/12/17 a given instead of 3 un MAR date 03/12/17 a given instead of 2 un MAR date 03/13/17 a given instead of 11 un MAR date 03/13/17 a given instead of 11 un MAR date 03/13/17 a units given instead of 03/06/17. An interview on 05/1 of Nursing (DON) and they did not know who 03/06/17 with the SS did not get placed on expectation that every physician's order she computer and confirm Review of the currend date of 3/21/17 reversible and confirm Re	at 6:30 AM, CBG 143. at 11:30 AM, CBG 68. at 4:30 PM, CBG 225, 2 units at 9:00 PM, CBG 158, 1 unit at 6:30 AM, CBG 436, 5 units at 6:30 AM, CBG 436, 5 units anits as ordered on 03/06/17 at 6:30 AM, CBG 254, 2 at 11:30 AM,	F 30	9	

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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				24/2017
	ROVIDER OR SUPPLIER	L		1	STREET ADDRESS, CITY, STATE, ZIP CODE 09 S HOLDEN ROAD GREENSBORO, NC 27407	1 03/	24/2017
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Review of the resider Administration Record range of CBG reading resident received insumonth of April 2017: 6:30 AM: CBG ranged Sliding scale insulin with during the month. 11:30 AM: CBG ranged Sliding scale insulin with during the month. 4:30 PM: CBG ranged Sliding scale insulin with during the month. 9:00 PM: CBG ranged Sliding scale insulin with during the month. 9:00 PM: CBG ranged Sliding scale insulin with during the month. Review of the Nursing the CBG was 530 at administered 11 units the nurse practitioner orders were given. Review of the Nursing revealed the resident morning, 284 at noon	tion Pen-injector 300 hit subcutaneously once a at's Medication d revealed the following gs and number of days the ulin per SSI order during the d from 43 - 450 mg/dL. vas administered 11 times and from 68 - 535 mg/dL. vas administered 18 times d from 67 - 450 mg/dL. vas administered 19 times and from 67 - 450 mg/dL. vas administered 19 times and from 67 - 450 mg/dL. vas administered 19 times and Note on 4/28/17 revealed and 30 AM. Nursing staff of sliding scale insulin and (NP) was notified. No new and Note dated 4/29/17 CBG was 200 in the and 397 in the evening. histered as ordered. No	F	309	,		
	Record revealed the freadings and number	nt's Medication Administrator following range of CBG of days the resident g the period of May 1-8,					

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 05/24/2017	
	ROVIDER OR SUPPLIER		<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	1 05/1	24/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE
F 309	Sliding scale insulin viduring the month. 11:30 AM: CBG range Sliding scale insulin viduring the month of Mid:30 PM: CBG range Sliding scale insulin viduring the month. 9:00 PM: CBG range Sliding scale insulin viduring the month of Mid:30 PM: CBG range Sliding scale insulin viduring the month of Mid:30 PM: CBG was sunresponsive and dia administered and CB minutes and it was 10 after the incident. Review of the progressive and the attributes and he attributes and he attributes and he attributes and responsive was alert and responsive mas alert and responsive mas no noted distressive on 5/10/17 at 4:55 PM: Were interviewed. Numanager/administration at MDS nurse. Nurse 5/8/17, three nurses of shift. The facility called come in and work on Resident #2 resided.	d from 96 - 375 mg/dL. vas administered 5 times ed from 64 - 400 mg/dL. vas administered 7 times May. d from 202 - 430 mg/dL. vas administered 7 times d from 114 - 320 mg/dL. vas administered 5 times May. ote dated 5/1/17 revealed the G. The resident was sphoretic. Glucagon was G was rechecked in 15 G. The resident ate lunch as notes dated 5/2/17 has increased participation tended social events. ote dated 5/2/17 revealed the sive with confusion. a whole with water. There s. M, Nurse #1 and Nurse #3 urse #1 was a unit ve nurse and Nurse #3 was #1 and Nurse #3 said on called in sick on the first ed Nurse #1 and Nurse #3 to	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		INSTRUCTION	(X3) DATE COMP	SURVEY
		345116	B. WING _				24/2017
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	,	•
STARMOL	JNT HEALTH AND REHA	B CENTER			S HOLDEN ROAD		
01711111100				GRE	ENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	e 42	F:	309			
1 309	Nurse #1 and Nurse : Hall. Resident #2 wa At 6:30 AM his blood given 11 units of insu scheduled units of insu scheduled units of insu glucose was 288, and sliding scale insulin a insulin with meals. He On 5/11/17 at 11:23 A conducted with NA #7 AM to 3 PM. She was responsible for Fresident was his usua during the last two mindependent with tolk and take himself to the morning of 5/8/17, he he said he felt like a 'usually wheeled himse well that morning and had a good appetite. were 4 to 6 aides on 10-12 residents. She any care that was not said it was very busy. A review of the Nursindated 5/8/17 at 9:25 15/8/17, Nurse #2 wall and noticed that the reproperly". His skin we blood glucose was che (a machine used to measure the gustered "HI" (the g	#3 manned the carts on 100 is doing okay on their shift. In glucose was 375. He was lin as sliding scale and 4 isulin. At noon time his blood of the was given 5 units of and 4 scheduled units of the was a brittle diabetic. AM, an interview was a the worked on 5/8/17 from worked on the 100 Hall and wesident #2's care. The sail self except he slept in fornings. Resident was eating and was able to stand the bathroom. On the shaved and showered and shiften the wheelchair. He ate will for lunch. He would not say if there was at provided, however, she and it was too much. In g Note, written by Nurse #2, PM, revealed at 4 PM on weed in Resident #2's room wesident was not responding as cool and clammy. His necked using a glucometer measure how much glucose the blood). The glucometer lucometer registered "HI"		309			
	Vital signs were chec	was more than 600 mg/dL.) ked and blood pressure was Physician #1 and she gave					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345116	B. WING		C 05/24/2017	
	ROVIDER OR SUPPLIER	B CENTER		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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 309	Zofran every 8 hours #2 checked the reside and the glucometer recalled Physician #2 a order to give 14 units resident's status did resident's status did resident's status did resident's status did resident was incontinent or remained lethargic. The notified of the resider send him to the hosp resident complained Resident was sent to were as follows: templood pressure was 9 respiration 20, O2 sand Review of the Emerg report revealed EMS 5/8/17. The EMS perblood glucometer. The resist surrounding but was person, time, and everevealed that through insulin coverage, the norm, which was aler without being letharginesident was hypoten resident's pupils were to light. Multiple attensuccess to administe A telephone interview #2 on 5/11/17 at 11:1 usually worked from 5/8/17, the facility cal	nits of Novolog and 4 mg of for nausea. At 7 PM, Nurse ent's blood glucose again egistered "HI." Nurse #2 and she received a verbal of Novolog and if the not get better then to send to t's condition did not improve. If bowel and bladder and the resident's family was nt's status and agreed to ital. 911 was called. The of an ache in his abdomen. The hospital. Vital signs perature 98.3 Fahrenheit, 98/46, heart beat 82/minute, turation 92%. The ency Medical Service (EMS) was called at 8:25 PM on resonnel checked the resident registered "HI" on their dent was not alert to alert to verbal stimuli to	F 30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345116	B. WING				24/2017
NAME OF P	ROVIDER OR SUPPLIER		1	STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				109 S I	HOLDEN ROAD		
STARMOL	JNT HEALTH AND RE	HAB CENTER		GREE	NSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	empty, tube feeding needed to flush feeded to flush feeded hind. One reside out so she had to around 4 PM, she The resident was him. He was lether and he had vomite the trash can. The wrong, he told her checked his vital solow and his blood glucometer so she notified him of the the "HI" blood glucometer so she notified him of the the "HI" blood glucometer so she notified him of the tresident 17 un nausea. The resident 17 un nausea. The resident tondition the medications. In urse to look at the resident condition incoming nurse very Nurse #2 checked registered HI. She and the physician scale insulin and to minutes and send improved. When shim, he had a bow was unusual for hi him up. Nurse #2 complete her tasks	tube feeding bags were ag pumps were going off, she eding tubes, and that put her lent had his feeding tube pulled put it back in. It was busy. At went to Resident #2's room. In bed which was unusual for argic. His speech was slurred as dried up on his face and in enurse asked him what was he was not feeling well. She igns. His blood pressure was sugar registered high on the called physician #1 and resident's condition, including cose, lethargy, nausea, slurred	F	309			

