DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES		(DMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C
		345116	B. WING		10/19/2018
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
STARMOL	JNT HEALTH AND REHA	B CENTER		99 S HOLDEN ROAD REENSBORO, NC 27407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
F 000	INITIAL COMMENTS		F 000		
		complaint survey was 4/18 through 10/19/18.			
	An extended survey	was conducted.			
	Immediate Jeopardy CFR 483.12 for tag F	was identified at: F600 at a scope and severity			
	CFR 483.24 for tag F severity J	F678. at a scope and			
		constituted Substandard ediate Jeopardy began on oved on 10/19/18.			
	complaint investigation	encies as a result of the ons. Event #910211 review resulted in deletion			
F 641 SS=D		ients	F 641		11/15/18
	resident's status.	t accurately reflect the			
	by:	is not met as evidenced		0044 400 00/-> A	
	interviews, the facility	ns, record review, and staff failed to accurately code		0641 483.20(g) Accuracy of Assessme	
	residents (Resident #	Data Set) for 1 out of 5 62) reviewed for ions and 1 out of 3 residents		Preparation and/or execution of this Pla of Correction does not constitute admission by the provider of the truth of	
		ved for pressure ulcers.		facts alleged or the conclusions set forth in the statement of deficiencies. This P	lan
	Findings include:	s admitted to the facility on		of Correction is prepared solely because is required by the provision of the Feder and State Law.	
		a definition to the idenity off			
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE
Electroni	cally Signed				11/12/2018

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.

	0MB NO. 0938-0391 X3) DATE SURVEY COMPLETED C 10/19/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STARMOUNT HEALTH AND REHAB CENTER 109 S HOLDEN ROAD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	-
STARMOUNT HEALTH AND REHAB CENTER 109 S HOLDEN ROAD GREENSBORO, NC 27407 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG	
STARMOUNT HEALTH AND REHAB CENTER GREENSBORO, NC 27407 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
Image: Constraint of the system GREENSBORO, NC 27407 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	
	(X5) COMPLETION DATE
F 641 Continued From page 1 F 641	
9/24/18 with diagnoses that included fracture of	
the femur, and Diabetes. The Resident Care Management Directo	or
(RCMD) or designee will complete an	
Resident #62's most recent MDS was coded as audit of current residents receiving an	
an admission assessment and dated 10/1/18.Omnibus Budget Reconciliation ActThe resident's active diagnoses includedAssessment during the last 14 days to	
Diabetes Mellitus, hip fracture, and hypertension.	N
The medication 7 day look back for Resident #62 of the Minimum Data Set (MDS) per the	
was coded as having an anticoagulant 2 out of 7 Resident Assessment Instrument (RAI)	
days and no injections for the past 7 days in the Manual guidelines. If needed,	
look back period. modifications will be completed by the RCMD and or MDS Designee per the RA	A1
Resident #62's most current care plan dated Manual guidelines. Resident #62 had	ור
10/1/18 revealed the resident was not care modification of section N to reflect	
planned for anticoagulant therapy. accurate medical diagnoses for	
A seview of Decident #2015 MAD (Mediantian	3.
A review of Resident #62's MAR (Medication Administration Record) revealed that the resident Administration Record) revealed that the resident	
received Lovenox 30mg subcutaneous every 12 medications for Assessment Reference	;
hours from 9/25/18 through 10/1/18. Date 07/30/2018. The process breakdow	vn
occurred when the coding of the Minimur	m
An interview with the MDS nurse was conducted Data Assessments did not correspond	
on 10/18/18 at 4:50pm. The MDS nurse reportedwith the Resident Assessment Instrumentit is her responsibility to accurately code the MDSManual.assessments. She reported the MedicationManual.	nt
section of the MDS should have been coded to District Director Care Management will	
reflect Resident #62 received an injection for 7 provide education to the Interdisciplinary	/
out of 7 days in the look back period of theTeam members who participate in MDS	
admission assessment. She also reported the coding of sections I and N related to	_
MDS should have been coded to reveal the accurate coding of MDS according to the resident was on an anticoagulant 7 out of 7 days RAI Manual on November 8, 2018. The	
in the look back period.	
MDSs weekly for 12 weeks and then five	
An interview was conducted on 10/18/18 at random MDSs monthly for an additional	3
8:10pm with the DON (Director of Nursing). She months to verify accurate coding of	
reported it was the MDS nurse's responsibility to correctly code the MDS assessments. She education will be provided if opportunities	
reported it was her expectation that all MDS for corrections are as identified as a result	
assessments be coded accurately with the 7 day of these audits. Modifications to the MDS	

Facility ID: 953473

If continuation sheet Page 2 of 30

TATEMENT	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE (CONSTRUCTION	(X3) DATE	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, í			` '	LETED
							C
		345116	B. WING			10/	19/2018
NAME OF PF	OVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
STARMOU	NT HEALTH AND REHA	B CENTER			9 S HOLDEN ROAD REENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	Continued From page	e 2	F 64	11			
	look back of medicati				will be completed as needed. Audits w	rill	
					begin on 11/12/18.		
		as admitted to the facility on			-		
		es that included Multiple			The results of these audits will be		
		, neurogenic bladder, and			presented by the Resident Care		
	multiple pressure ulc			Management Director monthly for 6			
	A review of Resi			months at Facility Quality Assurance Performance Improvement (QAPI)			
		assessment was completed			Committee Meeting. The QAPI		
	on 10/8/18. Active dia			Committee will make changes or			
	Sclerosis, paraplegia			recommendations as indicated.			
	buttocks, and pressu						
		ent #16's MDS was coded			The Resident Care Management Direct	ctor	
	as resident having 4 of which were preser	Stage IV pressure ulcers, 3 at on admission.			is responsible for implementing and sustaining the plan of correction.		
		dent #16's care plan revealed					
		dated on 7/23/18 and essure ulcer care to pressure					
		left sacrum, left posterior					
	-	and right medial heel.					
		dent #16's medical record					
		essments dated 10/2/18					
		t had a Stage IV pressure ium, a Stage IV pressure					
	•	I foot, a Stage IV pressure					
		im, and a Stage IV pressure					
	ulcer to the coccyx a	- ·					
		of Resident #16 receiving					
		ducted on 10/17/18 at					
		ent nurse performed wound					
		dent's pressure ulcers using was observed that Resident					
		ers of the left ankle, sacrum,					
	left ischium, and right						

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/03/20 M APPROVE D. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE COM	E SURVEY PLETED
		345116	B. WING			C / 19/2018
NAME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
STARMOL	INT HEALTH AND REHA	B CENTER		S HOLDEN ROAD EENSBORO, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 641 F 655 SS=D	only been on staff for weeks, the resident h of the elbow. NA #2 with dressing change for a couple of month pressure ulcer of the An interview was nurse on 10/18/18 at her responsibility to a After reviewing Resid assessments, she rep 10/8/18 had inaccura An interview was 8:10pm with the DON reported it was the M correctly code the MI reported it was her ex assessments be code diagnoses. Baseline Care Plan CFR(s): 483.21(a)(1) §483.21 Comprehens Planning §483.21(a) Baseline of §483.21(a) The fac implement a baseline that includes the instre effective and person- that meet professiona The baseline care pla (i) Be developed with admission.	NA #2 on 10/17/18 at hent nurse reported she had 2 weeks but during the 2 had not had a pressure ulcer reported she had assisted is and care of Resident #16 is and she had not had any elbow during that time. a conducted with the MDS 5:10pm. She reported it was inccurately code the MDS. The MDS dated the coding of diagnoses. is conducted on 10/18/18 at (Director of Nursing). She DS nurse's responsibility to DS assessments. She expectation that all MDS ed accurately with correct -(3) sive Person-Centered Care Care Plans cility must develop and e care plan for each resident fuctions needed to provide centered care of the resident al standards of quality care.	F 641			11/15/18

