PRINTED: 12/11/2017 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345116	B. WING _			C 09/14/2017	
NAME OF P	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 007	1-7/2017
				1	09 S HOLDEN ROAD		
STARMOL	INT HEALTH AND REHA	B CENTER		C	GREENSBORO, NC 27407		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X 	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 241	DIGNITY AND RESP	ECT OF INDIVIDUALITY	F2	241			10/12/17
SS=E	CFR(s): 483.10(a)(1)						
	(a)(1) A facility must t	reat and care for each					
		and in an environment that					
	·	ce or enhancement of his or gnizing each resident's					
	individuality. The facil	-					
	promote the rights of						
	This REQUIREMENT	is not met as evidenced					
	by:						
		ns, record reviews, resident			Preparation and / or execution of this		
		ne facility failed to provide en requested, resulting in			plan of correction does not constitute admission or agreement by the provide	er of	
		for 3 of 4 residents who			the truth of facts alleged or conclusions		
		sistance with personal			set forth in the statement of deficiencie		
		26, Resident #113, and			The plan of corrections is prepared and		
	Resident #111.				or executed solely because it is require by provisions of federal and state law.	ed	
	Findings included:				Per review of concern log and interview		
		admitted to the facility on			with the surveyors Residents #26, #113	3,	
	05/17/17 with current	diagnoses of chronic y disease, hypothyroism,			#111 stated their call bells were not answered timely. Per interview with the	_	
	and obstructive sleep				surveyors Residents #26, #113 and #1		
	and obouldouve oleep	арпоа.			were not provided care timely. Call bel		
	A review of the conce	rn logs from 06/17 until			are being answered timely. Timely		
	-	Resident #26 had concerns			Incontinent care is being provided as		
		being answered in a timely			requested and or as needed.		
		the resident had urinated ked before staff answered			Staff mambara are to respend to call be	alla	
	her call bell.	ked before stall allswered			Staff members are to respond to call be in a timely manner and address the	5115	
					residents □ requests, if able, at that time	e.	
	Review of Resident #	26's quarterly Minimum			If staff is unable to meet the residents		
		d 08/21/17, revealed that			request at the time the call bell is		
		gnitively intact, legally blind			answered the request should be met as		
		needs known. The resident			quickly as possible. Staff is to interact		
	required extensive as				with residents in a respectable manner		
		son physical assist, and for was totally dependent on			Staff members were in-serviced by the		
ADODATODY		SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

10/05/2017 **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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		SURVEY PLETED
		045440	D WING				С
		345116	B. WING _			09	/14/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
STARMOI	JNT HEALTH AND R	EHAR CENTER		10	9 S HOLDEN ROAD		
OTAKWO	JINI HEAEHI AND K	ENAB CENTER		G	REENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 241	Continued From p	page 1	F	241			
	staff with one per	son physical assist. Resident ly incontinent of bowel and			Administrator and or Staff Developme Coordinator and or the Director of Nur and or the Unit Managers on answerir	sing	
					call bells in a timely manner and meet	ing	
		the concern log revealed another concern dated			the request if able. Staff members we in-serviced by the Administrator and o		
	08/31/17 that she	had another episode of urinary			Staff Development Coordinator and or		
	incontinence and	her bed was soaked before			Director of Nursing and or the Unit		
	staff answered he	r call bell.			Managers that if staff is unable to mee		
					the residents□ request at the time the		
	_	w on 09/11/17 at 6:45 PM			bell is answered the request should be	9	
		ealed that during her first week			met as quickly as possible. Staff		
		ne waited 2 hours or longer to			members were in-serviced by the		
		dent # 26 indicated when she			Administrator and or Staff Developme		
	1 -	Il no one answered. Resident #			Coordinator and or the Director of Nur	-	
		use she waited so long she			and or the Unit Managers that staff is		
	1	h urine and bowel movement).			interact with residents in a respectable		
		cated that was a bad feeling			manner. Nursing staff were in-serviced		
		be changed. Resident #26			the Staff Development Coordinator an		
		all had been reported to the			the Director of Nursing and or the Unit		
		#26 indicated she wanted to go			Managers that incontinent care is bein	•	
		and hoped that staff would care			provided as requested with incontinen	ι	
	situation.	er feel better about her			checks being provided approximately every two hours and or as needed.		
					•		
	_	w with the Social Worker on			The Administrator, Director of Nursing		
		PM she revealed that she had			Unit Managers and Nurse Supervisors		
		#26 on 09/06/17 to a new room.			conduct ten random resident observat	ions	
		during this interview that			per week to validate call bells are		
		issues with her call bell not			responded to in a timely manner. The		
	being answered a	and staff not changing her.			Department Managers (including the Administrator, the Director of Nursing,	the	
	During an intervie	w with Nursing Assistant (NA)			Business Office Manager, the		
		26 on 09/13/2017 at 3:30 PM,			Maintenance Director, the Activities		
		she had only been working with			Director, the Social Services Director	and	
		two days. NA #3 indicated she			the Scheduler) will interview ten reside		
		concerns with this resident and			per week to validate timely provision of		
	·	eated her residents with respect			incontinent care. The Department		
	and dignity.				Managers will interview ten residents	per	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245446	B. WING				С
		345116	B. WING _			09	/14/2017
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STARMOL	JNT HEALTH AND RE	HAB CENTER		1	09 S HOLDEN ROAD		
01711111101	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			G	GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From p	age 2	F 2	241			
	During an interviev	w with Director of Nursing			week to validate residents are being treated in a respectable manner. The		
		7 at 3:45 PM, she indicated that			Administrator will present the results of	;	
	, ,	vere for all staff to answer a call			the call bell audit and the Director of		
		utes. Her expectation would be			Nursing will present the results of the		
		all residents with respect and			timely incontinence care audit to the		
		rs be given as scheduled.			center⊡s Quality Assurance and		
					Performance Improvement Committee		
	2. Resident # 113	was admitted to facility on			The audits will be conducted weekly fo		
		e current diagnoses of			minimum of twelve weeks or until the		
	hypertension, seiz	ure disorder and cerebral palsy.			Quality Assurance and Performance Improvement Committee determines the	ne	
	Resident #113 Mir	nimum Data Set (MDS) dated			audits remain necessary to sustain		
	07/07/17 revealed	the resident was cognitively			compliance ongoing. The audits will be	Э	
	intact. The resider	nt required extensive assistance			presented for a minimum of three month	ths,	
		transfers, toilet use with two			in the Quality Assurance and Performa	nce	
		ssist, and with locomotion,			Improvement Committee Meeting to		
		sonal hygiene she required			determine recommendations and further		
		ice with one person physical			actions indicated. At the end of the thr	ee	
		nt was incontinent of bladder			months, the Quality Assurance and		
	and incontinent of	bowei.			Performance Improvement Committee determine any further actions needed t		
	During an Intervie	w with Resident # 113 on			sustain compliance ongoing. The	O	
	_	M, Resident #113 indicated that			Administrator is ultimately responsible	for	
		7 through 09/10/17) she waited			the plan of correction and ensuring		
		ours for staff to change her.			compliance ongoing.		
		her call bell was on and NA#					
	34 came in, cut of	f her call bell, and stated she					
	would be back in a	a few minutes, and it was an					
	hour before the NA	A came back to change her.					
		icated that her buttocks were					
		n on it from waiting so long.					