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 24/2017
NAME OF PI	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE	1 03/	27/2011
				109	S HOLDEN ROAD		
STARMOL	JNT HEALTH AND REHA	B CENTER		GREENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	wanted her to take on That took some time and forth. That also pure and forth. That also pure ended up not let PM. She said with all have enough time to When asked what preson the resident after at 4 PM, she said she washift report, stock the tube feeding, talk abocart of the other hall, needed to document She had been employ three months and she a physician order for with that. She said the administrative staff to unexpected came up A telephone interview at 3:01 PM with NA # resident from 3 PM to resident was usually was cognitively alert assistance. He can use the staff know of he aide stated that her adue to staffing. She is facility staff to figure of the staff to figure of t	ing from 3 PM to 6 PM ver the carts for two hall. discussing and going back but her behind. The other eaving until 15 minutes till 7 I of this going on, she did not take care of the resident. evented her from checking she gave him insulin around vas trying to get a change of medication cart, check on but taking over medication had to get Zofran and in residents' medical record. yed at the facility for only e did not know how to put in Zofran. So she needed help here was no extra	F	309	DEFICIENCY)		
	saw the resident. Sh on the resident. He w normal for him. She because she was bus residents. She did no	e did not see any vomiting vas asleep, which was did not go back any more sy taking care of other ot deliver his meal tray since or residents in the dining					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345116	B. WING		C 05/24/2017	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 309	conducted with NA resident on 5/8/17 fusually she worked But she was called early. She said that permanent assignment assignment wherever was need the resident rooms shift, she saw the rehim how he was feeling well. She sat the meal tray was nhim if he was going he did not feel well he wanted unsweet went and told the nicleaned the resident The nurse called El to the hospital. The wheelchair and more came to the facility unusual for him. An interview with Nicevealed she usuall She stated, on average which was a manage different with a lot of a lot of staff assignment started that day and where they worked.	AM, a telephone interview was #2 who provided care to the from 7 PM to 7 AM. She said from 11 PM through 7 AM. that day on 5/8/17 to come to usually she did not have a ment but she was assigned led. On 5/8/17, she went to hortly after she started her esident mumbling. She asked leling, he told her he was not id he usually fed himself but not touched. When she asked to eat his dinner, he told her and he did not want to eat but lened tea. The aide said she lurse, then she came back and at from a bowel movement. WS and the resident was sent to resident usually was up in his lying around. But when she he was in bed which was A #4 on 5/12/17 at 12:35 PM y worked from 3 PM -11 PM. Tage, she had 12-14 residents geable load. On 5/8/17, it was if things going on. There were ment changes. New staff if they were confused about. There were one new nurse was not familiar with the	F 309			
	residents on the ha work with the reside He was in bed and	II. NA #4 stated she did not ent. She just took him his tray. he told her he did not feel like d not eat. It was around 6 or				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345116	B. WING			C 05/24/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407		03/24/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 309	not eat. The nurse so On 5/11/17 at 5:15 P interviewed. The phyhad a history of being because of high blood diabetic (the person extreme swings in blood extreme swings in blood shown the 5/8/17 Nu #2 regarding the resist The physician stated called on 5/8/17 abount remember giving insulin. The physician She said if they calle resident had vomiting and blood glucose rehave sent the resident because the nursing resident in that condit this statement more physician said "no wapatient without intravisaid she reviewed the and his blood glucos hospital and he died An interview was con AM with the nurse proders were written of and they should be for Review of the hospital department (ED) data test results from the collected on 5/8/17 at	ed to the nurse that he would aid okay. M, Physician #1 was vician stated the resident ground unconscious drouglucose. He was a brittle experiences frequent, and glucose levels). The physician was ring Note written by Nurse dent's change in condition. She did not remember being at this resident and she did the order for 17 units of an said "I was never called." If the rand told her the graph state of the physician repeated than one time. The graph I would not manage the tion. The physician repeated than one time. The graph I would have kept the enous fluids." The physician reresident's hospital record the was 1123 mg/dL at the of myocardial infarction. Inducted on 05/12/17 at 10:44 actitioner (NP), she stated on the physician order sheet collowed by the facility. The mergency room and the state of the sample of 5/8/17 revealed laboratory resident's urine sample to 10:44 PM were as follows: ose was more than 1000	F3	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345116	B. WING			C 05/24/2017	
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, Z 109 S HOLDEN ROAD GREENSBORO, NC 27407	(IP CODE	39/2 11/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	-	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 309	Continued From page	e 48	F:	309			
	The urine ketones warrange was negative).	as 15 mg/dL (reference					
	The ED laboratory tenton 5/8/17 at 11:43 PM	st results of blood collected // were as follows:					
	resident's heart rate wand blood pressure wand blood pressure wand having agonal (abnor brainstem reflex charalbored breathing, activocalizations) breathing still resident was lying still The resident died on The administrator wand jeopardy on 5/11/17 at The administrator pro-	d on 5/9/17 at 12:50 AM, the was at 27 beats per minute was 48/38. The resident was mal pattern of breathing and acterized by gasping, companied by strange ng 4-5 times a minute. The ll with pale skin color. 5/8/17 at 12:55 AM. s notified of the immediate					
	Residents identified t deficient practice.	o be affected by the alleged					
	responding as usual. clammy. His Blood gread "HI" with no valumanufacturer insert for that a reading of "HI" value of greater than was notified and order administer 17 units or Zofran 4 mg every 6 At approximately 4:30	d noticed that he was not His skin was cool and lucose was checked and lucose on the monitor. The lor this glucometer stated indicated a blood glucose 600 mg/dL. The Physician lers were received to f Novolog one time and hours for nausea. D PM NA#3 entered room to 2 who was resting in bed					

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345116	B. WING _			C 05/24/2017	
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407		33/24/2017	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	Resident #2 his dinn he was not feeling go NA#4 stated this was Resident #2 remains set up. At 7:00 PM, Nurse # blood sugar and it ag notified the Physician administer 14 units of	e:30 PM, NA #4 delivered er tray. Resident #2 reported cod and didn't want to eat. es then reported to Nurse #2. ed in the bed and the tray was 2 rechecked the resident gain read "HI". Nurse #2 en and received orders to en Novolog and instructions to	F3	09			
	status did not improvof bowel and bladder Resident complained Family was notified called at 8:25 PM, ar hospital at 9:26 PM. The nurse reported at the resident more free insulin administration reading with nausea and that she did not	ital if not improved. Resident ve. Resident was incontinent or and remained lethargic. It of an ache in his abdomen. It of resident status, 911 was not resident arrived at the she was too busy to check on equently to reassess following on for a "HI" blood sugar and a low blood pressure communicate with a las not able to recheck on the					
	the Director of Nursin Coordinator regarding identification and assemincluding, managemincluding monitoring intervention implementation. Residents with the publication of the public deficient practice.	ed education on 5/12/17 from any and Staff Development go the facility policy for sessment of changes in ent of residents with diabetes of residents following entation, and physician otential to be affected by the ctice.					
		anges in condition have the ed by the alleged deficient					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	03/24/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 309	Nurse Managers or diabetic residents win condition related the last 30 days and documentation to viassessment has be interventions were intervention in the Director of Nurconducted acute chart assessments of have been assessed as ordered or care physician was notified. The Director of Nurconducted training beginning May 11, it existing policy for iconformation of changes in conditioning monitoring intervention implementation. Education included - When a resident's glucometer, Reside 30 minutes to 1 hou administration and include parameters administration and include parametersPhysician's Orders administration of Nurconditions in the Director of Nurconditions in the Director of Nurconditions.	7, the Director of Nursing and onducted an audit of current who have had an acute change to high blood glucose levels in direviewed their corresponding alidate that a nursing en completed and implemented according to the and the care plan. Sector of Nursing and Nurse withose residents who have inges in condition to assure or observations of symptoms direventions were initiated planned, and the attending ed. Sing, Staff Development in the intervention and assessment toon, Diabetic Management of of residents following itentation, and physician clarification of existing policy: blood sugar read HI on the ints will be re-assessed within	F 30		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	COMPLETE	(X3) DATE SURVEY COMPLETED		
		345116	B. WING		05/24/2	047	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	03/24/2	017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COM	(X5) MPLETION DATE	
F 309	reporting an observation condition to the Nursian Condition to the Nursian Beginning May 12, 2 and Agency Licensed allowed to work until Licensed nursing state ducation at least an Nursing or Resident This education will be hire orientation and restaff will not be permited their orientation. Date of Immediate Jegonate of Immediate Jegonate was valid implemented their content of the immediate jeopate evidence of an audit insulin dependent dia had an acute change blood glucose levels facility reviewed their documentation to values assessment has been interventions were in of diabetic residents they received care to ordered by the physical evidence of inservice how to manage diabetic residents.	ith Certified Nursing May 11, 2017 regarding tion of a resident's change of e. 017 Licensed nursing staff d nursing staff will not be the training is completed. If will be provided this mually via the Director of Care Management Director. In included in the facility's new newly hired licensed nursing itted to assume their floor they have completed this In it will be provided allegation of dated to ensure the facility prective actions to remove redy. The facility provided on 5/12/17, of current abetic residents who have en in condition related to high in the last 30 days. The r corresponding lidate that a nursing	F 3	09			