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 12/03/2018 MAPPROVED O. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345116	B. WING		C 10/19/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
STARMOL	JNT HEALTH AND REHA	B CENTER		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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 655	necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services (E) Social services. (F) PASARR recomm §483.21(a)(2) The far comprehensive care care plan if the comp (i) Is developed with admission. (ii) Meets the require (b) of this section (ex- this section). §483.21(a)(3) The far resident and their rep of the baseline care p limited to: (i) The initial goals o (ii) A summary of the dietary instructions. (iii) Any services and administered by the f on behalf of the facili (iv) Any updated info of the comprehensive This REQUIREMENT by: Based on record rev- interviews the facility baseline care plan with	 y care for a resident ted to- d on admission orders. hendation, if applicable. cility may develop a plan in place of the baseline rehensive care plan- in 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the presentative with a summary plan that includes but is not f the resident. e resident's medications and d treatments to be facility and personnel acting fy. rmation based on the details e care plan, as necessary. T is not met as evidenced iew, staff and resident failed to complete the thin 48 hours of admission 	F 6	F655 483.21(a)(1) - (3) BAS PLAN		
	review the baseline c resident responsible	interventions and failed to are plan with the resident, party and/or family member sions (Resident #136 and		Preparation and/or execution of Correction does not consti admission by the provider of facts alleged or the conclusion	tute the truth of	

Facility ID: 953473

If continuation sheet Page 5 of 30

(EACH DEFICIENCY	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345116 B CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	A. BUILDING B. WING ID PREFIX	PLE CONSTRUCTION S STREET ADDRESS, CITY, STATE, ZIP C 109 S HOLDEN ROAD GREENSBORO, NC 27407 PROVIDER'S PLAN OF	сом 10	E SURVEY PLETED C /19/2018
T HEALTH AND REHA SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	109 S HOLDEN ROAD GREENSBORO, NC 27407		
T HEALTH AND REHA SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	PREFIX	109 S HOLDEN ROAD GREENSBORO, NC 27407	CODE	
SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	PREFIX	GREENSBORO, NC 27407		
SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	PREFIX			
(EACH DEFICIENC REGULATORY OR L	Y MUST BE PRECEDED BY FULL	PREFIX			
Continued From page		TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	(X5) COMPLETION DATE
	<u>ک</u>	F 65	55		
		1 00		oioo Thio Dlan	
(esident #02)					
Finding include:				-	
-			and State Law.		
			The Desident Orac Manage		
	sy, and Diabetic			•	
Resident # 136 admis	ssion Minimum Data Set				
vas not due until Octo	ober 18, 2018. However			-	
Resident #136 was al	ble to make her needs know				
o staff.					
-	-				
	-				
•					
				•	
During an interview w	rith Resident #136 on		therapy.	-	
October 17, 2018 at 4	1:30 pm, revealed she does				
				-	
			-		
	-		-		
ne care plan nor rece	eiveu a copy of it.		-		
Ouring an interview w	ith the Assistant Director of				
			-		
completed by the Reg	gistered Nurse and that her			-	
completed per state re	egulation.				
-	-				
	2018 with current diag anemia, iron deficience (atoacidosis type 1. Resident # 136 admis vas not due until Oct Resident #136 was al o staff. During a review of the Resident #136 dated Dotober 17, 2018 at 4 no medications, no ge Resident #136. During an interview w Dotober 17, 2018 at 4 not recall any staff tal paseline care plan. R not know what a base Resident #136 also in the care plan nor rece During an interview w Nurses (ADON) on O evealed that the basi completed by the Reg expectation were that completed per state r DURING an interview w DON) on October 18 hat her expectation fevas to address all the	Finding include: 1. Resident #136 was admitted on October 10, 2018 with current diagnoses of microcytic, anemia, iron deficiency, and Diabetic tetoacidosis type 1. Resident # 136 admission Minimum Data Set vas not due until October 18, 2018. However Resident #136 was able to make her needs know o staff. During a review of the baseline care plan for Resident #136 dated October 12, 2018 on Dctober 17, 2018 at 4 pm revealed no diagnoses, no medications, no goals and no intervention for Resident #136. During an interview with Resident #136 on Dctober 17, 2018 at 4:30 pm, revealed she does not recall any staff talking to her about her baseline care plan. Resident #136 indicated does not know what a baseline care plan was. Resident #136 also indicated she never signed he care plan nor received a copy of it. During an interview with the Assistant Director of Nurses (ADON) on October 18, 2018 at 8:30 am evealed that the baseline care plan are completed by the Registered Nurse and that her expectation were that the baseline care plan be completed per state regulation. During an interview with the Director of Nurses DON) on October 18, 2018 at 9:15 am revealed hat her expectation for the baseline care plan, vas to address all the issues and concerns for	Finding include: 1. Resident #136 was admitted on October 10, 2018 with current diagnoses of microcytic, anemia, iron deficiency, and Diabetic setoacidosis type 1. Resident # 136 admission Minimum Data Set vas not due until October 18, 2018. However Resident #136 was able to make her needs know o staff. During a review of the baseline care plan for Resident #136 dated October 12, 2018 on Dctober 17, 2018 at 4 pm revealed no diagnoses, no medications, no goals and no intervention for Resident #136. During an interview with Resident #136 on Dctober 17, 2018 at 4:30 pm, revealed she does not recall any staff talking to her about her baseline care plan. Resident #136 indicated does not know what a baseline care plan was. Resident #136 also indicated she never signed he care plan nor received a copy of it. During an interview with the Assistant Director of Nurses (ADON) on October 18, 2018 at 8:30 am evealed that the baseline care plan are completed by the Registered Nurse and that her expectation were that the baseline care plan be completed per state regulation. During an interview with the Director of Nurses DON) on October 18, 2018 at 9:15 am revealed hat her expectation for the baseline care plan, vas to address all the issues and concerns for	 of Correction is prepared s is required by the provision and State Law. The Resident #136 was admitted on October 10, 2018 with current diagnoses of microcytic, anomia, iron deficiency, and Diabetic actoacidosis type 1. Resident #136 admission Minimum Data Set vas not due until October 18, 2018. However Resident #136 was able to make her needs know o staff. During a review of the baseline care plan for Resident #136 dated October 12, 2018 on Doctober 17, 2018 at 4 pm revealed no diagnoses, no medications, no goals and no intervention for Resident #136. During an interview with Resident #136 on Doctober 17, 2018 at 4:30 pm, revealed she does not recall any staff talking to her about her baseline care plan was. Resident #136 also indicated she never signed he care plan. Resident fare applan or received a copy of it. During an interview with the Assistant Director of Nurses (ADON) on October 18, 2018 at 8:30 am evealed that the baseline care plan are completed by the Registered Nurse and that her expectation were that the Disector of Nurses DON) on October 18, 2018 at 9:15 am revealed hat her expectation for the baseline care plan, was to address all the issues and concerns for 	 and ginclude: I. Resident #136 was admitted on October 10, 018 with current diagnoses of microcytic, nemina, iron deficiency, and Diabetic tetoacidosis type 1. Resident #136 admission Minimum Data Set vas not due until October 18, 2018. However Resident #136 dated October 12, 2018 on 0 staff. During a review of the baseline care plan for Resident #136. During an interview with Resident #136 on October 17, 2018 at 4 pm revealed no diagnoses, no medications, no goals and no intervention for Resident #136. During an interview with Resident #136 on October 17, 2018 at 4 pm revealed she does not recail any staff talking to her about her paseline care plan nor received a copy of it. During an interview with the Assistant Director of Nursing an interview with the Director of Nurses DON) on October 18, 2018 at 9:15 am revealed DON) on October 18, 2018 at 9:15 am revealed hat her expectation for the baseline care plan, are opingleted by the Registered Nurse and then five resident the paseline care plan are oprimeted by the Registered Nurse and then five resident the asseline care plan are oprompleted by the Registered Nurse and then five resident baseli

