2S FOR MEDICARE & I						M APPROVED
	MEDICAID SERVICES	_			OMB NO	<u>). 0938-0391</u>
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			COM	E SURVEY PLETED
	345116	B. WING				C / 23/2017
ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNT HEALTH AND REHA	B CENTER					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
483.10(d)(3)(g)(1)(4)(RIGHTS, RULES, SE (d)(3) The facility mus remains informed of th of contacting the phys professionals respons §483.10(g) Informatio (1) The resident has th his or her rights and co governing resident co during his or her stay (g)(4) The resident has notices orally (meanin (including Braille) in a or she understands, in (i) Required notices a The facility must furni- description of legal rig (A) A description of th personal funds, under section; (B) A description of th procedures for establi- including the right to r	5)(13)(16)-(18) NOTICE OF RVICES, CHARGES at ensure that each resident he name, specialty, and way sician and other primary care sible for his or her care. In and Communication. he right to be informed of of all rules and regulations induct and responsibilities in the facility. Is the right to receive ing spoken) and in writing format and a language he including: is specified in this section. sh to each resident a written ghts which includes - e manner of protecting paragraph (f)(10) of this is e requirements and ishing eligibility for Medicaid, equest an assessment of	TAG		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		3/27/17
(C) A list of names, ac email), and telephone State regulatory and i resident advocacy gro Survey Agency, the S State Long-Term Care protection and advoca	numbers of all pertinent nformational agencies, pups such as the State tate licensure office, the ombudsman program, the acy agency, adult protective					(X6) DATE
	OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER UNT HEALTH AND REHAN SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L 483.10(d)(3)(g)(1)(4)(RIGHTS, RULES, SE (d)(3) The facility must remains informed of tt of contacting the phys professionals respons §483.10(g) Informatio (1) The resident has t his or her rights and c governing resident co during his or her stay (g)(4) The resident has notices orally (meanir (including Braille) in a or she understands, in (i) Required notices a The facility must furni- description of legal rig (A) A description of th personal funds, under section; (B) A description of th procedures for establi- including the right to r resources under secti Security Act. (C) A list of names, ac email), and telephone State regulatory and i resident advocacy gro Survey Agency, the S State Long-Term Care protection and advoca	OF DEFICIENCIES FORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345116 345116 345116 ROVIDER OR SUPPLIER UNT HEALTH AND REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. Ş483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. 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WING PROVIDER OR SUPPLIER IDENTIFICATION NUMBER: ID VINT HEALTH AND REHAB CENTER ID ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES F (d)(3) The facility must ensure that each resident remains informed of the name, specially, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. 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STATE 2P CODE 199 SHOLDEN ROAD CREENSBORO, NC 27407 INT HEALTH AND REHAB CENTER ID PREFX TAG (M2) MULTIPLE CONSTRUCTION CONSTRUCTION (2CAH CORRECTIVE ACTION SHOULD BE CROSS-REFLICTION MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFICIENCY, and Way of contacting the physician and other primary care professionals responsible for his or her care. F 156 \$483.10(q) Information and Communication. (1) The resident has the right to be informed of his or her stay in the facility. F 156 \$483.10(q) Information and Communication. 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Electronically Signed

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.

03/15/2017

TATEMENT	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER		A. BUILDING			C	
		B. WING		02	2/23/2017	
			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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 156	services where state in long-term care faci agency for informatio community and the M and (D) A statement that f complaint with the St concerning any suspe- federal nursing facility not limited to residen exploitation, misappro- in the facility, non-cor- directives requirement information regarding (ii) Information and co and local advocacy o not limited to the Stat Long-Term Care Oml (established under se Americans Act of 196 U.S.C. 3001 et seq) a advocacy system (as as established under Disabilities Assistanc 2000 (42 U.S.C. 1500 [§483.10(g)(4)(ii) will November 28, 2017 ((iii) Information regard eligibility and coverage [§483.10(g)(4)(iii) will November 28, 2017 ((iv) Contact information	law provides for jurisdiction lities, the local contact n about returning to the ledicaid Fraud Control Unit; the resident may file a ate Survey Agency ected violation of state or y regulations, including but t abuse, neglect, opriation of resident property mpliance with the advance its and requests for returning to the community. ontact information for State rganizations including but te Survey Agency, the State budsman program ection 712 of the Older 35, as amended 2016 (42 and the protection and designated by the state, and the Developmental e and Bill of Rights Act of 01 et seq.) be implemented beginning Phase 2)] ding Medicare and Medicaid ge; be implemented beginning Phase 2)]	F 156			