		dicated that she was admitted to					
		/2017 and this has been an					
		acement. Resident #113 also					
		several falls because staff did					
		call bell. Resident # 113					
		roommate had a clock on the					
	wall in front of her	bed, and this was how she					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345116	B. WING			C <b>9/14/2017</b>
	ROVIDER OR SUPPLIER  JNT HEALTH AND REH	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  109 S HOLDEN ROAD  GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 241	call bell. Resident # 09/09/17 or 09/10/1 feces for over two h was how she got th Resident #113 indic during the day. Resident #16 during the day. Resident #16 during the day. Resident down a lot in the so slow and their at but she had to get to buring an interview #34 on 09/13/2017 was not the NA that urine and feces last #34 revealed she we residents soaked in #34 also indicated serident's room and coming back in 10 thand treatment.  During an Interview 10 AM, NA #43 indi	ge 3 waited for staff to answer her # 113 revealed that on 7 she waited in her urine and ours and she believed that e rash on her bottom. Fated her brief was soiled a lot sident #113 indicated this having to wait so long to ent #113 revealed she felt sad e facility because staff were titudes are not the greatest better so she could go home.  with Nursing Assistant (NA) at 2:45 PM, she revealed she left Resident # 111 in her week but it was NA #43. NA ould never leave any urine and feces that long. NA she would never go in a I cut off the call bell without to 15 minutes to provide care  with NA #43 on 09/14/2017 at cated that she would never urine and feces for that long.	F 24	.1		
	(DON) on 09/13/17 her expectations we bell within 3-5 minu	with Director of Nursing at 3:45 PM, she indicated that ere for all staff to answer a call tes. Her expectation would be residents with respect and				
		vas admitted to facility on current diagnoses of tes mellitus and				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345116	B. WING		C 09/14/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  109 S HOLDEN ROAD  GREENSBORO, NC 27407	09/14/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 241	Resident #111's qua (MDS) dated 08/30/was cognitively intal extensive assistant one person physical Resident #111 was with two personal plant was always inconting incontinent of bowed During an interview 09/12/2017 at 1:30 of 09/04/17 through bed for 2 hours for sindicated that her can assistant #34 cames stated she would be was an hour before 111 indicated that had a rash from wa also revealed that the times during her state that she had a clock and that was how sfor staff to answer hrevealed that on 09 in her urine and fee believed that incide Resident #111 indicated that staff took since the property of the prop	arterly Minimum Data Set (2017 revealed the resident ct. The resident required the with personal hygiene with I assist and for bathing totally dependent upon staff thysical assist. The resident thent of bladder and always I.  with Resident # 111 on PM, she indicated (the week 09/10/17), she waited in her staff to change her. She tall bell was on and Nursing the in, cut off the call bell, and the back in a few minutes but it the she came back. Resident # ter buttocks were red and she titing so long. Resident # 111 this had happened several the knew how long she waited the call bell. Resident # 111 (706/17 or 09/09/17, she waited the for over two hours, and she that caused her red bottom. The tated that this made her feel too long to provide care for her.  The indicated that she the tall we have and dirty on 09/09/17 that the bottom was sore and the ling lying in her urine and	F 24	11	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	_	(X3) DATE COMP	SURVEY LETED
		345116	B. WING		_	1	C <b>14/2017</b>
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, S 109 S HOLDEN ROAD GREENSBORO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	was not the NA that he urine and feces the p #43. NA #34 revealer residents soaked in u #34 also indicated shresident's room and coming back in 10 to and treatment.  During an Interview v 10 AM, NA #43 indicated a resident in uring an interview v (DON) on 09/13/17 a her expectations for a within 3-5 minutes. Hall staff treat all resides SELF-DETERMINAT CHOICES CFR(s): 483.10(f)(1)-(f)(1) The resident has schedules (including health care and proviconsistent with his or and plan of care and of this part.  (f)(2) The resident has about aspects of his are significant to the (f)(3) The resident has members of the comments.	t 2:45 PM, she stated she eft Resident # 111 in her revious week but it was NA ed she would never leave any urine and feces that long. NA he would never go in a cut off the call bell without 15 minutes to provide care  with NA #43 on 09/14/2017 at ated that she would never rine and feces for that long.  with Director of Nursing t 3:45 PM, she indicated that all staff to answer a call bell her expectation would be that ents with respect and dignity.  ION - RIGHT TO MAKE  (3)  Is a right to choose activities, sleeping and waking times), iders of health care services her interests, assessments, other applicable provisions  Is a right to make choices or her life in the facility that		241			10/12/17

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		E SURVEY IPLETED
		345116	B. WING		0.0	C 9/14/2017
NAME OF P	ROVIDER OR SUPPLIER	0.00		STREET ADDRESS, CITY, STATE, ZIP COI	•	9/14/2017
TO UNE OF TH	to tibert of tool i elert			109 S HOLDEN ROAD	<i>5</i> L	
STARMOL	INT HEALTH AND RI	EHAB CENTER		GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 242	Continued From p	page 6	F 24	42		
	·	ENT is not met as evidenced				
	by:	io not mot as evidenced				
	,	ation, staff and resident		Resident #135 requested to	the Social	
		ility failed to honor a resident's		Worker get up early. The So		
		of bed early for 1 of 3 residents		forgot to notify nursing staff r		
	_	ces (Resident #135.)		Resident #135 staying in bed	-	
		,		her preference. Resident #13		
	Finding included:			was updated per her prefere		
	J			Resident #135 is currently go		
	Resident # 135 w	as admitted to the facility on		getting up from bed per her o	choice.	
	March 22, 2016 w	ith cumulative diagnoses which				
	included hyperten	sion, chronic pain and		Staff members are to honor r	esident	
	pneumonia organ	ism.		preferences for time of going	to and	
				getting out of bed. The Depa	rtment	
		imum Data Set (MDS) dated		Managers (including the Adm		
		ealed Resident #135 was alert		Director of Nursing, the Busin		
		cognitively intact and able to		Manager, the Maintenance D		
		nown to staff. Resident # 135		Activities Director, the Social		
		to total assistance from staff for		Director and the Scheduler) i		
		all of her activities of daily living		alert and oriented residents t		
	except for eating.			residents □ choices for time of		
		1. 1.1.1.4		and getting out of bed. The I	•	
		re plan dated August 24, 2017		Managers (including the Adm		
		ere no interventions about		Director of Nursing, the Busin		
		#135 up at 5:30AM nor was it		Manager, the Maintenance D		
	observed on her of	are card.		Activities Director, the Social		
	During an observe	ation on September 12, 2017 at		Director and the Scheduler) i family members, where avail		
	_	nt # 135 was still in bed with her		residents who are not alert a		
	bed clothes on.	it # 155 was still in bed with her		to determine resident times for		
	bed ciotiles on.			and getting out of bed.	or going to	
	During an intervie	w with Resident # 135 on		and gotting out of bod.		
	_	117 at 11:01 AM Resident # 135		Nursing staff were in-service	d by the by	
		had been asking to get out of		the Administrator and or Staf	•	
		A and no one would get her up.		Development Coordinator an		
		dicated "I am a country girl up		Director of Nursing and or the		
		every day all my life". During this		Managers on honoring reside		
		t #135 was observed with her		preferences for time of going		
	bed clothes on.			getting out of bed and honori		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		LETED
		345116	B. WING _			l	C <b>14/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
STARMOL	JNT HEALTH AND REHA	B CENTER		10	9 S HOLDEN ROAD		
STARWOO	ONT TIEAETH AND KEHA	BOLNIER		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	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242	During an observation 12, 2017 Resident #1 transported down to the Resident #135 indicated that she be getting her dressed at SW indicated that Resident #135 was observed in clothes on.  Observation on Septer #135 was observed in clothes on.  Observation on Septer #135 was observed in clothes on.  Observation on Septer #135 was observed in clothes on.  During an interview with 11 AM on September knew that Resident #1 third shift (11:00 PM indicated that she be getting her dressed at SW indicated that Resident #1 shift (11:00 PM indicated that Shift (11:00 P	n at 11:30 AM on September 35 was observed being he main dining room. ated "they got me up."  ember 13, 2017 Resident # bed at 7 AM with her bed  ember 13, 2017 Resident in bed at 9 AM with her bed  ember 13, 2017 Resident in bed at 9 AM with her bed  ember 13, 2017 Resident in bed at 9 AM with her bed  ember 13, 2017 Resident in her wheel chair out of rise's station at 10:30 AM.  with Social Worker (SW) at 13, 2017 revealed that SW 135 requested to get up on		242		he the and nts for re	DATE
	worked with Residen that she wanted to get During an second into September 13, 2017 indicated that she tall still wanted to get up	t #135 and was not aware et up so early. erview with the SW on at 2: 30PM, the SW ked with Resident # 135 who at 5:30 AM.			correction and ensuring compliance ongoing.		
		vith the Director of Nursing 13, 2017 at 2:35PM, she					

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		345116	B. WING		C <b>09/14/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.12011
				109 S HOLDEN ROAD	
STARMOL	INT HEALTH AND REHA	BCENIER		GREENSBORO, NC 27407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 242	Continued From page	÷ 8	F 24	2	
	revealed each resider	nt's choice of time to get up red.			