Facility ID: 953473

TATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345116	B. WING		C
NAME OF P	ROVIDER OR SUPPLIER	545110		STREET ADDRESS, CITY, STATE, ZIP	10/19/2018
	INT HEALTH AND REHA	B CENTER		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 O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETIO D THE APPROPRIATE DATE
F 655	complete this form wither blood sugar got la never completed this 2. Resident #62 was 9/24/18 with diagnost the femur, Diabetes, Resident #62's most Set) was coded as an dated 10/1/18. The re- included Diabetes Ma hypertension. The ma Resident #62 was co anticoagulant 2 out of the past 7 days in the Resident #62's basel revealed the resident anticoagulant therapy A review of Resident Administration Recor- received Lovenox 30 hours from 9/25/18 th An interview with the on 10/18/18 at 4:50p it is her responsibility residents' care plans baseline care plan was	ated she was not able to ith Resident #136 because ow. DON indicated she process with Resident #136. admitted to the facility on es that included fracture of and depression. recent MDS (Minimum Data n admission assessment and esident's active diagnoses ellitus, hip fracture, and edication 7 day look back for ded as having an f 7 days and no injections for e look back period. ine care plan dated 9/26/18 s was not care planned for /. #62's MAR (Medication d) revealed that the resident mg subcutaneous every 12	F 6	appropriate diagnoses an are addressed. One to on be provided by the DON i for corrections are as ider of these audits. Revisions care plans will be comple ADON or RCMD as need The results of these audit presented by the Resider Management Director mo months at Facility Quality Performance Improvemer Committee Meeting. The Committee will make chai recommendations as india The Resident Care Mana- is responsible for implement sustaining the plan of com	e education will f opportunities ntified as a result s to the baseline ted by the DON, ed. s will be nt Care onthly for 6 Assurance nt (QAPI) QAPI nges or cated. gement Director enting and
		ducted on 10/18/18 at I (Director of Nursing). She			

						FC	TED: 12/03/2018 ORM APPROVED NO. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) D	DATE SURVEY OMPLETED
		345116	B. WING		C 10/19/2018		
NAME OF P	ND PLAN OF CORRECTION DENTIFICATION NUMBER: A BUILDING 345116 B. WING STARMOUNT HEALTH AND REHAB CENTER STREET ADDRESS, CITY, ST TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFING INFORMATION) D FREFX CACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFING INFORMATION) TG F 655 Continued From page 7 reported the registered nurse from corporate was responsible for making sure the baseline care plan was completed. Shar eported it was her expectation that all new admissions have a completed baseline care plan within 48 hours of admission. F 656 F 656 Develop/Implement Comprehensive Care Plan S483.21(b)(1) F 656 GFR(s): 483.21(b)(1) Ş483.31(b)(2) and Ş483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - ()) The services that are to be furnished to attain or maintain the resident's is medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) (The services that are to be furnished to attain or maintain the resident's is therwise be required under §483.24, \$483.25 or \$483.40; and (ii) Any services that would otherwise be required under \$483.24, \$483.25 or \$483.40; and (iii) Any services the nursing facility will provide due to the resident's medical's medical, nursing. If a facility disagrees		EET ADDRESS, CITY, STATE, ZIP CODE				
STARMOL	JNT HEALTH AND REHA	B CENTER		109	S HOLDEN ROAD		
			1	GRE	EENSBORO, NC 27407		
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 655	Continued From page	e 7	F	655			
		•					
		•					
F 656	Develop/Implement C	Comprehensive Care Plan	F	656			11/15/18
SS=D	CFR(s): 483.21(b)(1)						
	§483.21(b)(1) The fact implement a compret care plan for each res- resident rights set for §483.10(c)(3), that im- objectives and timefra- medical, nursing, and needs that are identif assessment. The com- describe the following (i) The services that a or maintain the reside physical, mental, and required under §483 (ii) Any services that under §483.24, §483. provided due to the re- under §483.10, include treatment under §483. (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside	cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's d mental and psychosocial ied in the comprehensive mprehensive care plan must Q - are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized as the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)-					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/03/20 FORM APPROVE OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345116 B. WING			10/19/2018
NAME OF PI	ROVIDER OR SUPPLIER	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
CTA DMOI	INT HEALTH AND REHA	R CENTER	10	09 S HOLDEN ROAD	
STARMUL	INT REALTS AND REDA		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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 656	Continued From page desired outcomes.		F 656		
	future discharge. Fac whether the resident's community was assess local contact agencie entities, for this purpo (C) Discharge plans i plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on record revi facility failed to develor comprehensive care of (Resident #62) whose for unnecessary med Findings include: Resident #62 was ad 9/24/18 with diagnose the femur, and Diabe Resident #62's most 10/1/18 revealed the planned for anticoagu care plan meeting to plan on 10/3/18 but th include anticoagulant A review of Resident Administration Record received Lovenox 300 hours from 9/25/18 th	n the comprehensive care in accordance with the n in paragraph (c) of this is not met as evidenced iews and staff interviews, the op and implement a plan for 1 out of 5 residents e care plans were reviewed ications. mitted to the facility on es that included fracture of tes. current care plan dated resident was not care alant therapy. There was a review Resident #62's care here was no update to therapy on the care plan. #62's MAR (Medication d) revealed that the resident mg subcutaneous every 12		F656 483.21(b)(1) DEVELOP/IMPLEMENT COMPREHENSIVE CARE PLAN Preparation and/or execution of this P of Correction does not constitute admission by the provider of the truth facts alleged or the conclusions set fo in the statement of deficiencies. This of Correction is prepared solely becau is required by the provision of the Fed and State Law. The Resident Care Management Dire (RCMD) or designee will complete an audit of current residents care plans w receive anti-coagulant therapy to ensu all risks are identified on an anti-coagu therapy care plan per the Resident Assessment Instrument manual	of rth Plan use it leral ctor vho ure
	it is her responsibility comprehensive care Resident #62 should anticoagulant therapy	plans. She reported have been care planned for		not having an accurate anti-coagulant therapy care plan. The anti-coagulant therapy care plan was developed by t Resident Care Management Director Minimum Data Set Coordinator (MDS	he or