Facility ID: 953473

If continuation sheet Page 2 of 9

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345116 B. WING				C 23/2017			
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 156	Act); or other No Wro [§483.10(g)(4)(iv) will November 28, 2017 ((v) Contact informatio Control Unit; and [§483.10(g)(4)(v) will November 28, 2017 ((vi) Information and c grievances or compla suspected violation of facility regulations, inc resident abuse, negle misappropriation of re facility, non-compliand directives requirement information regarding (g)(5) The facility must manner accessible ar residents, resident rep (i) A list of names, add and telephone number agencies and advoca Survey Agency, the S protective services wi jurisdiction in long-ter of the State Long-Tern program, the protection home and community and the Medicaid Frant (ii) A statement that the concerning any suspent	ng Door Program; be implemented beginning Phase 2)] an for the Medicaid Fraud be implemented beginning Phase 2)] ontact information for filing ints concerning any f state or federal nursing cluding but not limited to ect, exploitation, esident property in the ce with the advance ts and requests for returning to the community. at post, in a form and hd understandable to presentatives: dresses (mailing and email), ers of all pertinent State cy groups, such as the State state licensure office, adult here state law provides for m care facilities, the Office m Care Ombudsman on and advocacy network, based service programs, ud Control Unit; and he resident may file a	F	150	5			

Facility ID: 953473

If continuation sheet Page 3 of 9

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
345116		B. WING				23/2017		
NAME OF P	ROVIDER OR SUPPLIER		•	5	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 SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 156	limited to resident abu misappropriation of re facility, and non-comp directives requirement I) and requests for inf to the community. (g)(13) The facility mu written information, and applicants for admissi- information about how Medicare and Medicar receive refunds for pr such benefits. (g)(16) The facility mu and services to the re admission and during (i) The facility must in and in writing in a lang- understands of his or regulations governing responsibilities during (ii) The facility must a the State-developed r obligations, if any. (iii) Receipt of such in amendments to it, mu writing; (g)(17) The facility mut (i) Inform each Medicar	use, neglect, exploitation, esident property in the pliance with the advanced ts (42 CFR part 489 subpart ormation regarding returning ust display in the facility nd provide to residents and ion, oral and written v to apply for and use id benefits, and how to evious payments covered by ust provide a notice of rights sident prior to or upon the resident's stay. form the resident both orally guage that the resident her rights and all rules and resident conduct and the stay in the facility. Iso provide the resident with notice of Medicaid rights and formation, and any tst be acknowledged in	F	156				

If continuation sheet Page 4 of 9

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/28/2017 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345116	B. WING		_		C 23/2017
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
STARMOU	INT HEALTH AND REHA	B CENTER		09 S HOLDEN ROAD GREENSBORO, NC 274	407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 156	Continued From page Medicaid of-	- 4	F 156				
	. ,	vices that are included in es under the State plan and may not be charged;					
	facility offers and for w	and services that the which the resident may be ount of charges for those					
	changes are made to	aid-eligible resident when the items and services ns (g)(17)(i)(A) and (B) of					
	before, or at the time periodically during the available in the facility services, including an	e resident's stay, of services and of charges for those y charges for services not are/ Medicaid or by the					
	and services covered Medicaid State plan, t	coverage are made to items by Medicare and/or by the he facility must provide the change as soon as is					
	items and services the facility must inform the	e made to charges for other at the facility offers, the e resident in writing at least mentation of the change.					
	(iii) If a resident dies of transferred and does facility must refund to	not return to the facility, the					

Facility ID: 953473

If continuation sheet Page 5 of 9

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIE	PLE CONSTRUCTION		NO. 0938-039
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	· · ·	C		
		B. WING		c	2/23/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
STARMOL	INT HEALTH AND REHA			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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 156	Continued From pag	e 5	F 15			
1 100		e o tate, as applicable, any		00		
		ready paid, less the facility's				
		days the resident actually				
	resided or reserved of	or retained a bed in the				
		any minimum stay or				
	discharge notice requ	uirements.				
	(iv) The facility must	refund to the resident or				
		ve any and all refunds due				
) days from the resident's				
	date of discharge fro	m the facility.				
	v) The terms of an ac	dmission contract by or on				
		al seeking admission to the				
	-	lict with the requirements of				
	these regulations.	L is not mot as suideneed				
	by:	Γ is not met as evidenced				
	•	iew, resident and staff		"Preparation and / or exec	cution of this	
		failed to provide written		plan of correction does no		
		f three sampled residents		admission or agreement b	• •	
	received notification			the truth of facts alleged o		
		pon admission to the facility		set forth in the statement of		
		#2). The findings included:		The plan of corrections is or executed solely becaus		
	1. Resident #5 was	admitted to the facility on		by provisions of federal an		
		liagnoses included purulent		51		
		affecting the lining of the		3 of the 3 resident's admis		
	abdominal cavity) an	d chronic pain.		have been reviewed with t		
		Data Sat (MDS) had not		/ or responsible party and		
	been completed.	Data Set (MDS) had not		signed and dated appropri	-	
	On 2/22/17 at 2:000	A an intension was		All residents who admit to		
	On 2/22/17 at 2:00Pl	vi, an interview was dent #5. Resident #5 was		the potential to be affected admissions residing in the		
		e stated he received a copy		audited by the Admissions	•	
		n 2/20/17 after asking for		and the appropriate admis		
		5	1			1