F 253	HOUSEKEEPING & I	MAINTENANCE SERVICES	F 25	3	10/12/17
SS=E	CFR(s): 483.10(i)(2)				
		and maintenance services			
	necessary to maintair comfortable interior;	n a sanitary, orderly, and			
		is not met as evidenced			
	by: Based on observatio	n staff intonvious and		The facility did not complete Maintena	nco
		facility failed to replace		Request Forms to communicate repair	
		g tiles in 4 out of 4 rooms		the window, blinds and stained ceiling	
	_	(,). The facility also failed to		to perform corrections. Rooms 112, 1	l l
		of and failed to repair vertical		115 and 132 stained ceiling tiles were	
		vindow in 1 of 1 rooms		replaced in the bathroom and bedroon	IS.
	(109).			Room 109 blinds and window were replaced.	
	The findings included				
				Repairs to resident rooms are to be	
		room 112 occurred on		addressed in a timely manner. Staff w	l l
		he bathroom in room 112		communicate concerns and issues wri	iten
		ater stains on the ceiling		on a Maintenance Request Form for	
	tiles.			minor repairs. Any concern/repair that	
	An observation of roo	m 112 occurred on 9-13-17		may affect resident safety, the concerr will be immediately reported to the	1
		nn 112 occurred on 9-13-17		Maintenance Director and or Supervise	or
	to have water stains of			on Duty and or Administrator.	"
		and doming and o		Maintenance will present Maintenance	
	1b: An observation of	room 113 occurred on		Request Forms from the previous day	
	9-12-17 at 8:30am. T	he ceiling tiles in this room		the daily Department Head Stand Up	
	were noted to have w	ater stains present.		Meeting to the Administrator.  Maintenance Request Forms will be	
	An observation of roo	m 113 occurred on 9-13-17		reviewed for completion and any	
		ne ceiling tiles in this room		outstanding work orders will be presen	ted
	were noted to have w	_		to be completed that day.	
	1c: An observation of	room 115 occurred on		Staff were in-serviced by the	

02.11.2.1	OT OIT MEDIO/ ITE G	MEDIO/ ND CEITTIOEC				<del></del>	<del>2. 0000 000 1</del>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			7 56.25.	_		(	С
		345116	B. WING				14/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
CTADMOL	INT UEALTH AND DELIA	D CENTED		10	09 S HOLDEN ROAD		
STARWOO	INT HEALTH AND REHA	AB CENTER		G	REENSBORO, NC 27407		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 253	Continued From page	e 9	F	253			
		There were water stains			Maintenance Director and or the		
		iles in both the bedroom			Administrator and or the Staff		
	area and the bathroo				Development Coordinator and or the		
					Director of Nursing and or the Unit		
	An observation of roc	om 115 occurred on 9-13-17			Managers regarding requesting repairs	for	
	at 1:50pm. The ceiling	g tiles in both the bedroom			environmental issues. Whenever there		
		m were noted to have water			an issue identified, a Maintenance		
	stains on them.				Request Form must be completed and	in	
					writing. Any concern/repair that may		
	1d: An observation of	f room 132 occurred on			affect resident safety, the concern will	be	
	9-11-17 at 3:55pm. T	he ceiling tiles above the			reported to the Maintenance Director a	nd	
	window were noted to	o have water stains on them.			or Supervisor on Duty and or		
					Administrator. An audit of ceiling tiles	was	
		om 132 occurred on 9-13-17			completed in resident rooms and		
		g tiles above the resident's			bathrooms by Maintenance to ensure i	10	
	window were noted to	o have water stains on them.			other stained ceiling tiles are present.  Any identified stained ceiling tiles have	<b>:</b>	
		maintenance manager			been replaced. An audit of windows in	the	
		at 2:10pm. The maintenance			resident rooms was completed by		
	_	ad not noted any of the			Maintenance to ensure no other broke	n	
	_	idents rooms with water			areas. Any identified broken windows		
		only checks the ceiling tiles			have been replaced.		
		maintenance manager also					
	_	tiles have not been a			The Department Managers (including t		
	priority.				Administrator, the Director of Nursing,	uie	
	Δn interview with the	maintenance manager			Business Office Manager, the Maintenance Director, the Activities		
		at 2:10pm. The maintenance			Director, the Social Services Director a	ınd	
		eplacing ceiling tiles in the			the Scheduler) will audit five resident	ii iu	
		ain. He also stated that the			rooms per week to ensure no ceiling til	es	
		g for as long as he had			are stained, blinds are intact, and		
		which he stated had been 3			windows are not broken. The		
	years. The				Administrator will present the results of	f	
	-	er stated he had tried to do			the room observation audit to the		
		the roof to stop the leaks but			center⊟s Quality Assurance and		
	that he had been uns				Performance Improvement Committee		
					The audits will be conducted weekly fo	ra	
	An attempt to review	the maintenance log			minimum of twelve weeks or until the		
	occurred on 9-13-17	to verify the repairs however			Quality Assurance and Performance		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345116	B. WING		C <b>09/14/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP C	•
STARMOL	JNT HEALTH AND REHA	AB CENTER		109 S HOLDEN ROAD	
				GREENSBORO, NC 27407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  YMUST 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 COMPLETIC HE APPROPRIATE DATE
F 253	Continued From pag	e 10	F 2	53	
F 253	there were not any local 2: An observation of 9-12-17 at 11:20am. 109 were noted to habroken in the middle shut completely. The also noted to have 2 corner and the upper were taped with clea. An interview with res 9-12-17 at 11:22am. blind had been broke could not state exact also stated he does in noticed the window be fixed however the broken with clear tap	room 109 occurred on The vertical blinds in room ave one broken slat that was preventing the blind to be window in room 109 was broken areas; bottom right right corner. Both areas r tape.  ident #78 occurred on The resident stated that the en for "several" months but time frame. The resident not see well enough to have	F 29	Improvement Committee de audits remain necessary to compliance ongoing. The apresented for a minimum or in the Quality Assurance an Improvement Committee M determine recommendation actions indicated. At the ermonths, the Quality Assura Performance Improvement determine any further action sustain compliance ongoing Administrator is ultimately in the plan of correction and ecompliance ongoing.	sustain audits will be f three months, ad Performance eeting to as and further ad of the three ance and Committee will as needed to g. The esponsible for
	occurred on 9-13-17 manager stated that the window of room was the one who pla	at 2:10pm. The maintenance he knew about the glass in 109 being broken and that he ced clear tape over the s unable to state how long			
	9-14-17 at 1:50pm. T she expected repairs writing and given to t he can keep a log of also stated that she completed as soon a	Administrator occurred on The Administrator stated that that were needed be put in the maintenance manager so what was completed. She expected repairs to be s possible. The she would review the			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED
		345116	B. WING		09/14/2017
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  109 S HOLDEN ROAD  GREENSBORO, NC 27407	1 03/14/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 253	Continued From pag maintenance log wee were being complete	ekly to ensure that repairs	F 25	53	
F 279 SS=D	CFR(s): 483.20(d);48	EHENSIVE CARE PLANS 33.21(b)(1)	F 27	79	10/12/17
	assessments comple months in the resider results of the assess	ust maintain all resident eted within the previous 15 nt's active record and use the ments to develop, review ent's comprehensive care			
	comprehensive perseach resident, consists set forth at §483.10(dincludes measurable to meet a resident's land psychosocial necomprehensive assecare plan must describe to maintain the resident physical, mental, and required under §483.24, §483 provided due to the residence provided to the residence provi	develop and implement a con-centered care plan for stent with the resident rights c)(2) and §483.10(c)(3), that objectives and timeframes medical, nursing, and mental eds that are identified in the ssment. The comprehensive ribe the following -  are to be furnished to attain ent's highest practicable dipsychosocial 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345116	B. WING		C 09/14/2017
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	,