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	-	ID HUMAN SERVICES			PRINTED: 12/03/20 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
		345116	B. WING		10/19/2018
NAME OF F	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	
STARMO	JNT HEALTH AND REHA	B CENTER		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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO
F 656 F 657 SS=D	8:10pm with the DON reported it was the M develop comprehens resident. She reporte residents' care plans	d Revision (i)-(iii)	F 65	District Director Care Management provide education to the Interdiscipil Team members who participate in the implementation of care plans accord the RAI Manual on November 8, 20 The RCMD will randomly audit five residents care plans, receiving anti-coagulant therapy, weekly for 1 weeks and then five residents care receiving anti-coagulant therapy, me for an additional 3 months to verify appropriate anti-coagulant therapy of plans. One to one education will be provided by the DON if opportunitie corrections are as identified as a rest these audits. Revisions to the care field will be completed by the RCMD or M as needed. The results of these audits will be presented by the Resident Care Management Director monthly for 6 months at Facility Quality Assurance Performance Improvement (QAPI) Committee Meeting. The QAPI Committee will make changes or recommendations as indicated. The Resident Care Management Di is responsible for implementing and sustaining the plan of correction.	inary ne ding to 18. 2 plans, onthly care s for sult of plans MDSC e

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/03/2018 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345116	B. WING		C 10/19/2018
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
STARMOL	INT HEALTH AND REHA	B CENTER		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 657	the comprehensive a (ii) Prepared by an in includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prace the resident and the resident and the resident and the resident and the resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and cases comprehensive and cases	 7 days after completion of ssessment. terdisciplinary team, that inted to	F 657	F657 483.21(b)(2)(i)-(iii)CARE PLAN TIMING AND REVISION Preparation and/or execution of this I of Correction does not constitute admission by the provider of the truth facts alleged or the conclusions set fi in the statement of deficiencies. This of Correction is prepared solely beca is required by the provision of the Fe	Plan n of orth s Plan use it
		#84's most recent MDS dated 10/5/18 was coded as		and State Law. The Resident Care Management Dire	ector

Facility ID: 953473

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		MEDICAID SERVICES				<u> 8-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVE COMPLETED	
			A. BUILDING	<u> </u>	с	
		345116	B. WING		10/19/20	18
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		10
				109 S HOLDEN ROAD		
STARMOU	JNT HEALTH AND REHA	AB CENTER		GREENSBORO, NC 27407		
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COM HE APPROPRIATE	(X5) IPLETIC DATE
F 657	Continued From page	o 11	F 65	.7		
1 007			F 05		alata an audit	
		ssessment. Active diagnoses becified organism and		(RCMD) or MDSC will com of current residents care pla		
		der the Treatment section of		antibiotics to ensure all risk	C I	
		84 was coded as having IV		on an antibiotic care plan p		
	(intravenous) infusior			Assessment Instrument ma		
	A review of Resident			guidelines. Resident #84 w		
		s order dated 9/29/18 that		not having an accurate anti		
		Omg IV every 8 hours for		plan. The antibiotic care pla		
	cellulitis left lower ext	0,		developed by the Resident		
		#84's most recent care plan		Management Director or de		
		t address IV antibiotics.		Resident Care Managemer	-	
	An interview was con	ducted on 10/18/18 at		designee will complete an a		
	5:00pm with the MDS	S nurse. She reported it was		residents Fall Care Plans to	o ensure	
	her responsibility to c	levelop and update care		implemented interventions	are addressed	
	plans as residents' ne	eeds change. She reported		on the Fall Care Plan. Resi	dent #84's Fall	
		have been care planned for		Care Plan did not address t		
	IV antibiotics.			replacement of the wheelch		
		iducted on 10/18/18 at		the wheelchair following a f		
		I (Director of Nursing). She		Care Plan was revised add	-	
	_ ·	xpectation that all care plans		replacement of the wheelch		
	-	resident's needs change and		the wheelchair. The Reside		
	that care plans reflec			Management Director or M		
		as admitted to the facility on		complete an audit of curren		
		es that included Multiple		with an Ostomy to ensure a		
		, neurogenic bladder, and		identified on an Ostomy Ca Resident #16 was identified		
	multiple pressure ulc	dent #16's most recent MDS		an accurate Ostomy care p	ę	
		assessment was completed		Ostomy Care Plan was dev		
		agnoses included Multiple		Resident Care Managemer		
		, and neurogenic bladder.		MDSC on 10/18/18.		
		ection of Resident #16's				
		appliances: ostomy with		District Director Care Mana	aement will	
	urinary continence no			provide education to the Int	-	
	continence rated as a			Team members who partici		
		dent #16's medical record		implementation of care plan		
		was hospitalized 7/30/18 -		the RAI Manual on Novemb		
		performed for an urostomy.		The RCMD will randomly a		
		dent #16's most current care		residents care plans who a		
		evealed the resident was care		anti-coagulant therapy, hav		

Facility ID: 953473

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TATEMENT	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
			A. BUILDING	3		C
		345116	B. WING			0/19/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
STARMO	JNT HEALTH AND REHA	B CENTER		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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 657	Continued From page	e 12	F 65	57		
	 planned for a urinary An interview was 5:10pm with the MDS her responsibility to u to a resident's chang Resident #16's care p An interview was the DON on 10/18/18 expectation that a rest all care areas. 3. Resident #84 was and diagnoses includ weakness, cerebral w pain syndrome, mood thrive and stage 4 pro- Resident #84 was re- 9/22/18 with a diagnose Review of an inciden Resident #84, provide (DON), revealed the her right side in the d a small skin tear on to upper arm with swelli The wheelchair cushi resident ' s wheelchait A comprehensive min 9/29/18 for Resident had a fall with a fract person assist with be an impairment in range extremities and her con A care plan dated 100 the resident had falls 	catheter and a colostomy. a conducted on 10/18/18 at 5 nurse. She reported it was update care plans according ing needs. She reported plan was incorrectly updated. a conducted at 6:10pm with 3. She reported it was her sident's care plan reflected admitted to the facility 5/8/14 led osteomyelitis, muscle vascular accident, chronic d affective disorder, failure to essure ulcer to right hip. -admitted to the facility on osis of left femur fracture. t report dated 9/27/18 for ed by the Director of Nursing resident was found lying on lining room. The resident had op of her right hand and right ing. First aide was provided. ion was replaced in the ir. himum data set (MDS) dated #84 revealed the resident ure, required extensive, two id mobility and transfers, had ge of motion to both lower		 and have a Fall Care plan, weeks and then five resider who are receiving anti-coag have an Ostomy and have plan, monthly for an addition to verify appropriate anti-coage therapy, Ostomy and Fall of to one education will be propriate anti-coage plant of the second se	nts care plans gulant therapy, a Fall Care onal 3 months bagulant are plans. One ovided by the rrections are as se audits. will be the RCMD or will be Care thly for 6 assurance (QAPI) AAPI ges or ated. ement Director nting and	