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(X3) DATE SURVEY COMPLETED		
		345116	B. WING		C 05/24/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	1 03/24/2017	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 309	Continued From pa	nge 52	F 30	09		
	re-entered the facil diagnoses included Hyperglycemia, An Major Depressive I Hypertension, Hyperglycome, Venous Peripheral, Muscle of Diabetic Foot Uld Review of the most dated 03/06/17 door venous, arterial, and Cognition was documented assist for hygiene and toilet ure for dressing and baindicated that he didinterventions on 05 dressings per order monitor intake, assonands and prn, programmer of the wound Physician orders or integrity included: 1. Decubi-Vite Carlo Ensure air mat with setting locked and prn, programmer of the wound programmer of the	erlipidemia, Chronic Pain Insufficiency Chronic Spasms and Personal History cer. recent MDS Assessment cumented that the resident had id diabetic foot ulcers. cumented as intact. He was rebed mobility, personal cuse. He was totally dependent of thing. The assessment id not walk. The care plan recomplete labs as ordered, complete labs as ordered, care doctor as scheduled. appule (2) daily custress is functioning properly at 5 every shift free liquid 30cc twice daily felf foot with Normal Saline, culfa Cream 1%, apply 4 x 4, culting interest as totally continued to supply continued to skin continued				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345116	B. WING _			C 05/24/2017
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	•	00/2-4/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	7. Apply Hydrocol venous wound every Review of the most progress notes date there was no chang progress for the (2) wounds on that date that the measureme remained the same. An observation on that the dressing on extremity of Resider The surveyor was u because the resider was medicated for pure In an interview with PM she revealed that 05/08/17 and 05/09/09/09/17. In an interview with edoing the dressing of agreed that the dress and the wounds were under the wounds were under the worked together on shift. They both state to the second shift in an interview with 11:20 AM she reveal.	shift for skin alteration loid to left heel Stage 2 by 3 days recent wound care specialist do 04/28/17 documented that in the wound healing arterial and (1) venous in the recent wounds have since 3/31/17. 15/10/17 at 4:45 PM revealed the left foot and left lower in the word wound care in the wound the left foot and left lower in the word wound care in the word word word word word word word word	F3	309		
	resident #5 on 05/08	3/17 from 3:00 PM to 11:00 t she did not get report when				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 11 2012211			С	
		345116	B. WING		05	/24/2017	
	ROVIDER OR SUPPLIER	B CENTER		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 CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309 F 314 SS=D	treatments on her shirmuch to do. She said caring for forty-two re she was relieved by a In an interview with the 05/12/17 at 5:00 PM s	said she did not do the ft because she had too If for part of the shift she was sidents until 11:00 PM when In Agency Nurse. The Director of Nursing on She stated that she expected done as ordered by the		314		6/27/17	
	facility must ensure the facility must ensure	ssment of a resident, the nat- scare, consistent with soft practice, to prevent loes not develop pressure vidual's clinical condition by were unavoidable; and essure ulcers receives and services, consistent with soft practice, to promote tion and prevent new ulcers is not met as evidenced ons, staff interviews and		Resident #4 attending physician responsible party were notified on of two questionable treatments m Facility audit will be completed of residents identified with physician	n 5/10/17 issed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345116	B. WING			C 05/24/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				1	09 S HOLDEN ROAD		
STARMOL	INT HEALTH AND REHA	B CENTER		G	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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 314	Findings include: Record review shows the facility on 01/3/17 included Cerebral Inf. Disorder, Cerebral Va Hyperlipidemia, Alcol Induced Mood Disord Depression, Peripher Cardiac Arrest, Resis Vitamin B12 Deficien Infection, Wound Bot Dysphagia and Epilel Review of the care pl that the resident had hip and her right heel apply dressings per cordered, monitor intal reposition on rounds supplements as orde doctor as scheduled. dated 4/10/17 indicat facility acquired Stagpressure reducing de and nutrition and hyd manage skin problem	s that resident #4 re-entered C. Current diagnoses arction, Dementia, Mood ascular Accident, nol Abuse with Alcohol der, Hypertension, Major ral Vascular Disease, stance to Vancomycin, cy Anemia, Urinary Tract ulism, Pressure Ulcer (Hip), psy. an on 05/10/17 documented a pressure area to her right Interventions included to orders, complete labs as ke, assist to turn and and prn, provide red, and see the wound care The most recent MDS ed the resident had (2) e 4 pressure ulcers, vices for her chair and bed, ration intervention to ns. Cognition was intact.		314		ne by am for br ths.	DATE
	 Apply to right hip to moist dressing twice Apply Santyl Oin every day shift Multivitamin one 	tment to right heel topically tab daily ounces at lunch and dinner			additional interventions as needed to ensure continued compliance.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345116	B. WING		05/24/2017		
	ROVIDER OR SUPPLIER JNT HEALTH AND REH	IAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	03/24/2017		
(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 CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR	BE COMPLETION		
F 314	6. House 2.0 Med 7. Geri-Sleeves to Review of the most progress notes date there was no change for either wound on revealed that both whave improved. Wound care for resi 05/10/17 at 2:40 PM Nurse #6. Proper handoning was observed. It was observed from the Swas dated 05/07/17 malodorous with a lexudate present. Twound was reddene with gauze soaked covered with a dry ophysician. Nurse # dressing from the reducer on her right hand dated 05/07/17. It was detected to the wound was white applied to the wound properly. In an interview with PM she revealed the 05/08/17 and 05/09 nurses working the doing the dressing agreed that the dresand the wounds we	Pass 120cc three times daily	F 314	4			