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 279	rehabilitative service provide as a result of recommendations. I findings of the PASA rationale in the residential in the residential regidential representation of the passion of the provide passion of the passion of the provided provided passion of the provided prov	services or specialized es the nursing facility will of PASARR f a facility disagrees with the ARR, it must indicate its dent's medical record.  with the resident and the ative (s)- coals for admission and  reference and potential for coilities must document t's desire to return to the essed and any referrals to es and/or other appropriate cose.  in the comprehensive care in in accordance with the oth in paragraph (c) of this  IT is not met as evidenced  on, staff interview and record illed to develop a e plan for ADL care and especifically for e-stim therapy for 1 of 1 residents (resident #  area assessment (CAA)	F 279	Resident #165 care plan did not incle-stim and bowel regimen. Resident was updated to reflect ADL care beir received including e-stim therapy an bowel regimen.  Comprehensive care plans are to ref the resident current status. Areas indicated in the Care Area Assessme be care planned are to be care plans	t #165 ng d flect sent to ned
	triggered for activity	aled that resident #165 of daily living (ADL) function be care planned in this area		as indicated. Residents care plans w reviewed and updated, as needed, b MDS Coordinator and the Interdiscip	y the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345116	B. WING _				C <b>14/2017</b>	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,		
				1	09 S HOLDEN ROAD			
STARMOL	INT HEALTH AND REHA	B CENTER			GREENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 279	279 Continued From page 13		F 2	279				
	with the goal of "inde	pendent in all activity of daily			Care Team Members, including the			
	living (ADL's) and be				Director of Social Services, the			
	community by next re				Registered Dietician, the Director of			
					Therapy and the Activity Director to ref	lect		
	A review of the care p	plan for resident #165 dated			resident⊡s current status and ensure			
	8-11-17 revealed ther	e was no care plan for ADL			Care Area Assessment triggers were c	are		
	function and there wa	is no goal of "independent in			planned if indicated.			
	all activity of daily living							
	discharged to the con	nmunity by next review".			MDS Coordinator and Interdisciplinary			
					Care Team Members, including the			
		area assessment (CAA)			Director of Social Services, the			
	dated 5-11-17 revealed				Registered Dietician, the Director of			
		ence and that he was to be			Therapy and the Activity Director, who			
		rea for bowel and e-stim			complete Minimum Data Set were			
	_	al of "no signs or symptoms			in-serviced by the District Director of	_		
		and for staff to ensure that			Care Management that care plan areas			
	manner.	e e-stim in the correct			triggered in Care Area Assessment that are indicated to be care planned. MDS			
	mamici.				Coordinator and Interdisciplinary Team			
	A review of the care r	plan for resident #165 dated			Members who complete Minimum Data			
	8-11-17 revealed ther				Set were in-serviced that comprehensi			
		ng to the resident's bowel			care plan is to be reflective of resident			
	and e-stim schedule.				current status.			
	An interview with the	Minimum Data Set (MDS)			The District Director of Care Managem	ent		
		14-17 at 12:22pm. The MDS			will audit three Care Plans per week to			
		AA and then the care plan			validate care plans are reflective of the			
		have been care planned. I			resident □s current status. The audits			
	made a mistake and	did not do it".			be conducted weekly for a minimum of			
					twelve weeks or until the Quality	ĺ		
					Assurance and Performance			
					Improvement Committee determines th	ie		
					audits remain necessary to sustain	_		
					compliance ongoing. The audits will be	9		
					presented by the Administrator and or	ĺ		
					Director of Nursing monthly, for a			
					minimum of three months, in the Qualit	.y		
					Assurance and Performance	ĺ		
					Improvement Committee Meeting to			

I` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3	(X3) DATE SURVEY COMPLETED	
		345116	B. WING _			C <b>09/14/2017</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	I	09/14/2017	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 279	Continued From pag	ge 14	F 2	determine recommendations a actions indicated. At the end of months, the Quality Assurance Performance Improvement Condetermine any further actions in sustain compliance ongoing. The plan of correction and ensuronments of the plan of correction and ensuronments.	f the three and mmittee will needed to he onsible for		
F 312 SS=E	RESIDENTS CFR(s): 483.24(a)(2  (a)(2) A resident who activities of daily living services to maintain personal and oral hy This REQUIREMEN by: Based on record reviews to incontinence care for to provide showers of evident for 3 of 4 respectivities of daily living Resident # 111 and Finding included:  1. Resident # 113 we 6/30/2017 with the continency seizur Resident # 113's admits a continuation of the c	(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by:  Based on record reviews, observations, staff and resident interviews the facility failed to provide incontinence care for 3 of 4 residents and failed to provide showers for 1 of 4 residents. This was evident for 3 of 4 residents that were reviewed for activities of daily living (ADL's). (Resident #26, Resident # 111 and resident #113).		Per review of concern log and with the surveyors Residents # #111 stated their call bells were answered timely. Per interview surveyors Residents #26, #113 were not provided care timely. are being answered timely. Tin Incontinent care is being provice requested and or as needed. I #26 was not receiving showers request. Resident #26 prefere updated to reflect her shower publication. Staff members are to respond in a timely manner and address residents requests, if able, at If staff is unable to meet the receivers at the time the call bell answered the request should be	26, #113, e not with the sand #111 Call bells nely ded as Resident per her nees were preference. to call bells that time. sidents is	10/12/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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		345116	B. WING _			09/	14/2017
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				10	09 S HOLDEN ROAD		
STARMOU	INT HEALTH AND REH	AB CENTER		G	REENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE
F 312	9/12/2017 at 2PM, Relast week (September waited in her bed for her. She indicated to NA #34 came in, cut she would be back in #113 stated it was an back to change her. her buttocks was recommended waiting so long. Resolved waiting so long. Resolved waiting so long. Resolved was admitted to the has been an issue so Resident #113 indicated clock on the wall in formal section of the section of the wall in formal section of th	with Resident # 113 on Resident #113 indicated that er 4 through 10, 2017) she is 2 hours for staff to change hat her call bell was on and a off her call bell, and stated in a few minutes. Resident in hour before the NA came Resident #113 indicated that it and had a rash on it from ident #113 indicated that she facility on 6/30/2017 and this ince her placement. In a tend that her roommate had a front of her bed and that on 2017 she waited in her urine we hours and she believed but the rash on her bottom. In a tend her brief was soiled a lot dent #113 indicated this inat staff took so long to and that the facility did not	F	312	quickly as possible. Staff is to interact with residents in a respectable manner Staff members are to provide showers the shower schedule and as requested the resident.  Staff members were in-serviced by the Administrator and or Staff Developmen Coordinator and or the Director of Nurs and or the Unit Managers on answering call bells in a timely manner and meeting the request if able. Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or Director of Nursing and or the Unit Managers that if staff is unable to meet the residents request at the time the obell is answered the request should be met as quickly as possible. Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursiand or the Unit Managers that staff is to interact with residents in a respectable manner. Nursing staff were in-serviced the Staff Development Coordinator and the Director of Nursing and or the Unit Managers that incontinent care is being provided as requested with incontinent checks being provided approximately every two hours and or as needed. Stamembers were in-serviced by the Administrator and or Staff Development Coordinator and or Staff Development Coordinator and or the Director of Nursiand or the Unit Managers on providing showers per the schedule and as requested by the resident.  The Department Managers (including	t ing g g g g g g g g g g g g g g g g g g	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_	<del></del>	، ا	С	
		345116	B. WING				′ 14/2017	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	14/2017	
				109 S HOLDEN ROAD				
STARMOL	INT HEALTH AND REHA	B CENTER			REENSBORO, NC 27407			
	OUR MAA DV OT	TELEVIT OF DEFICIENCIES			·			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE	
F 312	Continued From page	e 16	F:	312				
		as painful and itchy. That	'	012	Administrator, the Director of Nursing,	the		
		that the area still hurts. She			Business Office Manager, the	iiic		