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		ND HUMAN SERVICES			FOI	ED: 12/03/20 RM APPROVE IO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345116	B. WING		10/19/2018		
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP COD			
STARMOL	INT HEALTH AND REHA	B CENTER		9 S HOLDEN ROAD REENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
F 657	related to falls in the opiate medication. No staff assistance with a included call light and reach, remind her fre with transfers, mats b antilock brakes and e wheelchair, medicatio increase safety when de-clutter room and finight shift. There was wheelchair cushion. An interview on 10/18 Director of Nursing (D falls were reviewed in at-risk meetings. She most recent fall was of intervention to replac with one that had a s implemented. The DO expectation that new updated on the reside An interview on 10/18 MDS Nurse revealed the daily clinical and stated she did attend nurse explained she intervention of chang for Resident #84 and resident 's care plan. Free of Accident Haz	ssion. Continued risk for falls past and antidepressant / oncompliant with calling for transfers. Interventions d personal items within quently to call for assistance beside her bed, apply extended brake handle to on review, provide reacher to a reaching for items, requent rounding during the s no intervention for the 8/18 at 9:47 am with the DON) revealed all resident in the daily clinical and weekly e stated Resident #84 ' s on 9/27/18 and a new e her wheelchair cushion light indent in the seat was DN added it was her fall interventions were ent ' s care plans. 8/18 at 4:28 pm with the that falls were reviewed in weekly at-risk meetings. She these meetings. The MDS did not recall the new fall ing the wheelchair cushion hadn ' t added it to the ards/Supervision/Devices	F 657			11/15/18	
F 689 SS=D	S483.25(d) Accidents The facility must ensu	(2)	F 009			11/10/18	

Facility ID: 953473

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 12/03/20 [.] RM APPROVE <u>NO. 0938-03</u> 9
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345116	B. WING _		C 10/19/2018		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
STARMOL	JNT HEALTH AND REHA	B CENTER			9 S HOLDEN ROAD REENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	Continued From page 14 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.		F	589			
	This REQUIREMENT by: Based on observation interviews the facility that were identified a resident that had re-or- was evident for 1 of 3 accidents (Resident # Findings Included: Resident #84 was ad and diagnoses included weakness, cerebral w pain syndrome, mood thrive and stage 4 pro- Resident #84 was re- 9/22/18 with a diagno Review of the incider months, provided by (DON), for Resident #	Imitted to the facility 5/8/14 led osteomyelitis, muscle vascular accident, chronic d affective disorder, failure to essure ulcer to right hip. -admitted to the facility on osis of left femur fracture. Int reports for the past 2 the Director of Nursing #84 revealed the following:			F689 483.25(d)(1)(2) FREE OF ACCIDENT/HAZARDS/SUPERVISION EVICES Preparation and/or execution of this of Correction does not constitute admission by the provider of the trut facts alleged or the conclusions set of in the statement of deficiencies. Thi of Correction is prepared solely beca is required by the provision of the Fe and State Law. The DON provided Resident #84 wit bedside fall mat per the care plan or 10/18/18. The process breakdown was due to housekeeping staff not educated on moving equipment and devices inclu fall mats when they perform a room	Plan h of forth s Plan ause it ederal h a h ding move.	
	hit her left arm on the obtained a skin tear of treated. The bedside that had rounded edg - On 8/28/18 the resid floor in her room. The trying to get a pillowo	bed to the wheelchair and bedside table. The resident on her left arm which was table was replaced with one			Housekeeping staff will be in-service ensuring devices and equipment are moved when a room change occurs. Nursing Staff will be in-serviced on validating devices and equipment ar place post room change. This will be completed on 11/12/18. The ADON inservice all nurses and certified nur assistants on accessing the cardex to determine what interventions to prev	e in e will sing	

Facility ID: 953473

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/03/2018 RM APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345116	B. WING			10	C D/19/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STADMO	INT HEALTH AND REHA	PCENTED		10	09 S HOLDEN ROAD		
STARMOL		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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 689	floor in her room besi resident had taken of resident complained x-rays were obtained greater trochanter wa resident was educate to wait for staff assist - On 9/27/18 the resid right side in the dining small skin tear on top upper arm with swelli The wheelchair cushi resident ' s wheelchai A comprehensive mir 9/29/18 for Resident had a fall with a fraction person assist with be an impairment in range extremities and her con A care plan dated 100, the resident had falls need for assistance with included call light and	ent was found sitting on the de her wheelchair. The f one of her shoes off. The of left hip pain. Multiple , and a fracture of the left as identified on 9/18/18. The d on using her call light and ance to get back into bed. dent was found lying on her g room. The resident had a of her right hand and right ng. First aide was provided. on was replaced in the ir. himum data set (MDS) dated #84 revealed the resident ure, required extensive, two d mobility and transfers, had ge of motion to both lower ognition was intact. (1/18 for Resident #84 stated related to weakness and the with activities of daily living of cerebral vascular accident, sion. Continued risk for falls past and antidepressant / oncompliant with calling for transfers. Interventions a personal items within	F	689	falls are in place for the residents. Th was completed on 11/12/18. The DON, ADON, and/or the Unit Managers will conduct observation au to ensure that devices and equipment in place for residents identified at High Risk for Falls on 11/12/18. Three times weekly the Housekeeping Supervisor, DON, ADON or Unit Managers will conducted an observati audit to validate equipment and device are moved post room change for 4 we then 2 X a week for 4 weeks, then we for one month. Audit results will be reviewed by the G committee to determine the effectiven and duration of the audit. The DON is responsible for execution this plan.	dits are on es eks, ekly API ess	
	with transfers and ma An observation of Re 9:31 am revealed she	sident #84 on 10/16/18 at was lying in bed asleep. position and there were no					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
AND I LAN OI	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILD	ING .			C
		345116	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER		•	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
STARMOL	INT HEALTH AND REHA	B CENTER			109 S HOLDEN ROAD GREENSBORO, NC 27407		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 689	Continued From page	e 16	F	689			
	An interview on 10/17	7/18 at 11:51 am with					
		A) #3 revealed Resident #84					
		f the time because she had some falls. She stated					
	-	ure what fall precautions					
	were in place for the	resident.					
		7/18 at 12:06 pm with Nurse					
		#84 had frequent falls. She ed to check on her frequently					
		y kept her bed in a low					
	position.						
	An observation of Re	sident #84 on 10/17/18 at					
		ne was awake and lying in ted to be in a low position.					
		ats present next to her bed.					
	An interview on 10/17	7/18 at 3:54 pm with NA #4					
		sure what fall interventions					
		ident #84. He stated he He was observed to speak					
	with Nurse #2 and the	en returned with a form that					
	identified safety need to have mats beside I	s for Resident #64 included					
		7/18 at 4:00 pm with Nurse					
		#84 was supposed to have bed and she would need to					
	locate them.						
	An interview on 10/18	3/18 at 9:47 am with the					
		ent #84 was supposed to					
		her bed due to her multiple esident had a room change					
		fall mats were not brought					
		DON stated it was her					
	expectation that the fa	all mats were in place as a					

Facility ID: 953473

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345116	B. WING		10/19/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
STARMOL	INT HEALTH AND REHA	B CENTER		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 (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 689	safety intervention for	Resident #84. I record revealed Resident	F 689		
F 692 SS=D			F 692	2	11/15/18
	(Includes naso-gastric both percutaneous er percutaneous endosc enteral fluids). Basec	ssment, the facility must			
	of nutritional status, s desirable body weigh balance, unless the re	ins acceptable parameters uch as usual body weight or t range and electrolyte esident's clinical condition s is not possible or resident otherwise;			
	§483.25(g)(2) Is offer maintain proper hydra	ed sufficient fluid intake to ation and health;			
	there is a nutritional p provider orders a ther This REQUIREMENT by: Based on observation interviews the facility intake as ordered by the second sec	is not met as evidenced ns, record review and staff failed to restrict the fluid the physician for 1 of 1 th a physician 's order for a		F692 483.25(g)(1)-(3) NUTRITION/HYDRATION STATU MAINTENANCE Preparation and/or execution of th of Correction does not constitute admission by the provider of the ti	iis Plan