Facility ID: 953473

If continuation sheet Page 6 of 9

TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,	PLE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	CO	MPLETED	
345116		B. WING			C 12/23/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		2/23/2017
STARMOUNT HEALTH AND REHAB CENTER			109 S HOLDEN ROAD			
STARMOL	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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIOI DATE
F 156	Continued From page	e 6	F 15	56		
	10	y Admission Packet revealed		The Admissions Coordin	ator will be	
		Resident Rights included in		re-educated by the Admi		
	the packet. The Adm			admission process and t		
	contained informatior	n regarding the care and the facility, contact numbers		admission paperwork re		
	for facility staff, physi	-		Admission packets will b	e reviewed by	
	insurance information			Administrator/Designee		
				admission paperwork ha		
	On 2/22/17 at 5:15PM	۸, an interview was		and appropriately signed	l in a timely	
		dmissions Coordinator. She		manner upon admission	by resident and /	
	admission. If a resid	s packet was completed on ent was admitted on the		or responsible party.		
		ions packet would be		An admission process a		
	completed on Monda	-		completed 5 times a wee		
		r Resident #5 and said she		bi-weekly for 4 weeks ar		
		ode status form and the		weeks to ensure approp signature of the admission		
	#5 on 2/4/17. The A	that was signed by Resident dmissions Coordinator ioned Resident #5 ' s		resident and / or respons		
		that was why the admissions		The results of the audits	will be reviewed	
	-	completed as of 2/22/17.		at the monthly Quality As		
		normally call the family to		Performance Improveme		
	come and complete t	he admission packet if a		monthly times three mor	•	
		to complete the information.		recommendations as ide	entified.	
		ne had called the family, she				
		as his own RP and she was				
		ssion packet when he got				
		ne had no documentation of the admission packet that				
		t rights information. She				
		Id have been completed				
	sooner.					
		ated 2/22/17 at 6:32PM				
	revealed the admissi completed with Resid					
	On 2/23/17 at 2:58PM	M, an interview was				
		dministrator. She stated if a				

If continuation sheet Page 7 of 9

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C		
		345116	B. WING				23/2017	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
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 .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 156	resident was admitted hours, nursing staff w treat and the MOST fe where the resident rig for the packet to be co- include date as soon resident can sign the scope of treatment) fo they should be able to admission packet. 2. Resident #1 was a 2/9/17. A review of the admiss revealed the MOST fo form was signed by R party on 2/9/17. The packet had the respon- none of the forms were the packet had been of On 2/23/17 at 2:00PM conducted with the so did not have any door remainder of the admic completed and the for a date that would hav was completed. On 2/23/17 at 2:58PM conducted with the Adv resident was admitted hours, nursing staff w treat and the MOST fe where the resident rig for the packet to be co- include date as soon	d over the weekend or after ould obtain the consent to orm, tour of the facility, show this are posted; expectation ompleted in its entirety to as possible. She stated if a MOST (medical orders for orm and consent to treat, o complete and sign the admitted to the facility on sion packet for Resident #1 or and the consent to treat remainder of the admission nsible party 's signature but re dated to indicate when completed. A, an interview was ocial worker. She stated she umentation on when the issions packet was rms should have contained re indicated when the packet	F	150	6			

Facility ID: 953473

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 03/28/2017 / APPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMF	SURVEY LETED
		345116	B. WING			_		C 23/2017
NAME OF P	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
STARMOL	JNT HEALTH AND REHA	B CENTER			09 S HOLDEN ROAD GREENSBORO, NC 274	407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 156	scope of treatment) for they should be able to admission packet. 3. Resident #2 was a 1/6/17. A review of the admiss revealed the MOST for form was signed by R party on 1/6/17. The packet had the respon no one of the forms w the packet had been of On 2/23/17 at 2:00Pl conducted with the so did not have any door remainder of the adm completed and the for a date that would hav was completed. On 2/23/17 at 2:58PM conducted with the Ad resident was admitted hours, nursing staff w treat and the MOST for where the resident rig for the packet to be or include date as soon resident can sign the scope of treatment) for	orm and consent to treat, o complete and sign the admitted to the facility on assion packet for Resident #2 orm and the consent to treat Resident #2 ' s responsible remainder of the admission nsible party ' s signature but vere dated.to indicate when completed. M, an interview was bocial worker. She stated she umentation on when the hissions packet was rms should have contained re indicated when the packet	F	1156				

Facility ID: 953473

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