		ept this rash". A new brief			Maintenance Director, the Activities			
		ident as well as pants and			Director, the Social Services Director, a	and		
		ed back in her wheelchair			the Sc8heduler) will interview ten			
		om 1 person via stand and			residents per week to validate timely			
	pivot. Observation of	care revealed only one staff			provision of incontinent care. The			
		r on 9/12/2017 at 3:23 PM.			Department Managers will interview ter			
	Resident #113 was interviewed on 9/13/2017 at				residents per week to validate resident	S		
	2PM. Resident #113 indicated that "I sometimes				are being treated in a respectable			
		et, my bottom being sore			manner. The Administrator, the			
		e and feces for a long time			Department Managers, the Director of			
	was not a good feelin alone."	g. It makes you feel sad and			Nursing, Unit Managers and Nurse			
	alone.				Supervisors will conduct ten random resident observations per week to valid	lato		
	During an interview w	vith NA #34 09/13/2017 at			call bells are responded to in a timely	iaic		
	_	d she was not the NA that			manner. The Department Managers w	ill		
		urine and feces last week			interview 10 residents per week to			
	but it was NA #43.				validate showers are being given per th	ne		
					schedule and as requested. The			
	During an Interview w	vith NA #43 on 9/14/2017 at			Administrator, the Director of Nursing,			
	10 AM, NA #43 indica	ated that she would never			Unit Mangers and Nurse Supervisors w	/ill		
		ine and feces for that long.			audit ten residents per week to validate			
	She also stated she v				documentation of showers being given			
		hout coming back in 10 to 15			per the shower schedule and as			
	minutes to provide ca	are and treatment.			requested. The Administrator will prese			
	During on interview w	vith Director of Nursing			the results of the call bell audit and the Director of Nursing will present the results.			
	_	t 3:45 PM she stated her			of the timely incontinence care audit ar			
		all staff should answer a call			the shower audit to the center s Quali			
		s of the resident putting the			Assurance and Performance	- ,		
		xpectation would be all staff			Improvement Committee. The audits v	vill		
		care as so as possible.			be conducted weekly for a minimum of			
		·			twelve weeks or until the Quality			
		as admitted to the facility on			Assurance and Performance			
		diagnoses of chronic			Improvement Committee determines th	ie		
		y disease, hypothyroism,			audits remain necessary to sustain			
	and obstructive sleep	apnea.			compliance ongoing. The audits will be			
					presented for a minimum of three mont	hs.		

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		345116	B. WING		00	C 0/ <b>14/2017</b>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		14/2017	
				109 S HOLDEN ROAD			
STARMOL	JNT HEALTH AND REH	AB CENTER		GREENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 312	Continued From pag	ge 17	F 3	12			
F 312	Review of Resident Data Set (MDS) date Resident #26 was co and able to make he required limited to exactivities of daily living which she required I person physical assist continent bowel and During an interview Resident #26 reveal on the long hall she be changed. Reside put on her call bell in #26 indicated that we long to be changed. This had been report #26 added she want and hoped that staff her feel better about A review of the concepts present revealed that about her call bell not manner. On 08/08/1	#26's quarterly Minimum ed 06/24/17, revealed that ognitively intact, legally blind or needs known. The resident extensive assistance for all her ng except for toilet use for imited assistance with one est. Resident #26 was bladder.  on 09/11/17 at 6:45 PM ed that during her first week waited 2 hours or longer to nt #26 indicated when she o one answered. Resident as a bad feeling waiting so Resident #26 indicated that ed to the facility. Resident ed to go to another facility would care for her and help	F 3°	in the Quality Assurance and Improvement Committee Med determine recommendations actions indicated. At the en months, the Quality Assurar Performance Improvement of determine any further actions sustain compliance ongoing Administrator is ultimately rethe plan of correction and encompliance ongoing.	eeting to s and further d of the three nce and Committee will ns needed to j. The esponsible for		
	answered her call be						
	09/13/17 at 2:30 PM moved Resident #26 SW indicated during #26 had issues with answered and staff r During an interview #3 for Resident # 26	with the Social Worker on she revealed she had son 09/06/17 to a new room. this interview that Resident her call bell not being not changing her.  with Nursing Assistant (NA) on 09/13/17 at 3:30 PM, she ally been working with					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345116	B. WING _			1	C 1 <b>4/2017</b>
	ROVIDER OR SUPPLIER  JNT HEALTH AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  109 S HOLDEN ROAD  GREENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 312	Resident #26 for two had not had any cond that she always treath and provided the care.  During an interview w (DON) on 09/13/17 a expectation was that bell within 3-5 minute call bell on and her exprovide incontinence.  2b. Resident #26 was 05/17/17 with current obstructive pulmonar and obstructive sleep.  Review of Resident #26 was cound able to make her required limited to exactivities of daily livin which she requi	days. NA #3 indicated she beens with this resident and ed her residents with respect to they needed.  with Director of Nursing to 3:45 PM she stated her all staff should answer a call to of the resident putting the expectation would be all staff care as so as possible.  So admitted to the facility on diagnoses of chronic to diagnoses of chr	F3	312			

`` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345116	B. WING		C <b>09/14/2017</b>	
	ROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  109 S HOLDEN ROAD  GREENSBORO, NC 27407	03/14/2017	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 312	Resident #26 stated 09/11/17. The SW in Resident #26 had in room. SW indicated Resident #26 had is being answered and A review of the poin 09/13/17 at 2 PM point there was no indicated been given a shown Resident # 26's nark care audit report.  During an interview 3:30 PM she indicated that all residents 3. Resident #111 w 8/05/2015 with the hypertension, diabed hyperlipidemia.  Resident #111's qual (MDS) dated 8/30/2 cognitively intact. The assistance with all 14 (ADL) except for easincontinent of bladd During an interview 9/12/2017 at 1:30 For August 5, 2017 throwaited in her bed for her. She indicated the minutes but it was a back. Resident #15 had a stated she minutes but it was a back. Resident #15 had a stated she minutes but it was a back. Resident #15 had a stated she minutes but it was a back. Resident #15 had a stated she minutes but it was a back. Resident #15 had a stated she minutes but it was a back. Resident #15 had a stated she minutes but it was a back. Resident #15 had a stated she minutes but it was a back. Resident #15 had a stated she minutes but it was a back. Resident #15 had a stated she minutes but it was a back. Resident #15 had a stated she minutes but it was a back. Resident #15 had a stated she minutes but it was a back. Resident #15 had a stated she minutes but it was a back. Resident #15 had a stated she minutes but it was a back. Resident #15 had a stated she minutes but it was a back. Resident #15 had a stated she minutes but it was a back.	d during her interview on indicated that that was why moved on 09/06/17 to a new diduring this interview that issues with her call bell not did staff not changing her. In of care audit report on rovided by the DON revealed attion that Resident #26 had beer during the past two weeks. The was not on the point of the with the DON on 09/13/17 at the did that her expectation would be had weekly showers.  Was admitted to facility on current diagnoses of the extensive the resident required extensive the resident required extensive ther Activities of daily living atting. The resident was always	F 31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345116	B. WING			C <b>09/14/2017</b>		