Event ID: 91O211

Facility ID: 953473

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				1 5 0 0 1		T	D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ISTRUCTION	· /	E SURVEY PLETED
							С
		345116	B. WING			10	/19/2018
NAME OF P	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE		
STARMOL	JNT HEALTH AND REHA	B CENTER			HOLDEN ROAD INSBORO, 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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 692	Continued From page	e 18	F 69	2			
1 002	-	dmitted to the facility on	F 09		the statement of deficiencies. This	Plan	
		s included end stage renal			Correction is prepared solely becau	-	
		eart failure, diabetes and			required by the provision of the Fed		
	dementia.	,			nd State Law.	-	
	A quarterly minimum	data set (MDS) dated		Re	esident #386 had her water pitcher		
		#386 revealed she received			moved to ensure compliance to the	fluid	
	dialysis, was on a the	erapeutic diet, was			striction. This was completed on		
	independent with eati	ing and had moderately		10)/19/18. Resident #386's Kardex ha	s	
	impaired cognition.				en updated by the Unit Manager to		
					flect no water pitcher due to fluid		
		view date of 10/6/18 for			strictions. This occurred on 11/2/18		
	Resident #386 stated	related to dietary restrictions			take sheet was implemented by the anager for the direct care staff to	Unit	
	-	itional diagnoses of end			easure fluid intake per shift to be tota	aled	
		and congestive heart failure.			the last shift of the day. This was	alou	
	-	1/16/18 stated to continue a			plemented 11/12/18.		
				Th	ne breakdown in the process occurre	ed	
	A care plan with a rev	view date of 10/6/18 for		wł	nen the Kardex was not updated to		
		I she required hemodialysis			flect the resident's fluid restriction as	6	
		e three times a week. An			ell as the intake sheet not being		
	intervention included output.	to monitor intake and		im	plemented.		
				N	ursing staff has been in-serviced by	the	
	Review of the physici	ian ' s orders for Resident			ON, ADON or Unit Managers on fluid		
		der dated 1/16/18 for a			strictions to include no water pitcher		
	-	ate, renal diet with a 1200 ml			edside, updating and following the		
	fluid restriction.				ardex and completing intake sheets.		
	Deview of the second	and provided by the Distant		Th	nis was completed on 11/12/18.		
		ard, provided by the Dietary esident #386 revealed a		ть	ne DON, ADON, and Unit Managers	will	
		ate, renal diet. The card			mplete an audit on fluid intake shee		
		tion with 4 ounces of fluid at			nd observation audits for water pitche		
		es of fluid at lunch and			bedside for residents on fluid		
	supper.				strictions 3 X a week for 4 weeks, th	en	
					eekly X 4 weeks to ensure completic		
		(a document the facility)			e fluid intake sheet for any resident		
	used to identify care	needs for the resident),		flu	id restrictions. This will begin 11/12	/18.	

Facility ID: 953473

If continuation sheet Page 19 of 30

STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		O. 0938-039 E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	PLETED	
						С	
		345116	B. WING		10	/19/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
STARMOL	JNT HEALTH AND REHA	B CENTER		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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 692	Continued From page	e 19	F 69	2			
		, for Resident #386 stated					
	-	rition section to provide a		Audits will be reviewed monthly			
	consistent carbohydra observe intake and o			QAPI committee to determine du and effectiveness of the audits.	uration		
	through 10/16/18, pro Resident #386 reveal	take records for 10/1/18 ovided by Nurse #2, for ed fluid intake was not for meals, between meals		The DON is responsible for exec the plan.	cution of		
		er 2018 medication (MAR) for Resident #386 ntation related to the 1200 ml					
	Resident #386 reveal	/17/18 at 11:45 am of led a 32-ounce water pitcher ly half full was present on de table.					
	An interview on 10/17/18 at 11:49 am with Nursing Assistant (NA) #2 revealed she was familiar with Resident #386. She stated the resident was on a renal diet and she believed the resident was also on a fluid restriction. NA #2 added the resident could have a water pitcher in her room and the amount of fluids she consumed was documented on the MAR.						
	revealed Resident #3 wasn ' t sure if the res special diet. She state with a water pitcher in liked to drink unswee	7/18 at 11:51 am with NA #3 86 went to dialysis and she sident was on any type of ed the resident was provided h her room and she also tened tea. NA #3 added she resident being on a fluid					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345116	B. WING				C 19/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
STARMOU	JNT HEALTH AND REHA	B CENTER			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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 692	An interview on 10/17 #3 revealed Resident days a week and was stated the NAs kept tr resident drank. An interview on 10/17 revealed he was fami she went to dialysis. If well, she liked unswer water pitcher in her ro believe the resident w the NAs documented and drank each shift f An observation on 10 Resident #386 reveal that was full was press An interview on 10/18 Registered Dietitian (f staff had a chart that f was provided by dieta residents on fluid rest restriction orders should breakdown. The RD a restrictions should no rooms. An interview on 10/18 Director of Nursing (D fluid restrictions should their rooms. She state document how much on their Activity of Dai the nurses should als what fluids the resider stated she expected r	7/18 at 12:09 pm with Nurse #386 went to dialysis 3 a on a fluid restriction. She rack of how much fluid the 7/18 at 3:47 pm with NA #4 liar with Resident #386 and He stated the resident drank etened tea and they kept a bom. NA #4 added he didn ' t vas on a fluid restriction and how much residents ate for meals and snacks. 7/17/18 at 4:01 pm of ed a 32-ounce water pitcher bent on her bedside table. 8/18 at 10:40 am with the RD) revealed the dietary broke down how much fluid ary and by nursing for rrictions. She stated fluid uid be clarified to reflect this added residents on fluid t have water pitchers in their 8/18 at 10:50 am with the DON) revealed residents on Id not have water pitchers in	F	692	2		

Facility ID: 953473

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		MEDICAID SERVICES			OMB NO. 0	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>,</i>	LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		345116	B. WING		C	0040
	ROVIDER OR SUPPLIER	545110		STREET ADDRESS, CITY, STATE, ZIP CODE	10/19/	2018
	ROVIDER OR SUFFLIER			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 PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE C	(X5) OMPLETIOI DATE
F 692	Continued From page	<u>م</u>	F 69	2		
	and totaled for the da		1 03	2		
F 809		5	F 80	a	11	/15/18
SS=E	CFR(s): 483.60(f)(1)-		1 00			10/10
	facility must provide a regular times compar the community or in a needs, preferences, r §483.60(f)(2)There m hours between a sub- breakfast the followin nourishing snack is so hours may elapse bet	esident must receive and the at least three meals daily, at able to normal mealtimes in accordance with resident requests, and plan of care. The stantial evening meal and g day, except when a erved at bedtime, up to 16 tween a substantial evening ne following day if a resident				
	meals and snacks mu who want to eat at no of scheduled meal se the resident plan of ca This REQUIREMENT by: Based on observatio interviews the facility	is not met as evidenced ns, staff and resident failed to offer or deliver		F809 483.60(f)(1)-(3) FREQUENC MEALS/SNACKS AT BEDTIME	YOF	
	bedtime snacks to 3 o Resident #286 and R	of 3 residents (Resident #32, esident #287).		Preparation and/or execution of this of Correction does not constitute	s Plan	
	-	v with Resident #32 on		admission by the provider of the tru facts alleged or the conclusions set in the statement of deficiencies. Th	: forth nis Plan	
	indicated that bedtime	2:30pm Resident #32 also e snacks were never passed she did not know she could		of Correction is prepared solely been is required by the provision of the F and State Law.		