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	B. WING		1	C 24/2017
	ROVIDER OR SUPPLIER	B CENTER		109 S HOLDEN	ESS, CITY, STATE, ZIP CODE N ROAD RO, NC 27407		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 353 SS=J	wounds were not treat 05/09/17. In an interview with NPM she stated that shon 05/09/17 during the the day had been verifirst priority was to ke give out the medicine had looked at the dresure everything was into do the treatments of the revealed that it was hear treatments but that the during the day shift to the treatments to be on the treatments and the treatments to be on the treatments to be on the treatments and the treatments and the treatments and and the treatments and considering the resident assessments and considering the rediagnoses of the facility accordance with	durse #7 on 05/11/17 at 2:30 the had care for resident #4 the day shift. She said that the y busy. She stated that her the ep the residents safe and the sissings on wounds to make that but did not have time ton her assignment. She there intention to do the there was too much going on the get everything done. The Director of Nursing on the stated that she expected done as ordered by the FICIENT 24-HR NURSING THANS THANS THANS THE STITE STATE TO THE STATE THE TH		314			6/27/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345116	B. WING _		05/24/2017		
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	1 00/24/2017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
F 353	(Phase 2)] (a) Sufficient Staff. (a)(1) The facility m sufficient numbers of personnel on a 2 nursing care to all resident care plans: (i) Except when waithis section, license (ii) Other nursing pelimited to nurse aide (a)(2) Except when this section, the facture to serve as a duty. (a)(3) The facility m nurses have the spessets necessary to certain sufficient section.	ginning November 28, 2017 ust provide services by of each of the following types 4-hour basis to provide esidents in accordance with ved under paragraph (e) of d nurses; and	F 3				
	assessing, evaluating resident care plans needs. This REQUIREMENT by: Based on observating interview, Nurse Prophysician interview, sufficient staffing to including emergence.	e includes but is not limited to ng, planning and implementing and responding to resident's IT is not met as evidenced ions, record review, staff actitioner (NP) interview and the facility failed to provide deliver care and services, y medical services (EMS), to nt brittle diabetic who was		Nurse #2 has received education 5/from the Director of Nursing and Staf Development Coordinator regarding facility policy for identification and assessment of changes in condition, management of residents with diabet	the		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED			
			A. BOILDI			١,	С	
		345116	B. WING			1	24/2017	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
STADMOL	JNT HEALTH AND REHA	D CENTED		1	09 S HOLDEN ROAD			
STARWOO	INT REALTH AND REHA	AD CENTER		G	REENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 353	above 600 mg/dL (misymptoms of distress diabetic residents (Rowas sent to the hospineart attack. The facts staffing to provide work Resident #4 and Resident #	ry blood glucose (CBG)	F	353	including monitoring of residents follow intervention implementation, and physician notification. Nurse #2 is no longer an employee and will not receive ducation about initiating EMS. All residents have the potential to be affected by the alleged deficient practic The Administrator and Director of Nurshave reviewed the schedule for the needays ending 5/19/17 to validate dedica Nursing Supervision is scheduled for a shifts each day including the weekend. Nursing Supervision includes the Director of Nursing, Assistant Director of Nursing Staff Development Coordinator, Unit Manager or Shift Supervisor.	e ce. ing kt 7 ted II 3		
	and unusual bowel in immediately initiated to assess the resider was removed on 5/23 provided an acceptate compliance. The facilicompliance at a scopactual harm with the minimal harm that is the facility to complet monitoring systems partner facility is also ou scope and severity for # 5. This tag was cro F309 and F314. Findings included: 1. Cross referenced	and nursing did not continue of the and nursing did not continue of the art. The immediate jeopardy is 3/17 when the facility on the credible allegation of lity will remain out of the and severity level of D (not potential for more than not immediate jeopardy) for the staff training and to ensure out into place are effective. It of compliance at the D or Resident #4 and Resident sereferenced to tags F224,			The Administrator has secured contract with multiple staffing agencies since December of 2016 to fill staffing needs required. The Administrator and Direct of Nursing have the authority to contact the staffing agency to fill vacant shift of Licensed Nurses and Certified Nursing Assistants. The Nursing Supervisor winotify the Administrator or Director of Nursing of a staffing need and authority contact the staffing agency to fill vacancies may be delegated to the Nursing Supervisor at the discretion of Administrator or Director of Nursing. The Administrator and Director of Nurs with the Interdisciplinary Team including input from Nursing Staff completed a reause analysis regarding coverage for vacant shifts a utilizing Agency staff,	s as tor t t ur II y to the ing		
	· ·	he facility neglected a			offering shift horuses to current staff a	nd		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345116	B. WING _				24/2017
NAME OF PR	ROVIDER OR SUPPLIER	I .		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2-7/2011
				10	09 S HOLDEN ROAD		
STARMOU	INT HEALTH AND REH	AB CENTER			GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	Continued From pag		FS	353			
	sliding scale insulin (reassessing an insuling resident that had a concept (CBG) above 600 mg resident was also should be pressure, unus vomiting. The facility medical services (EM became in distress. diabetic residents (Rowas sent to the hospite heart attack. The facility mot providing wound residents who were stated.	ving physician orders for (SSI), by not monitoring and in dependent brittle diabetic ritical capillary blood glucose g/dL (milligram/deciliter). The owing signs of lethargy, low sual bowel incontinence, and failed to initiate emergency MS) for the resident when he This was evident in 1 of 3 resident #2). The resident wital and shortly died of a cility neglected residents by care for two days for 2 of 3 supposed to have daily ed by the physician (Resident			scheduling dedicated Nursing Supervision daily for all shifts by May 12, 2017. Bay on this review it was determined that multiple Nurses had called out for 3 shon May 8, 2017 requiring Administrative Nursing staff to cover these shifts and therefore reducing the amount of availating Supervision. The Administrator and Director of Nursing Supervision is schedule for the new days ending 5/19/17 to validate dedication Nursing Supervision is scheduled for a shifts each day including the weekend. The Administrator and Director of Nursing and Certified Nursing Assistant staffing and scheduling for each day to ensure adequate coverage to include	ifts e able ing xt 7 tted II 3 ing	
	Nurse Practitioner (Ninterview, the facility orders for sliding scareassess an insulin or resident that had a co (CBG) above 600 my resident was also should be pressure, unus vomiting. The facility medical services (EM became in distress. diabetic residents (Rivas sent to the hospineart attack. The facility authors of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care for two days for supposed to have desired as a simple of the care f	review, staff interview, IP) interview and physician failed to follow physician ale insulin (SSI), monitor and dependent brittle diabetic ritical capillary blood glucose g/dL (milligram/deciliter). The owing signs of lethargy, low sual bowel incontinence, and y failed to initiate emergency MS) for the resident when he This was evident in 1 of 3 resident #2). The resident oital and shortly died of a cility failed to provide wound Resident #5 who was aily treatments as ordered by			dedicated Supervisor for each shift. Al attempts to assign familiar caregivers to maintain continuity of care for high risk residents will be discussed during this meeting. The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Licensed Nurses beginning May 11, 20 in the event the Nursing Supervisor is required to move to a resident care assignment as a result of a staffing shortage the Administrator and Director Nursing will be notified immediately to make further staffing adjustments as necessary. If a Nurse is feeling overwhelmed with completing the tasks due on their current assignment the Nurse is feeling to the staffing adjustment the Nurse is feeling overwhelmed with completing the tasks and the staffing adjustment the Nurse is feeling overwhelmed with completing the tasks and the staffing adjustment the Nurse is feeling overwhelmed with completing the tasks and the staffing adjustment the Nurse is feeling overwhelmed with completing the tasks and the staffing adjustment the Nurse is feeling overwhelmed with completing the tasks and the staffing adjustment the Nurse is feeling overwhelmed with completing the tasks and the staffing adjustment the Nurse is feeling overwhelmed with completing the tasks and the staffing adjustment the Nurse is feeling overwhelmed with completing the tasks and the staffing and	n D17,	
	wounds.	f 1 sampled residents with			will report to the Supervisor for	ırse	