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 109 S HOLDEN ROAD GREENSBORO, NC 27407		33/14/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 312	Resident #111 also re happened several tir #111 indicated that seront of her bed and long she waited for series Resident # 111 reveation, 2017 she waited over two hours, and caused her red botto that this made her fet to provide care for the to provide care for the During a second inte 9/13/2017 at 2:10 Pt terrible about her coon September 9 or 1 bottom was sore and lying in her urine and 10 During an interview #34 on 9/13/2017 at not the NA that left Fand feces the previor During an Interview 10 AM, NA #43 indicate leave a resident in ushe also stated that residents call bell wirminutes.  During an interview (DON) on September stated her expectation	revealed that this had me during her stay. Resident the had a clock on the wall in that was how she knew how staff to answer her call bell. aled that on September 9 or in her urine and feces for she believed that incident om. Resident #111 indicated tel bad that staff took so long ter. Resident # 111 indicated to have enough staff to residents. The review with Resident #111 on the she indicated that she felt indition of being wet and dirty to, 2017. She stated her the it was not a great feeling the feces for a long time.  With Nursing Assistant (NA) 2:45 PM, she stated she was the stated she was the stated she was the stated that she would never rine and feces for that long. The she would not cut off a thout coming back in 10 to 15  With Director of Nursing the 13, 2017 at 3:45 PM she on was that all staff should thin 3-5 minutes of the call bell on and her the all staff provide	F 31					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		E SURVEY IPLETED
		345116	B. WING		C 09/14/2017	
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407		71-72-011
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		ECTION HOULD BE PROPRIATE	(X5) COMPLETION DATE
F 322 SS=E	EATING SKILLS CFR(s): 483.25(g)(4)  (g) Assisted nutrition (Includes naso-gastri both percutaneous en percutaneous endose enteral fluids). Based comprehensive asses ensure that a residen  (4) A resident who ha alone or with assistan methods unless the r demonstrates that en indicated and conser  (5) A resident who is receives the appropri to restore, if possible prevent complications but not limited to asp vomiting, dehydration and nasal-pharyngea This REQUIREMENT by: Based on record rev observations the facil placement of a gastro administrating medica with feeding tubes (R  Findings included:  The facility's policy for 2/2017 stated that nu gastrostomy tube pla feedings and periodic	and hydration. c and gastrostomy tubes, indoscopic gastrostomy and copic jejunostomy, and d on a resident's essment, the facility must it- as been able to eat enough ince is not fed by enteral esident's clinical condition iteral feeding was clinically ited to by the resident; and fed by enteral means ate treatment and services it, oral eating skills and to is of enteral feeding including iration pneumonia, diarrhea, in, metabolic abnormalities, il ulcers. T is not met as evidenced iew, staff interviews and lity failed check the costomy feeding tube before ations for 2 of 4 resident's resident 92, resident #122).	F 33	Per observation by surveyor on Residents #92 and #122 did not gastrostomy tubes checked for per procedure. Residents #92 adid not have any adverse effects checking the gastrostomy feedir placement checked prior to med administration. Residents #92 a are currently having the placement checked prior to intermittent feed periodically during continuous feand prior to flushes and or medical administration. Licensed Nurse	t have their placement and #122 s from not ng tube dication and #122 ent dings and eedings cation	10/12/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345116	B. WING_				
	201/1252 02 01/221/152	345116	B. WING _	0.70.55		09/	14/2017
NAME OF PI	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE		
STARMOL	INT HEALTH AND REHA	AB CENTER		109 S H	HOLDEN ROAD		
0174141100		.5 02.11.2.1		GREEI	NSBORO, NC 27407		
(X4) ID PREFIX TAG			ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 322	Continued From page 22 administration.		F 3	22			
				pro	ovided a one to one competency		
					service by the Staff Development		
	1. Resident #92 was diagnosis of a stroke			pordinator.			
	malnutrition.	, 31		Ga	astrostomy tubes are to be checked	for	
					acement prior to intermittent feeding		
	Resident #92 had a	Gastrostomy tube (G tube). A			d periodically during continuous		
	gastrostomy tube is a	a tube that is inserted		fee	edings and prior to flushes and or		
	through the abdomer	n that delivers nutrition		me	edication administration. Residents	with	
	directly to the stomad	ch.		-	strostomy tubes have been identifie		
					d are currently having the placemen		
		ders dated 11/18/16 to give			ecked prior to intermittent feedings a		
		ia Gastrostomy tube before			riodically during continuous feedings		
		administration and 5 ml of			d prior to flushes and or medication		
	free water between e		adı	ministration.			
	Resident's #92 Quar	terly Minimum Data Set		Lic	censed Nurses were in-serviced by t	:he	
		revealed that the resident			aff Development Coordinator and or		
	, ,	d. The resident had weight			rector of Nursing and or the Unit		
	gain of 5% or more a	ind had a feeding tube. The		Ma	anagers that gastrostomy tubes are	to	
	resident received 51°	% or more of total calories		be	checked for placement prior to		
	through tube feeding	S.		inte	ermittent feedings and periodically		
				du	ring continuous feedings and prior to	٥	
		ation orders revealed the		flus	shes and or medication administration	on.	
	following medications	s were ordered for 9/2017:				.	
		. 0.1.1			e Staff Development Coordinator ar		
		g via G tube every 12 hours			the Director of Nursing and or the U	nit	
		uid 10 ml via G tube two			anagers will observe five resident		
	times a day	ordin O tob a farmation and address			strostomy tubes checks for placeme	nt	
	_	y via G tube four times a day			or to intermittent feedings and		
	Decubi-vite capsule	1 capsule one time a day			riodically during continuous feedings		
	During medication as	Aministration observation on			d prior to flushes and or medication ministration. The results of the audi		
		dministration observation on //erapamil, Docusate Sodium,			ministration. The results of the audi	ເວ	
		shed and Decubi-vits					
					ursing to the center⊡s Quality surance and Performance		
	capsule contents were	rided into individual cups and			provement Committee for review an	nd	
		rater. Nurse #2 did not			provement Committee for review and commendation. The audits will be	.u	
		f the feeding tube before			nducted weekly for a minimum of		
	Committe placement of	the recalling table belone	1	601	hadded weekly for a fillillificial of		ı

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(	
		345116	B. WING _			09/	14/2017
	ROVIDER OR SUPPLIER	B CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 09 S HOLDEN ROAD BREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 322	flush the resident's G medication in the G to medication, the medication, the medication tube and the medication. The nurse dumped the feeding tube and pour G tube. Then she promedication into the G between each medication into the G between each medication was administered, shiml of water.  Nurse #2 interviewed would check the place make sure there was give the medications. Safter the medications usually listen for the "auscultating the feeding knew her mistakes and nervous when adminitation the consultant pharm 9/14/17 at 1:33 PM. It pass observation was this week at the facilitation stated that he would was flushed before an given through a feeding placement of the feeding placement of the facilitation 19/14/17 at 2:57 PM expect that placement	ations. Nurse #2 did not tube before pouring the ube. After pouring in the first cation would not go into the ion was stuck in the syringe. It is medication back out of the red 30 ml of water down the ceeded to dump each tube without flushing in ation. After each medication is flushed the G tube with 30 and on 9/13/16 at 2:30 PM. She is ement of the feeding tube, no residual and then would she would flush before and its she would flush before and its she would swoosh" sound when ing tube. She stated that she indicated that she was strating the medications.  In acist was interviewed on the stated that a medication is completed on Tuesday of the syby the pharmacy. He expect that the feeding tube and after medications were ing tube and for the ling tube was checked ty's policy.  In g (DON) was interviewed on the feeding tube would wit of the feeding tube would wing medications and that	F	322	twelve weeks or until the Quality Assurance and Performance Improvement Committee determines the audits remain necessary to sustain compliance ongoing. The audits will be presented by the Director of Nursing monthly, for a minimum of three month in the Quality Assurance and Performal Improvement Committee Meeting to determine recommendations and further actions indicated. At the end of the three months, the Quality Assurance and Performance Improvement Committee determine any further actions needed to sustain compliance ongoing. The Administrator is ultimately responsible the plan of correction and ensuring compliance ongoing.	e s, nce er ee will	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345116	B. WING		C 09/14/2017
	ROVIDER OR SUPPLIER	IAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  109 S HOLDEN ROAD  GREENSBORO, NC 27407	03/14/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 322		ge 24 as admitted on 6/30/15 with mood disorder, malnutrition	F 3:	22	
	Resident #122 had A gastrostomy tube	a Gastrostomy tube (G tube). is a tube that is inserted en that delivers nutrition ach.			