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		ND HUMAN SERVICES					M APPROVE D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/19/2018	
		345116	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			S	IREET ADDRESS, CITY, STATE, ZIP CODE		
STARMOL	INT HEALTH AND REHA	B CENTER			99 S HOLDEN ROAD REENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 809	Continued From page 22		F	809	The resident #386, #387, and #32 bay	<i>.</i>	
	2018 from 7:40pm un observed passing out residents that resided During a second inter October 16, 2018 at 9 snacks were not offer night. Resident #32 in room tonight (Octobe An observation of Re October 16, 2018 at 9 had been left in her ro During an interview w on October 16, 2018 snacks were passed NA #267 revealed that snacks and she had n resident #32 tonight. During an interview w Nursing on October 1 indicated that her exp would be offered a be During an interview w on October 16, 2018 expectation was all re bedtime snack nightly During an interview w October 17, 2018 at 2 labeled snacks were residents and bulk sn	rview with Resident #32 on 9:25 pm, she revealed that red or passed out during the indicated no one came by her er 16, 2018). esident #32's room on 9:05 pm revealed no snack oom. with Nurse Assistant #267 at 9:30pm revealed that out between 8pm and 9pm. at only specific residents got not passed out a snack to with the Assisted Director of 16, 2018 at 9:45pm she bectation was all residents edtime snack every night. with the Director of Nursing at 9:45pm revealed that her esidents who wanted a y would receive one. with the Dietary Manager on 2:45pm, he revealed that prepared daily for diabetic nacks were available for the efacility. He added the			The resident #386, #387, and #32 have been offered HS snack each evening beginning on 11/1/18. The process that led to the breakdown was a lack of education of the standar for offering of HS snacks by the nursing staff. Nursing staff has been in-serviced by DON, ADON or Unit Managers on the offering of HS snacks each night. Thi was completed by the ADON on 11/1/ An audit tool was developed to validar that HS snacks are being provided an offered in accordance with the regulat The audit will be conducted by the Un Manager, ADON, DON 5 X week for 4 weeks, then weekly X 4 weeks. The audits began on 11/12/18. All audits will be reviewed in the QAP meeting to determine effectiveness are duration of the audits. The DON is responsible for the execut of this plan.	n rd ng the is 18. te id ion. it t	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	·		
		345116	B. WING				C 19/2018
NAME OF PI	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE	1	
STARMOL	INT HEALTH AND REHA	B CENTER			109 S HOLDEN ROAD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 809	Continued From page	23	F	808	9		
		ng out the snacks between					
	pm he also indicated	with Resident #286 at 2:31 he only been here two received any bedtime been offer one.					
	2018 from 7:40pm un	n on Tuesday October 16, til 9:23pm, no one was t or offering snacks to the I on the 200 hall.					
	October 16, 2018 at 9 snacks were not offer	view with Resident #286 on 9:27 pm, he revealed that red or passed out during the indicated no one came by ober 16, 2018).					
		sident # 286's room on 9:08 pm revealed no snack 9om.					
	on October 16, 2018 snacks were passed NA #267 revealed tha	with Nurse Assistant #267 at 9:30pm revealed that out between 8pm and 9pm. at only specific residents got not passed out a snack to					
	Nursing on October 1 indicated that her exp	vith the Assisted Director of 6, 2018 at 9:45pm she pectation was all residents edtime snack every night.					
	on October 16, 2018	vith the Director of Nursing at 9:45pm revealed that her esidents who wanted a v would receive one.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C 10/19/2018	
345116		B. WING					
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
STARMOU	INT HEALTH AND REHA	B CENTER			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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 809	Continued From page	24	F	809	9		
	October 17, 2018 at 2 labeled snacks were i residents and bulk sn other residents in the nursing assistants (Nuresponsible for passin 8pm and 9pm. 3. During an interview pm she revealed that bedtime snack and be During an observation 2018 from 7:40pm un observed passing out residents that resided During a second inter October 16, 2018 at 9 snacks were not offer night. Resident #287 her room tonight (Oct An observation of Res October 16, 2018 at 9 had been left in his ro During an interview w on October 16, 2018 snacks were passed of NA #267 revealed that snacks and she had r resident #287 tonight	ng out the snacks between with Resident #287 at 2:33 she had never been offer a een here almost two year. In on Tuesday October 16, til 9:23pm, no one was or offering snacks to the l on the 200 hall. We with Resident #287 on 0:28 pm, she revealed that red or passed out during the indicated no one came by ober 16, 2018). Sident # 287's room on 0:15 pm revealed no snack oom. With Nurse Assistant #267 at 9:30pm revealed that out between 8pm and 9pm. at only specific residents got not passed out a snack to					
	Nursing on October 16, 2018 at 9:45pm she indicated that her expectation was all residents						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVE MB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345116		(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING			C 10/19/2018		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CC	DE		
STARMOL	INT HEALTH AND REHA	B CENTER		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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE	
F 809 F 812 SS=E	would be offered a be During an interview w on October 16, 2018 a expectation was all re bedtime snack nightly During an interview w October 17, 2018 at 2 labeled snacks were p residents and bulk sn other residents in the nursing assistants (Na responsible for passir 8pm and 9pm. Food Procurement, St CFR(s): 483.60(i)(1)(2 §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe from consuming food §483.60(i)(2) - Store, serve food in accorda standards for food set	edtime snack every night. it the Director of Nursing at 9:45pm revealed that her isidents who wanted a would receive one. it the Dietary Manager on 2:45pm, he revealed that prepared daily for diabetic acks were available for the facility. He added the As) on the halls were ing out the snacks between ore/Prepare/Serve-Sanitary 2) y requirements. re food from sources ed satisfactory by federal, es. bod items obtained directly subject to applicable State ulations. s not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents is not procured by the facility. prepare, distribute and nce with professional rvice safety.	F 8	309		11/15/18	
	Food Procurement, St CFR(s): 483.60(i)(1)(2 §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe from consuming food §483.60(i)(2) - Store, serve food in accorda standards for food ser	2) y requirements. The food from sources ed satisfactory by federal, es. bod items obtained directly subject to applicable State ulations. s not prohibit or prevent roduce grown in facility pompliance with applicable d-handling practices. es not preclude residents is not procured by the facility. prepare, distribute and nce with professional	F 8	312		11/15/1	