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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				24/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	24/2017
					9 S HOLDEN ROAD		
STARMOL	JNT HEALTH AND REHA	B CENTER			REENSBORO, NC 27407		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	Continued From page 3.Cross referenced a observations, staff interest the facility failed to provide the facility failed to fail failed the facility failed the facility failed the facility failed the failed	t F314: Based on rerviews and record review, ovide pressure ulcer care for a sordered by the physician sidents with pressure ulcers s notified of the immediate at 5:00 PM. rvided the following credible are effective 5/12/17 at 6:30 be affected by the alleged Nurse #2 went into do noticed that he was not his skin was cool and lucose was checked and lee on the monitor. The por this glucometer stated indicated a blood glucose 600 mg/dL. The Physician are were received to followed notice and the same and	F:	353		be sing f g ng r. ly ed	DATE
	Resident #2 his dinner he was not feeling go NA#4 stated this was Resident #2 remainer set up.	30 PM, NA #4 delivered er tray. Resident #2 reported od and didn't want to eat. then reported to Nurse #2. d in the bed and the tray was			Physician S Orders and the care plan, including emergency medical services initiated immediately as directed by physician completed May 12, 2017. Beginning May 12, 2017 the Director or Nursing and Nurse Managers will revie those residents who have exhibited act	f w	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY MPLETED
		345116	B. WING			C 5/24/2017
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		3/24/2017
	10110211 011 001 1 21211			109 S HOLDEN ROAD	<i></i>	
STARMOL	INT HEALTH AND REHA	AB CENTER		GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 353	Continued From pag	e 62	F 3	53		
	blood sugar and it ag notified the Physician administer 14 units of transport to the hosp status did not improve of bowel and bladder Resident complained Family was notified of called at 8:25 PM, and hospital at 9:26 PM. The nurse reported so the resident more free insulin administration reading with nausea and that she did not	gain read "HI". Nurse #2 n and received orders to of Novolog and instructions to ital if not improved. Resident re. Resident was incontinent rand remained lethargic. If of an ache in his abdomen. of resident status, 911 was ond resident arrived at the she was too busy to check on requently to reassess following of or a "HI" blood sugar and a low blood pressure		changes in condition to assist assessments or observation symptoms have been assess interventions were initiated care planned, and the attent was notified. The Director of Nursing, State Development Coordinator at Managers have conducted at Licensed Nurses beginning regarding the facility' sexist identification and assessment in condition, Diabetic Managericluding monitoring of resident intervention implementation physician notification. Education included clarifications	ns of ssed, as ordered or ding physician aff and Nurse training with May 11, 2017 sting policy for ent of changes gement dents following and	
	the Director of Nursin Coordinator regardin identification and assecondition, managemincluding monitoring intervention implementification. Residents with the palleged deficient practal deficient practal deficient and Director of Nursing Scheduled for all 3 sliveekend. Nursing Scheduled for Nursing Scheduled for Nursing Scheduled for all 3 sliveekend. Nursing Scheduled for Nursing Scheduled fo	e potential to be affected by practice. The Administrator ng have reviewed the t 7 days ending 5/19/17 to		policy: Beginning May 11, 2017 of - When a resident s blood on the glucometer, Residen re-assessed within 30 minu following insulin administrat according to the physician -Physician S Orders for slic insulin administration and b monitoring will include para physician notification Identification of an obviou change in condition, and ap response and physician not - Ensuring staff awarenes provide care and services, i to initiate EMS, can constitu neglect EMS will be imitated by and/or advanced directives.	sugar read HI Its will be Ites to 1 hour Ites of the state of the stat	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		24544.0	B. WING				С
NAME OF B	201/1252 02 01 1251 155	345116	B. WING _		TDEET ADDRESS SITV STATE TIP SODE	05/	24/2017
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STARMOL	INT HEALTH AND REHA	AB CENTER			09 S HOLDEN ROAD		
				G	REENSBORO, NC 27407		
(X4) ID PREFIX TAG			ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	Continued From page	e 63	F3	353			
	Shift Supervisor.				Licensed nursing staff, and agency licensed nursing staff will not be allowed	ed	
		r has secured contracts with ncies since December of			to work until this training is complete.		
		eeds as required. The			The Director of Nursing, Staff		
	Administrator and Dir	rector of Nursing have the			Development Coordinator and Nurse		
	authority to contact the	ne staffing agency to fill			Managers have conducted training with	1	
		sed Nurses and Certified			Certified Nursing Assistants beginning		
		The Nursing Supervisor will			May 11, 2017 regarding reporting an		
		or or Director of Nursing of a			observation of a resident □s change of		
		thority to contact the staffing			condition to the Nurse immediately.		
		es may be delegated to the t the discretion of the			Nursing assistants will not be allowed to work until this training is complete.	O	
	Administrator or Dire				work until this training is complete.		
	Administrator or Dire	otor or rearring.			The Director of Nursing, Staff		
	The Administrator an	d Director of Nursing with			Development Coordinator and Nurse		
		eam including input from			Managers have conducted education v	vith	
		eted a root cause analysis			Licensed Nursing staff and nurses aide		
	regarding coverage f	or vacant shifts a utilizing			on Abuse and Neglect Prevention on M	lay	
		shift bonuses to current			22, 2017 including prompt response to		
	staff and scheduling				resident□s change of condition.		
		all shifts by May 12, 2017.			Beginning May 22nd, Licensed Nursing	-	
		it was determined that			staff, nurses□ aides and Agency Licen		
		called out for 3 shifts on May			nursing staff will not be allowed to work	(
		ministrative Nursing staff to			until the training is complete. This		
		d therefore reducing the			education also included ensuring staff	and	
	amount of available N	nursing Supervision.			awareness that failure to provide care		
	The Administrator an	d Director of Nursing have			services, including when to initiate EMS can constitute resident neglect.	٥,	
		le for the next 7 days ending			can constitute resident neglect.		
		edicated Nursing Supervision			Beginning May 22, 2017 Licensed nurs	sina	
		shifts each day including the			staff and Agency Licensed nursing staf		
		nistrator and Director of			will not be allowed to work until the		
		a daily meeting to review			training for Abuse and Neglect Prevent	ion,	
	_	Nursing Assistant staffing			including prompt response to resident		
		ach day to ensure adequate			change of condition is completed. This		
		a dedicated Supervisor for			education also includes ensuring staff		
	each shift. All attemp				awareness that failure to provide care	and	
	caregivers to maintai	n continuity of care for high			services, including when to initiate EM	3,	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG		С	
		345116	B. WING			1	24/2017
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STADMOL	JNT HEALTH AND REH	AD CENTED		10	09 S HOLDEN ROAD		
STARWOO	ONT REALITIAND RED.	AB CENTER		G	REENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	meeting. The Director of Nurs Coordinator and Nur conducted training v beginning May 11, 2 Supervisor is require assignment as a res Administrator and D notified immediately adjustments as nece overwhelmed with coverwhelmed with conversion the Supervisor for as Nursing Supervisor assignment the Director of Nursing Supervisor of Superviso	sing, Staff Development rese Managers have with Licensed Nurses 1017, in the event the Nursing and to move to a resident care sult of a staffing shortage the irector of Nursing will be to make further staffing essary. If a Nurse is feeling completing the tasks due on ment the Nurse will report to sesistance. In the event the	F	3353	can constitute resident neglect. License nursing staff will be provided this education at least annually via the Director of Nursing or Resident Care Management Director. This education be included in the facility s new hire orientation and newly hired licensed nursing staff will not be permitted to assume their floor responsibilities until they have completed this education. Resident #2 no longer resides at the facility. Resident #4 attending physician and responsible party were notified on 5/10 of two questionable missed treatments	will	
	and Agency License allowed to work until Licensed nursing stated education at least at Nursing or Resident This education will be hire orientation and staff will not be perm responsibilities until education On 5/12/17 at 6:30 From compliance was valify implemented their content implemented their content immediate jeopate evidence of an audit insulin dependent dinad an acute change.	2017 Licensed nursing staff and nursing staff will not be the training is completed. The training is completed this annually via the Director of Care Management Director. The included in the facility's new newly hired licensed nursing nitted to assume their floor they have completed this assume the facility provided to ensure the facility prective actions to remove and the facility provided to			Resident #5 attending physician and responsible party were notified on 5/10 of two questionable missed treatments A member of nurse administration team (Staff Development Coordinator, Assist Director of Nursing and /or Director of Nursing) will review physician orders for past thirty days of residents identified receiving sliding scales per physician orders to validate by 6/27/17. Facility audit will be completed of residents identified with physician order for daily wound care to ensure that wound treatment were completed for the past thirty days per orders by 6/27/17 by the Director of Nursing and / Nurse Manager. A member of nurse administration team	n tant rr rs ne	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345116	B. WING _			C 05/24/2017	
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP (109 S HOLDEN ROAD GREENSBORO, NC 27407	CODE	00/2 //20 //	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD			
F 353	diabetic residents we they received care to ordered by the physic evidence of inservice how to manage diabe sufficient staffing. Th	corresponding date that a nursing n completed and plemented. Record of re reviewed to ensure that manage diabetes as sian. The facility provided training to nursing staff on etic residents and regarding is was validated by s and nursing assistants.		(Staff Development Coord Director of Nursing and /or Nursing) will review treatmoresidents identified with doorders to ensure that treat completed five times a we month then weekly times to the Amember of nurse adminion (Staff development coording Director of Nursing and /or Nursing) will review new proming previous day to ensure transcribed correctly for five for one month and weekly months. Facility audit will be complete treatment administration recare orders five times a weard month then weekly times to Visual validation that daily treatments occur will be consumed the times and we completion of physician or facility audit will be complete to of physician or sidents identified with properties and the physical properties will be audited there was not a delay in infive times a week for one in the physical properties and properties and physical properties and properties are properties and properties and properties and properties are properties and properties and properties and properties and properties are properties and properties and properties and properties are properties and properties and properties and properties and properties and properties are properties and properties are properties and properties a	r Director of pent record for would be pent record of pent record for would be pent record for pent recor	re n ant ers ek and or	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245446	B. WING			С	
		345116	B. WING_			05/	24/2017
	ROVIDER OR SUPPLIER JNT HEALTH AND REHA	B CENTER		10	REET ADDRESS, CITY, STATE, ZIP CODE 9 S HOLDEN ROAD REENSBORO, NC 27407		
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	483.45(c)(1)(3)-(5) DEREPORT IRREGULA c) Drug Regimen Rev (1) The drug regimen reviewed at least once pharmacist. (3) A psychotropic drubrain activities associ and behavior. These	RUG REGIMEN REVIEW, R, ACT ON		428	Administrator/Director of Nursing and / Nurse Management will review the schedule for seven days forward for fivilidays a week for one month then weekly times two months to ensure sufficient staffing and supervision. The facility licensed nurses will be provided re-education regarding follow physician orders regarding wound care treatment by the Staff Development Coordinator by 6/27/17. The Director of Nursing will report finding audits to the Quality Assurance and Performance Improvement Committee monthly times three. Data will be reviewed and analyzed for patterns and trends. The Quality Assurance and Performance Improvement Committee evaluate the results and implement additional interventions as needed to ensure continued compliance.	e y ing ngs	6/27/17