	11/18/16 to verify plauscultation with st	e following order dated lacement of G tube via ethoscope and aspiration of each shift per protocol.			
	revealed the reside impaired. The resid loss or gain and ha	Data Set (MDS) dated 8/7/17 nt was severely cognitively ent did not have any weight d a feeding tube. The resident ore of total calories through			
	Resident #122 had orders for 9/2017:	the following medication			
	Metoprolol Tartrate	capsule twice a day via G tube 25mg via G tube twice a day 10 ml via G tube twice a day			
	administration on 9, crushed Metoprolol the Ziprasidone cap medication into its of medication with 15 placement of the fe administration and the G tube without in between each medication on 9, crushed the 2 placement of the fe administration and the G tube without in between each medication of the placement of	rved during medication /13/17 at 8:40 AM. Nurse #2 medication and opened up osules. She separated each own cup. She mixed each ml of water. She did not check eding tube prior to administered medications via flushing the G tube before or edication. After all medications #2 flushed the feeding tube			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G	COMPLETED
		345116	B. WING _		C <b>09/14/2017</b>
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  109 S HOLDEN ROAD  GREENSBORO, NC 27407	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 323 SS=D	would check the plan make sure there was give the medication. after the medications usually listen for the auscultating the feed knew her mistakes a nervous when admir. The consultant phare 9/14/17 at 1:33 PM. pass observation was this week at the facilistated that he would be flushed before are given through a feed placement of the feed according to the facility. The Director of Nurse 9/14/17 at 2:57 PM. expect that placement.	d on 9/13/16 at 2:30 PM. She cement of the feeding tube, is no residual and then would She would flush before and is. She stated that she would "swoosh" sound when ding tube. She stated that she and stated that she was instrating the medications.  It was interviewed on the stated that the feeding tube and for the eding tube was checked lity's policy.  It would be in medications and that the shed.  IT VISION/DEVICES	F3		10/12/17
	The facility must ens  (1) The resident env from accident hazard	sure that - ironment remains as free ds as is possible; and ceives adequate supervision			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345116	B. WING_			C 9/14/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		9/14/2017	
	10 113211 011 001 1 2.2.1			109 S HOLDEN ROAD			
STARMOL	INT 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 ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO TIVE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From page	e 26	F 3	323			
	and assistance device	es to prevent accidents.					
	appropriate alternativ bed rail. If a bed or s must ensure correct i	ails, including but not limited					
	(1) Assess the reside from bed rails prior to	nt for risk of entrapment installation.					
		and benefits of bed rails with ont representative and obtain or to installation.					
		ed's dimensions are sident's size and weight. is not met as evidenced					
	Based on observation resident interviews the two staff for transfer a incontinence care and supervision to prevent	ens, record reviews, staff and e facility failed to provide a resident to the bed for d the facility failed to provide at repeated falls for 1 of 3 tal. 3) sampled residents is.		On 9/12/17 NA#13 transfer #113 with one person assist Resident #133 is care plant assistance of 2 staff member stated she transferred Resident person assistance because wanted to observe the care normally would get help for	tance. ned for ers. NA#13 dent #113 per ause the state and she would		
	Findings include:			There were no complication Resident #113 being transfe	ns noted from		
	6/30/2017 with the cu hypertension, seizure	was admitted to facility on irrent diagnoses of disorder and cerebral palsy. um Data Set (MDS) dated		assistance of one Certified Assistant on 9/12/17. Residence of two staff memory was provided a one to one in	Nursing dent #113 is with the nbers. NA #13		
	7/7/2017 revealed the intact. The resident rewith bed mobility, trans	e resident was cognitively equired extensive assistance asfers, toilet use with two st and with locomotion,		the Staff Development Cool regarding transferring reside care plan. Resident #113 c responded to timely. Resident	rdinator ents per their all bell is being		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED	
		245446	B. WING			С	
		345116	B. WING _			9/14/2017	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
STARMOU	INT HEALTH AND REHA	AB CENTER		109 S HOLDEN ROAD			
O I A I I I I I	MI HEALIN AND REHA	OLIVIER		GREENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From pag	e 27	F 3	23			
	assistance with one p Resident total depen The resident was incincontinent of bowel. person physical assis During an Interview v 9/12/2017 at 2PM, R she was admitted to staffing has been an Resident #113 also n because staff did not	pal hygiene need extensive person physical assist. dence on staff for bathing. ontinent of bladder and Resident #113 needs two st at all times.  with Resident # 113 on esident # 113 indicated that the facility on 6/30/2017 and issue since her placement. evealed she had several falls respond to the call bell. ated that her roommate has		plan interventions related to prevention are being followed to prevent further falls.  Transfers are to be perform plan of care. Staff is to followed prevention care plans. The Nursing, Staff Development Unit Managers and or Nurswill interview alert and orier post fall to assist in determicause of the fall, then will a accordingly and implement assist in falls prevention.	ed in an effort  led per the low falls librator of t Coordinator, e Supervisors nt residents lining the root ddress it		
	a clock on the wall in 113 indicated that the long she waited for s Resident # 113 indica have enough staff to residents. Resident # why" I feel sad and d because staff are so	front of her bed. Resident # at was how she knew how taff to answer her call bell. ated that the facility does not		Nursing Staff members wer by the Staff Development Coor the Director of Nursing a Managers that transfers are performed per the plan of coprevention care plans are to The Staff Development Coor the Director of Nursing a Managers will observe five	coordinator and and or the Unit eto be are and falls be followed.  ordinator and or the Unit		
	PM. The resident was pive her wheelchair to the NA. The resident's but brief had a small amount resident had a red rabilaterally. The rash lextended from in bett around to buttock. The properly and Calazin resident's rash. The care that "her rash was not better that the resident of the resident's rash.	s observed on 9/12/17 at 3:23 s observed during ADL care. oted and transferred from bed by the assistance of 1 briefs were taken off and her bunt of yellow urine in it. The sh between her legs and red, raised bumped that ween her perineal area he resident was cleaned be lotion was applied to the resident stated during ADL as painful and itchy. That that the area still hurts. She		transfers per week to validate with the care plan. The State Development Coordinator at Director of Nursing and or Leand or Nurse Supervisor with alert and oriented residents assist in determining the root they will address it according implement measures to assuprevention. The Director of present the results of the transition as well as any trends from the interviews to the Quality Assuperformance Improvement.	ate compliance aff and or the Unit Managers Il interview spost fall to ot cause; then agly and sist in falls f Nursing will ansfer audits the resident surance and		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345116	B. WING _		C 09/1/	4/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	7/2017	
CTA DMOI	JNT HEALTH AND RI	EUAD CENTED		109 S HOLDEN ROAD			
STARWOO	INT REALIT AND RI	ENAB CENTER		GREENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE CROSS-REF	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From p	page 28	F3	23			