Facility ID: 953473

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345116			, <i>,</i>	PLE CONSTRUCTION		TE SURVEY MPLETED
		B. WING _		1	C 10/19/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		0/10/2010
				109 S HOLDEN ROAD		
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	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION (E ACTION SHOULD BE D TO THE APPROPRIATE (CIENCY)	(X5) COMPLETION DATE
F 812	Continued From pag	e 26	F 8	12		
	by: Based on observation and staff interviews the facility failed to ensure pots and pans were clean and allowed to air-dry before being stored. This was evident in 1 of 1 kitchen observation.			F812 483.60(i)(1)(2) F PROCUREMENT, STORE/PREPARE/SE	ERVE-SANITARY	
	Findings Included:	kitchen on $10/14/18$ at 4.05		Preparation and/or exe of Correction does not admission by the prov facts alleged or the co	t constitute ider of the truth of	
	An observation of the kitchen on 10/14/18 at 4:05 pm with Cook #1 revealed 4 - 1/3 size steam table pans were stacked together wet, 4 -full size steam table pans were stacked together wet and 6 - full size sheet pans were stacked together wet with white, greasy substances on them. All pans			in the statement of def of Correction is prepar is required by the prov and State Law.	ficiencies. This Plan red solely because it	
	clean, ready to use p An interview on 10/1	orage rack designated for oots and pans. 4/18 at 4:10 pm with Cook #1 able and sheet pans should		The steam table pans air dried in accordance They were then stored dried on 10/19/18.	e to the regulation.	
	sink before they were storage shelf. He sta	e drying section of the pot e put away on the clean ted all dishware should be air-dry before being put		The process breakdow deficiency was the Die to hold dietary staff ac process.	etary manager failed	
An interview on 10/17/18 at 7:30 am Dietary Manager (DM) revealed all p should be clean and allowed to air-du being stored.		 revealed all pots and pans allowed to air-dry before 		The dietary staff to inc Manager has been in- District Director of Die standard for cleaning a and pans to include ai storage. Dietary staff	serviced by the tary Services on the and storage of pots r drying prior to	
	An interview on 10/19/18 at 12:41 pm with the Administrator revealed he expected all pans to be clean and dry before being stored for use.			11/12/18. An audit tool was creat compliance to the regut will be conducted by th 5 X a week for 4 week for 4 weeks. The audit 11/12/18.	ulation. The audit he Dietary Manager s, then twice weekly	

Event ID: 91O211

Facility ID: 953473

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ATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	10. 0938-03
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345116		A. BUILDING		COM	MPLETED	
		B. WING		C 10/19/2018		
NAME OF PROVIDER OR SUPPLIER STARMOUNT HEALTH AND REHAB CENTER			s	TREET 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 812	Continued From page	e 27	F 812	Audit results will be reviewed by the committee to determine effectivene duration of the audits. The Dietary Manager is responsible	ess and	
F 867 SS=D			F 867	the execution of this plan.		11/15/18
	§483.75(g) Quality assessment and assurance.					
	 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews the facility 's Quality Assessment and Performance Improvement Committee (QAPI) failed to maintain implemented procedures and monitor the interventions that were put in place following the annual recertification and complaint survey of 9/12/17. This was for 2 recited deficiencies in the area of supervision to prevent accidents (F-689) and development of comprehensive care plans (F-656). These deficiencies were re-cited during the annual recertification and complaint survey of 10/19/18. The continued failure of the facility during 2 federal surveys of record showed a pattern of the facility 's inability to sustain and 			F867 483.75(g)(2)(ii) QAPI/QAA IMPROVEMENT ACTIVITIES Preparation and/or execution of this of Correction does not constitute admission by the provider of the tru facts alleged or the conclusions set in the statement of deficiencies. Th of Correction is prepared solely be is required by the provision of the F and State Law. The facility Administrator will condu Quality Assurance and Improvement (QAPI) Committee meeting on Nov	ith of t forth his Plan cause it Federal ict a nt	
	effective QAPI progra Findings Included: This tag was cross re	am.		12, 2018 to discuss the repeat deficiencies, F689 and F656, from two annual recertification surveys. meeting consisted of reviewing the regulation and not just the specific deficient practice cited. During this	our last The entire	

Event ID: 91O211

Facility ID: 953473

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		<u>NO. 0938-03</u> TE SURVEY
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	· · ·	COMPLETED		
				·		С
	345116		B. WING		1	0/19/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
				109 S HOLDEN ROAD		
STARMOU	JNT HEALTH AND REHA	AB CENTER		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 C (EACH CORRECTIVE AU CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
F 867	Continued From page	e 28	F 86	7		
		e supervision and assistance		meeting, initial audits wer	re reviewed and	
	devices to prevent ac			determined to be effective		
		ns, record review and staff		continue as stated in the	plans of	
		failed to provide fall mats		correction.		
		s a safety intervention for a				
		current falls with injuries. This		The QAPI committee det		
		3 residents reviewed for		alleged process breakdow		
	accidents (Resident #	#84).		when the facility complete		
	During the recertifica	tion and complaint survey of		the plan of correction fror the audits were discontin	· ·	
	-	as cited for failure to provide		further random auditing n		
		n transferring a resident to		occurred throughout the		
		care and failure to provide		Committee s discretion.		
	supervision to prever	nt repeated falls for 1 of 3				
	residents reviewed for	or accidents (Resident #113).		The Administrator will edu	ucate the QAPI	
				Committee by November		
		nt and Implementation of		regarding accurately repo	-	
	Comprehensive Care			revising current action pla		
		ews and staff interviews, the		developing and implement	•	
	facility failed to devel	plan for 1 of 5 residents		plans to assure complian federal regulations in the		
		e care plans were reviewed		QAPI committee determin		
	for unnecessary med	-		the plan of correction will		
	, , , , , , , , , , , , , , , , , , , ,			monthly throughout the y		
	During the recertification	tion and complaint survey of		sustained compliance on		
		as cited for failure to develop		Committee determined a	udits from the	
		e plan for ADL (activities of		plan of correction will be		
	daily living) care and			QAPI Meeting monthly th	•	
		erapy and bowel regimen for		year to validate sustained		
	1 of 1 residents (Res	ident #165).		ongoing. Should any inte		
	An interview with the	Administrator on 10/19/18 at		team member find that th need an Ad Hoc Quality A		
		e was the leader of the		Performance Improveme		
		nittee. He stated the team		facility compliance issue,		
	-	uded all of the department		Administrator will organiz		
	-	I the medical director and		notify all team members i		
		st attended the meetings		any present action plan o	or determine the	
		istrator stated they recently		need for a new action pla	n in order to	
	hired a new MDS nur	rse with many years of		maintain compliance in th	ne facility.	

Facility ID: 953473

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345116 NAME OF PROVIDER OR SUPPLIER			· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		B. WING		C		
			STREET ADDRESS, CITY, STATE, ZIP CODE	10/19/2018		
	JNT HEALTH AND REHA	AB CENTER		109 S HOLDEN ROAD 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 OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 867	deficiencies for deve care plans. He added not providing the falls history of falls. The A QAPI team would ne	e 29 IId help with the repeat lopment of comprehensive d the staff made a mistake by a mats for a resident with a doministrator explained the ed to evaluate and develop by monitoring, for these	F 86	 Quality assurance monitoring w place at each Quality Assurance Performance Improvement meet monthly and any AD Hoc meetin This monitoring tool will be sign the responsible Interdisciplinary member after each meeting acc and acknowledging monitoring revisions set forth by the QAPI Committee. The Vice Presiden Operations or District Director of Services will review the facility of meeting minutes at least month months. The Administrator is responsible implementing the plan of correct ensure the plan of correction is ongoing. 	e eting ngs held. ed off by r team cepting and t of of Clinical QAPI ly X 3 e for etion and to	

Facility ID: 953473

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