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345116	B. WING			C 05/24/2017	
	ROVIDER OR SUPPLIER		-	1	STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	<u> 05//</u>	24/2017
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	to the attending physical direct and these reports multiple in the control of the	aust report any irregularities ician and the ctor and director of nursing, st be acted upon. Ie, but are not limited to, any riteria set forth in paragraph an unnecessary drug. Inoted by the pharmacist st be documented on a cort that is sent to the not the facility's medical of nursing and lists, at a cut's name, the relevant drug, e pharmacist identified. It is in the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in I record. It is emonthly drug regimen ut are not limited to, time and tesps in the process and must take when he or she ity that requires urgent action	F	428			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345116	B. WING			1	C
NAME OF D	ROVIDER OR SUPPLIER	040110		ST.	REET ADDRESS, CITY, STATE, ZIP CODE	05/	24/2017
NAME OF T	NOVIDEN ON 3011 LIEN				9 S HOLDEN ROAD		
STARMOL	JNT HEALTH AND RE	HAB CENTER					
				GI	REENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 428	Continued From p	age 68	F 4	428			
		review, staff interview and			Resident #2 no longer resides in the		
		acist interview, the consultant			facility		
	1	to report to the facility that					
		or sliding scale insulin (SSI) for			A member of nurse administration tear	n	
	• •	ent brittle diabetic resident.			(Staff Development Coordinator, Assis	tant	
	This was evident in	n 1 of 3 diabetic residents			Director of Nursing and /or Director of		
	(Resident #2.)				Nursing) will review physician orders for	or	
					past thirty days of resident identified w	ith	
	Findings included:				capillary blood glucose monitoring, to		
					ensure that the resident receiving sliding	•	
		s admitted to the facility on			scales per physician orders by 6/27/17		
	_	noses including Type I			The Director of Nursing will provide re-		
	Disease.	(DM) with Chronic Kidney			The Director of Nursing will provide re- education to the facility consulting		
	Disease.				regarding documentation of residents		
	A review of the me	edical records revealed			identified with physician orders for slidi	na	
		notes, CBG level order changes			scale insulin on the consultant review	9	
	and insulin regime				record, to include any recommendation	1	
		dated 02/28/17 at 6:32 AM read			and no changes to current sliding scale		
	"NovoLOG Solutio	on 100 UNIT/ML, inject as per			regiment by 6/27/17.		
	,	BG) 150 - 210 = 1 (NovoLOG)					
		units; 271 - 330 = 3 units; 331 -			The Director of Nursing or Assistant		
	1	- 450 = 5 units; notify MD			Director of Nursing will review resident	s	
		is greater than 450,			identified with sliding scale insulin with		
	_	efore meals and at bedtime for			consulting pharmacist monthly, to ens		
	DM."				review has been completed by pharma monthly times three months.	CIST	
	Review of Resider	nt #2 handwritten physician			,		
		/17 revealed the following new			The Director of Nursing will report findi	ngs	
	order:	-			of audits to the Quality Assurance and		
		scale insulin) for patient			Performance Improvement Committee		
	, ,	als 151-200=2 units, 201-250=3			monthly times three. Data will be		
		units, 301-350=7 units,			reviewed and analyzed for patterns an	d	
		401-450=11 units, if greater			trends. The Quality Assurance and	•11	
	than 450 call MD.				Performance Improvement Committee	WIII	
	Daview of the M4	dination Administration Decord			evaluate the results and implement		
		dication Administration Record			additional interventions as needed to		
		erough 03/31/17 revealed the 8/6/17 was not transcribed on			ensure continued compliance.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345116	B. WING _			05/24/20	117
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRE 109 S HOLDEN GREENSBOR		1 00/2-11/20	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COM	(X5) IPLETION DATE
F 428	was the following: Novolog solution 100 scale: if 150-210=1 to 271-330=3 units, 33: units. Notify MD if C subcutaneously befo DM. Order date 02/2 Review of the March following CBG readin administered to Resi MAR date 03/06/17 a "8" was written which note." No written pro the medical record. On 05/18/17 at 11:10 conducted with Nurs Resident #2 on 3/6/1 glucose of 508 mg/d confirmed that the re 508 and stated she re 20 units one time fro that she knew to place medical records for i or low CBGs and never it that day. MAR date 03/06/17 a given instead of 5 un MAR date 03/07/17 a given instead of 2 un MAR date 03/07/17 a given instead of 2 un MAR date 03/07/17 a given instead of 2 un MAR date 03/07/17 a	cribed Novolog SSI order Dunit/ml, inject as per sliding unit, 211-270=2 units, 1-390=4 units, 391-450=5 BG is greater than 450, are meals and at bedtime for 7/17. 2017 MAR revealed the engs and SSI coverage dent #2: at 11:30 AM, CBG 508. Code an meant "other/see progress gress note or order found in 0 AM, an interview was ee #8 who worked with 7 and documented the blood L at 11:30 AM. The nurse sident blood glucose was eccived an order for Novolog m physician #1. She stated be a progress note in the enterventions related to high worders, but, she did not do at 4:30 PM, CBG 271, 3 units as ordered on 03/06/17 at 9:00 PM, CBG 220, 2 units units as ordered on 03/06/17	F	28			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY
		345116	B. WING			C)5/24/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 109 S HOLDEN ROAD GREENSBORO, NC 27407		33/24/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	given instead of 2 ui MAR date 03/08/17 "8" was written which note." No written prothe medical record. Review of the Nursing 5:37 AM revealed Condocumentation of slithe physician was not the note was not awhe was out of the continvestigation. MAR date 03/09/17 given instead of 2 ui MAR date 03/09/17 given instead of 11 ui MAR date 03/10/17 units given instead of 11 ui MAR date 03/10/17 units given instead of 7 ui MAR date 03/10/17 given instead of 2 ui MAR date 03/11/17 given instead of 2 ui MAR date 03/11/17 given instead of 2 ui MAR date 03/11/17 units given instead of 2 ui MAR date 03/11/17 given instead of 7 ui MAR date 03/11/17 given instead of 7 ui MAR date 03/11/17 given instead of 7 ui MAR date 03/11/17 given instead of 2 ui MAR date 03/11/17	at 9:00 PM, CBG 209, 1 unit nits as ordered on 03/06/17 at 6:30 AM, CBG 570, Code the meant "other/see progress ogress note or order found in ang Note dated 03/08/17 at the BG was 570. There was no iding scale insulin given or if otified. The nurse that wrote ailable for interview because	F 42	28		

345116 B. WING 05/	C
	24/2017
NAME OF PROVIDER OR SUPPLIER STARMOUNT HEALTH AND REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	2-1/2017
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428 Continued From page 71 MAR date 03/12/17 at 4:30 PM, CBG 225, 2 units given instead of 3 units as ordered on 03/06/17 MAR date 03/12/17 at 9:00 PM, CBG 158, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/13/17 at 6:30 AM, CBG 436, 5 units given instead of 2 units as ordered on 03/06/17 MAR date 03/13/17 at 16:30 AM, CBG 436, 5 units given instead of 11 units as ordered on 03/06/17 MAR date 03/13/17 at 11:30 AM, CBG 254, 2 units given instead of 5 units as ordered on 03/06/17 An interview on 05/12/17 at 1:15 PM with Director of Nursing (DON) and Administrator revealed that they did not know why the physician order of 03/06/17 with the SSI order and insulin changes did not get placed on the MAR. It was the expectation that every order was written on the physician's order sheet, signed off, placed in the computer and confirmed on the MAR. Review of the "Clinical Pharmacist Medication Regimen Review Summary" revealed the consultant pharmacist did a drug regimen review on 3/10/17 and 04/12/17. The review dated 3/10/17 included that the resident was a brittle diabetic and insulin doses were adjusted. The plan was to monitor the resident for blood glucose. Neither drug regimen review addressed that the resident did not receive SSI as ordered by the physician on 3/6/17. An interview of the consultant Pharmacist on 5/22/17 at 4:12 PM revealed that she usually checked the hard copy of physician orders were spossed by the physician orders were transcribed correctly to the MAR. She said the nurses were responsible for	

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F 428	3/6/17 SSI order into the order was not fol the hand written cop not in the resident m missed it.	ity staff did not transcribe the othe MAR and as a result, lowed. She said it was either y of the physician order was edical records or she just	F 42		0/07/47		
F 490 SS=J	483.70 Administration A facility must be adenables it to use its refficiently to attain or practicable physical, well-being of each restricted from the properties of the provided of the provided to an insuling who was having critical (CBG) above 600 missigns of distress. The diabetic residents (Richards was sent to the hosping have daily treatment of the physician for 1 of 3 significant whom the physician for 1 of 3 significant wounds.	ministered in a manner that resources effectively and r maintain the highest mental, and psychosocial	F 49	Nurse #2 has received education 5/1 from the Director of Nursing and Staff Development Coordinator regarding t facility policy for identification and assessment of changes in condition, management of residents with diabete including monitoring of residents follo intervention implementation, and physician notification. Nurse #2 is no longer an employee and will not recei education about initiating EMS. All residents have the potential to be affected by the alleged deficient pract The Administrator and Director of Nur have reviewed the schedule for the ne days ending 5/19/17 to validate dedic Nursing Supervision is scheduled for shifts each day including the weekend Nursing Supervision includes the Director of Nursing, Assistant Director of Nursing Supervision includes the Director of Nursing, Assistant Director of Nursing Supervision includes the Director of Nursing, Assistant Director of Nursing Supervision includes the Director of Nursing Supervision	the the the the the the the the		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 490	Continued From page	e 73	F.	490			
	HI on the glucometer	(blood glucose was more			Staff Development Coordinator, Unit		
		I the resident was showing			Manager or Shift Supervisor.		
		blood pressure, vomiting,					
	and unusual bowel in	continence. EMS was not			The Administrator has secured contrac	ts	
	immediately initiated	and nursing did not continue			with multiple staffing agencies since		
		t. The immediate jeopardy			December of 2016 to fill staffing needs	as	
	was removed on 5/23/17 when the facility				required. The Administrator and Direct		
	provided an acceptable credible allegation of				of Nursing have the authority to contact		
	compliance. The facility will remain out of				the staffing agency to fill vacant shift fo		
	compliance at a scope and severity level of D (not				Licensed Nurses and Certified Nursing		
	actual harm with the potential for more than minimal harm that is not immediate jeopardy) for				Assistants. The Nursing Supervisor wi	11	
	the facility to complete staff training and to ensure				notify the Administrator or Director of Nursing of a staffing need and authority	ı to	
	monitoring systems put into place are effective.				contact the staffing agency to fill	/ 10	
	The facility is also out of compliance at the D				vacancies may be delegated to the		
	_	or Resident #4 and Resident			Nursing Supervisor at the discretion of the		
		referenced to tags F224,			Administrator or Director of Nursing.		
	F309, F314 and F353						
					The Administrator and Director of Nurs	ing	
	Findings included:				with the Interdisciplinary Team including	g	
					input from Nursing Staff completed a r	oot	
	Cross referenced				cause analysis regarding coverage for		
		review, staff interview, and			vacant shifts a utilizing Agency staff,		
		he facility neglected a			offering shift bonuses to current staff at		
	l	ring physician orders for			scheduling dedicated Nursing Supervis		
		SSI), by not monitoring and			daily for all shifts by May 12, 2017. Ba	sea	
		n dependent brittle diabetic			on this review it was determined that	fto	
		ritical capillary blood glucose g/dL (milligram/deciliter). The			multiple Nurses had called out for 3 shi on May 8, 2017 requiring Administrative		
		owing signs of lethargy, low			Nursing staff to cover these shifts and	,	
		ual bowel incontinence, and			therefore reducing the amount of availa	able	
	-	failed to initiate emergency			Nursing Supervision.		
		IS) for the resident when he					
		This was evident in 1 of 3			The Administrator and Director of Nurs	ing	
		esident #2). The resident			have reviewed the schedule for the nex	-	
		ital and shortly died of a			days ending 5/19/17 to validate dedica	ted	
	heart attack. The fac	ility neglected residents by			Nursing Supervision is scheduled for a		
	not providing wound	care for two days for 2 of 3			shifts each day including the weekend.		
	residents who were s	supposed to have daily			The Administrator and Director of Nurs	ina	

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F 490	Continued From page	e 74	F	490			
		d by the physician (Resident		100	will conduct a daily meeting to review		
	#4 and Resident #5).	d by the physician (Resident			Nursing and Certified Nursing Assistan	t	
					staffing and scheduling for each day to		
					ensure adequate coverage to include		
	2. Cross referenced	at F309: Based on			dedicated Supervisor for each shift. Al		
	observations, record	review, staff interview,			attempts to assign familiar caregivers t		
	Nurse Practitioner (NP) interview and physician				maintain continuity of care for high risk		
	interview, the facility failed to follow physician				residents will be discussed during this		
	orders for sliding scale insulin (SSI), monitor and				meeting.		
	reassess an insulin dependent brittle diabetic						
	resident that had a critical capillary blood glucose				The Director of Nursing, Staff		
	(CBG) above 600 mg/dL (milligram/deciliter). The resident was also showing signs of lethargy, low blood pressure, unusual bowel incontinence, and				Development Coordinator and Nurse		
					Managers have conducted training with		
		failed to initiate emergency			Licensed Nurses beginning May 11, 2017, in the event the Nursing Supervisor is		
		IS) for the resident when he			required to move to a resident care		
	1	This was evident in 1 of 3			assignment as a result of a staffing		
		esident #2). The resident			shortage the Administrator and Directo	r of	
		tal and shortly died of a			Nursing will be notified immediately to		
		ility failed to provide wound			make further staffing adjustments as		
	care for two days for	Resident #5 who was			necessary. If a Nurse is feeling		
	1	ily treatments as ordered by			overwhelmed with completing the tasks		
		1 sampled residents with			due on their current assignment the Nu	ırse	
	wounds.				will report to the Supervisor for		
	0 0	at 5044: Daniel au			assistance. In the event the Nursing		
	3. Cross referenced				Supervisor has a resident care assignment the Director of Nursing will	ho	
		terviews and record review, rovide pressure ulcer care for			notified.	n c	
		nt who was supposed to			Houned.		
	-	s as ordered by the physician			Beginning May 12, 2017 Licensed nurs	sina	
	-	sidents with pressure ulcers			staff and Agency Licensed nursing staf	-	
	(Resident #4.)	•			will not be allowed to work until the		
	,				training is completed. Licensed nursing	g	
	4. Cross referenced	at F353. Based on			staff will be provided this education at	_	
		review, staff interview,			least annually via the Director of Nursir	•	
		P) interview and physician			or Resident Care Management Directo	r.	
	_	failed to provide sufficient			This education will be included in the		
		e and services, including			facility□s new hire orientation and new	ly	
	emergency medical s	services (EMS), to an insulin			hired licensed nursing staff will not be		

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F 490	Continued From pag	e 75	F 49	90			
	capillary blood gluco (milligram/deciliter) a This was evident in 1 (Resident #2). The r hospital and shortly of facility failed to have wound care for two of Resident #5 who wel treatments as ordere sampled residents w	s notified of the immediate		permitted to assume their floor responsibilities until they have this education The Administrator along with the Director of Nursing will ow make adjustments to the staff and scheduling within the facithe resident□s needs. The A will ensure staffing resources allocated appropriately. District Director of Clinical Se /or the District Director of Ope provide oversight of the admin providing onsite visits to the face week x 4 weeks, and then a rebimonthly visits X 6 months to	input from ersee and fing patterns elity to meet dministrator are rvices and erations will nistration by acility every ninimum of		
	Residents identified to deficient practice. At 4:00 PM on 5/8/17 Resident #2 room an responding as usual. clammy. His Blood gread "HI" with no valumanufacturer insert for that a reading of "HI" value of greater than was notified and order administer 17 units of Zofran 4 mg every 6 At approximately 4:3 check on Resident #2 with no new changes At approximately 6-6 Resident #2 his dinner.	d noticed that he was not His skin was cool and glucose was checked and ue on the monitor. The or this glucometer stated indicated a blood glucose 600 mg/dL. The Physician ers were received to f Novolog one time and hours for nausea. 0 PM NA#3 entered room to 2 who was resting in bed		implementation of all credible The Director of Nursing and N Managers conducted an audi diabetic residents who have h change in condition related to sugar levels in the last 30 day reviewed their corresponding documentation to validate tha assessment has been comple interventions were implement to the Physician orders an plan, including emergency me services initiated immediately by physician completed May Beginning May 12, 2017 the I Nursing and Nurse Managers those residents who have ext changes in condition to assur assessments or observations	allegations. Jurse t of current had an acute high blood as and It a nursing eted and hed according d the care edical has directed 12, 2017. Director of will review hibited acute e that		

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F 490	Continued From page	e 76	F	490			
	· -	then reported to Nurse #2.			symptoms have been assessed,		
		d in the bed and the tray was			interventions were initiated as ordered	or	
	set up.	·			care planned, and the attending physic	ian	
	i i	2 rechecked the resident			was notified.		
		ain read "HI". Nurse #2					
		and received orders to			The Director of Nursing, Staff		
	administer 14 units of Novolog and instructions to transport to the hospital if not improved. Resident status did not improve. Resident was incontinent				Development Coordinator and Nurse	_	
					Managers have conducted training with		
				Licensed Nurses beginning May 11, 20 regarding the facility s existing policy			
	of bowel and bladder and remained lethargic. Resident complained of an ache in his abdomen.				identification and assessment of chang		
	Family was notified of resident status, 911 was				in condition, Diabetic Management	,00	
	· · · · · · · · · · · · · · · · · · ·	d resident arrived at the			including monitoring of residents follow	ing	
	hospital at 9:26 PM.				intervention implementation, and	Ū	
	-	he was too busy to check on			physician notification.		
		quently to reassess following			Education included clarification of exist	ting	
		for a "HI" blood sugar			policy:		
		and a low blood pressure			Beginning May 11, 2017 of the followin		
	and that she did not o	s not able to recheck on the			- When a resident s blood sugar read on the glucometer, Residents will be	HI	
	resident.	s not able to recheck on the			re-assessed within 30 minutes to 1 hou	ır	
	resident.				following insulin administration and	41	
	Nurse #2 has receive	ed education on 5/12/17 from			according to the physician □s orders.		
	the Director of Nursin	g and Staff Development			-Physician □s Orders for sliding scale		
	Coordinator regarding	g the facility policy for			insulin administration and blood sugar		
		essment of changes in			monitoring will include parameters for		
	_	ent of residents with diabetes			physician notification.		
	including monitoring				- Identification of an obvious critical ac	ute	
		ntation, and physician			change in condition, and appropriate		
	notification.				response and physician notification Ensuring staff awareness that failur	e to	
	Residents with the no	otential to be affected by the			provide care and services, including w		
	alleged deficient prac				to initiate EMS, can constitute resident		
	and god as notone prac				neglect.		
	All residents have the	e potential to be affected by			- EMS will be imitated by physician o	rder	
		practice. The Administrator			and/or advanced directives.		
	and Director of Nursi				Licensed nursing staff, and agency		
		7 days ending 5/19/17 to			licensed nursing staff will not be allowe	ed	
	validate dedicated Nu	ursing Supervision is			to work until this training is complete.		

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F 490	Continued From pag	e 77	F 49	0			
1 490	scheduled for all 3 si weekend. Nursing 3 Director of Nursing, 3 Staff Development C Shift Supervisor. 3. The Administrator multiple Staffing Age 2016 to fill staffing ne Administrator and Dia authority to contact to vacant shift for Licer Nursing Assistants. notify the Administrator and agency to fill vacance Nursing Supervisor and Administrator or Director The Administrator of Director The Administrator of Director The Administrator of Director The Administrator or Director The Administrator or Director The Administrator of Director The Administrator or Director The	hifts each day including the Supervision includes the Assistant Director of Nursing, coordinator, Unit Manager or or has secured contracts with encies since December of eeds as required. The rector of Nursing have the he staffing agency to fill ased Nurses and Certified The Nursing Supervisor will tor or Director of Nursing of a thority to contact the staffing ies may be delegated to the eat the discretion of the ector of Nursing. In did Director of Nursing with Team including input from eted a root cause analysis for vacant shifts a utilizing g shift bonuses to current	F 49	The Director of Nursing, Staff Development Coordinator and Nu Managers have conducted trainir Certified Nursing Assistants begin May 11, 2017 regarding reporting observation of a resident schan condition to the Nurse immediate Nursing assistants will not be allo work until this training is complete The Director of Nursing, Staff Development Coordinator and Nu Managers have conducted educa Licensed Nursing staff and nurse on Abuse and Neglect Preventior 22, 2017 including prompt respor resident schange of condition. Beginning May 22nd, Licensed N staff, nurses aides and Agency nursing staff will not be allowed to until the training is complete. Th education also included ensuring awareness that failure to provide services, including when to initiat can constitute resident neglect. Beginning May 22, 2017 License staff and Agency Licensed nursin will not be allowed to work until th training for Abuse and Neglect Pr including prompt response to res change of condition is completed education also includes ensuring awareness that failure to provide services, including when to initiat can constitute resident neglect. L nursing staff will be provided this	ng with nning y an yge of ly. wed to e. urse ation with s aides n on May nse to ursing Licensed o work is staff care and e EMS, d nursing yg staff ne revention, ident□s . This staff care and e EMS, icensed		

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			-		,									
F 490	risk residents will be meeting.	ots to assign familiar In continuity of care for high Idiscussed during this Ing, Staff Development Is Managers have	F	490	Director of Nursing or Resident Care Management Director. This education be included in the facility s new hire orientation and newly hired licensed nursing staff will not be permitted to assume their floor responsibilities until they have completed this education.	will								
	beginning May 11, 20 Supervisor is required assignment as a resu Administrator and Dir notified immediately t adjustments as neces overwhelmed with co their current assignm the Supervisor for ass Nursing Supervisor h	217, in the event the Nursing d to move to a resident care allt of a staffing shortage the rector of Nursing will be so make further staffing ssary. If a Nurse is feeling mpleting the tasks due on ent the Nurse will report to sistance. In the event the as a resident care			Current facility residents identified as receiving capillary blood glucose monitoring will be reviewed five times a week for one month then weekly times two months to ensure that physicians were notified as stated in physician sorders of elevated capillary blood glucon Resident #2 no longer resides in the									
	assignment the Director of Nursing will be notified. Beginning May 12, 2017 Licensed nursing staff and Agency Licensed nursing staff will not be allowed to work until the training is completed. Licensed nursing staff will be provided this education at least annually via the Director of Nursing or Resident Care Management Director. This education will be included in the facility's new hire orientation and newly hired licensed nursing											Resident #4 attending physician and responsible party were notified on 5/10 of two questionable missed treatments Resident #5 attending physician and responsible party were notified on 5/10 of two questionable missed treatments	/17	
	responsibilities until the ducation. The Administrator alcomological Director of Nursing wadjustments to the standard within the residents' needs. The staffing resources are	affing patterns and facility to meet the e Administrator will ensure e allocated appropriately inical Services and /or the perations will provide			A member of nurse administration tean (Staff Development Coordinator, Assis Director of Nursing and /or Director of Nursing) will review physician orders for past thirty days of residents identified we capillary blood glucose monitoring, to ensure that the resident receiving sliding scales per physician orders by 6/27/17 Facility audit will be completed of residents identified with physician order for daily wound care to ensure that	tant or vith ng								

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F 490	Continued From page	· 79	F 4	190				
	providing on site visits 4 weeks, and then a r X 6 months to ensure	credible allegation, by s to the facility every week x minimum of bimonthly visits implementation of all			wound treatment were completed for the past thirty days per orders by 6/27/17 to the Director of Nursing and / Nurse Manager. A member of nurse administration team	рy		
	On 5/12/17 at 6:30 PM, the credible allegation of compliance was validated to ensure the facility implemented their corrective actions to remove the immediate jeopardy. The facility provided evidence of an audit, on 5/12/17, of current insulin dependent diabetic residents who have had an acute change in condition related to high blood glucose levels in the last 30 days. The facility reviewed their corresponding documentation to validate that a nursing assessment has been completed and interventions were implemented. Record of diabetic residents were reviewed to ensure that they received care to manage diabetes as ordered by the physician. The facility provided evidence of inservice training to nursing staff on how to manage diabetic residents and regarding sufficient staffing. This was validated by interviews with nurses and nursing assistants.				(Staff Development Coordinator, Assist Director of Nursing) will review treatment record or residents identified with daily wound care orders five times a week for one month and weekly for two months. A member of nurse administration team (Staff Development Coordinator, Assist Director of Nursing and /or Director of Nursing) will review new physician order transcribed correctly for five times a week for one month and weekly times two months. Facility audit will be completed of treatment administration record for word care orders five times a week for one month then weekly times two months. Visual validation that daily wound care treatments occur will be conducted randomly three times a week to ensure completion of physician order. Facility audit will be completed of residents identified with physician order for sliding scale insulin to ensure that a readings above 600 (HI) have physician notification, reassessment and monitor five times a week for one month and weekly times two months.	tant f are tant ers eek und rs iny n		

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NAME OF PROVIDER OR SUPPLIER STARMOUNT HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, S' 109 S HOLDEN ROAD GREENSBORO, NC 27-	, i	03/24/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CCTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)	
F 490	Continued From pag	e 80	F	Residents who recemergencies will be there was not a defive times a week for weekly times two received and anal trends. The Quality performance Impreevaluate the result.	ctor of Nursing and / nt will review the n days forward for five ne month then weekled to ensure sufficient vision. In durses will be action regarding followed and the second followed at the second followe	or e y ving e ngs