	was place on the the resident was pwith the assistant pivot.	as kept this rash". A new brief resident as well as pants and blaced back in her wheelchair be from 1 person via stand and are revealed only one staff asfer on 9/12/2017 at 3:23 PM.		review and recommendation will be conducted weekly for twelve weeks or until the Quantum Assurance and Performance Improvement Committee deaudits remain necessary to compliance ongoing. The apresented by the Director of	r a minimum of uality etermines the sustain udits will be		
	the Nursing Assis the ADL care on F completed care or wanted to observe normally would go During an intervie 9-14-17 3:30PM, follow the care gu present to transfe During an intervie Administrator on S indicated her expeteam would meet manager for unit)	monthly, for a min the Quality Assurance and an interview on 9/13/2017 at 3:30PM with a lursing Assistant #13 (NA) who performed actions indicated she allowed an interview with Director of nursing on a	in the Quality Assurance an Improvement Committee Modetermine recommendation actions indicated. At the enmonths, the Quality Assurar Performance Improvement determine any further action sustain compliance ongoing	for a minimum of three months, rality Assurance and Performance ment Committee Meeting to e recommendations and further indicated. At the end of the three the Quality Assurance and ance Improvement Committee will e any further actions needed to ompliance ongoing. The rator is ultimately responsible for of correction and ensuring			
	6/30/2017 with the hypertension, seize Resident #113 Mi 7/7/2017 revealed intact. The reside with bed mobility, person physical a dressing, and per assistance with or	3 was admitted to facility on e current diagnoses of zure disorder and cerebral palsy.  nimum Data Set (MDS) dated at the resident was cognitively not required extensive assistance transfers, toilet use with two ssist and with locomotion, sonal hygiene need extensive ne person physical assist.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		345116	B. WING			09/14/2017	
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 109 S HOLDEN ROAD GREENSBORO, NC 27407	· ·	0/14/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 323	incontinent of bowel. person physical assi  During an Interview of 9/12/2017 at 2PM, R she was admitted to staffing has been an Resident #113 also of because staff did not Resident # 113 indic a clock on the wall in 113 indicated that the long she waited for se Resident # 113 indic have enough staff to Review of the incide 7/10/2017 was review revealed that "Called resident to be lying in stated she bent over spoon she dropped over she fell out of h.  During an interview of 9/13/2017 at 1:45PM dropped her spoon minutes to come to h.  Review of incident/a 8/8/2017was review revealed "Nursing Asslid to floor. No injury During an interview of 9/13/2017 at 1:45PM.	Resident #113 needs two st at all times.  with Resident # 113 on Resident # 113 indicated that the facility on 6/30/2017 and rissue since her placement. Revealed she had several falls to respond to the call bell respond to the facility does not provide care for her.  Intraccident report dated report dated wed on 9/13/2017 at 11AM, at to room by NA noted resident floor face down. Resident report her in her wheelchair to get her to the floor. When she bent her wheelchair."  With Resident #113 on the floor face down and it took staff about 45 relp her.  Cocident report dated report dated red on 9/13/2017 at 11AM that resistance reported. Resident	F 32	23			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345116	B. WING		C 09/14/2017
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  109 S HOLDEN ROAD  GREENSBORO, NC 27407	1 00/14/2017
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F 323	Continued From pag	e 30	F 32	23	
	"Resident found on the door. Patient in a was trying to go to the During an interview was 2PM, she indicated the intentional because the Stated she felt the resindependent in going	o17 at 11AM that revealed the floor with back up against sitting position. States she to bathroom."  with NA #5 on 9-14-17 at that Resident #113 falls were the resident wanted attention. Sident wanted to be to the bathroom and getting			
	no one was present the resident knew to present the During an interview was 14-17 3:30PM, star	vith Director of nursing on ted she expected staff to /care plan and have 2 staff			
F 332 SS=D	During an interview v at 3:30PM, she indice falls was that the tea MDS, nurse manage falls were occurring, would be appropriate FREE OF MEDICAT	with Administrator on 9-14-17 ated her expectations for m would meet (DON, Admin, r for unit) to evaluate why the decide on interventions that	F 33	32	10/12/17
	that its- (1) Medication error in greater;	The facility must ensure rates are not 5 percent or			

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		I CENTRE CENTRICE				1	. 0000 0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345116	B. WING			1	14/2017
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STARMOU	INT HEALTH AND REHA	B CENTER			09 S HOLDEN ROAD		
				G	REENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 332	Continued From page Based on record reviobservations the facil medication error rate by 3 medication error resulting in a medicat 7 residents observed (Resident 92, resident Findings included: The facility's policy for 2/2017 stated that the feeding tube with 30 to water before and after medications and 5 to administration of multiple or when there feeding.  1. Resident #92 had tube). A gastrostomy inserted through the anutrition directly to the Resident #92 had ord 30 ml of free water via and after medication free water between ere seident #92 medica following medications Verapamil HCL 40 mg	e 31  ew, staff interviews and ity failed to have a less than 5%, as evidenced sout of 25 opportunities, ion error rate of 12% for 2 of for medication pass t #122).  r enteral nutrition dated enurse should irrigate the to 60 milliliters (ml) of tap r administration of 10 ml in-between iple medications (or as sian), before initiating a e is an interruption of da Gastrostomy tube (Gatube is a tube that is abdomen that delivers		332		7, their tent 22 not te 1 22 as er nt and s 22 er	DATE
	Baclofen tablet 20mg Decubi-vite capsule 1 a. During medicatio on 9/13/17at 8:23 AM Sodium, baclofen wer Decubi-vits capsule of medications were div mixed with 15ml of war	via G tube four times a day capsule one time a day n administration observation. Verapamil, Docusate re all crushed and ontents were opened up. All ided into individual cups and later. Nurse #2 did not the feeding tube before			and periodically during continuous feedings and prior to flushes and or medication administration. Medication are to be administered per physician order and center policy. Residents wit gastrostomy tubes have been identified and are currently having the placement checked prior to intermittent feedings a periodically during continuous feedings	s s h d t	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X DENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345116	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	0.01.0		6.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	14/2017
NAME OF F	KOVIDER OR SUFFLIER						
STARMOL	JNT HEALTH AND REI	HAB CENTER			09 S HOLDEN ROAD		
				G	REENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 332	Continued From pa	-	F;	332	and prior to flushes and or modication		
		lications. Nurse #2 did not			and prior to flushes and or medication		
		G tube before pouring the			administration. Residents with		
		S tube. After pouring in the first lication would not go into the			gastrostomy tubes are to have their gastrostomy tubes irrigated with 30 to 6	30	
	1	cation was stuck in the syringe.			ml of water before and after	,0	
		the medication back out of the			administration of medications and 5 to	10	
		oured 30 ml of water down the			ml in between administration of multiple	-	
		proceeded to dump each			medications or as ordered by the		
		G tube without flushing in			physician before initiating a feeding or		
		lication. After each medication			when there is an interruption of feeding	J.	
	was administered,	she flushed the G tube with 30			-		
	ml of water.				Licensed Nurses were in-serviced by the	ne	
	Nurse #2 interview	ed on 9/13/16 at 2:30 PM. She			Staff Development Coordinator and or	the	
		uld pull the medications from			Director of Nursing and or the Unit		
		t, crush all the medication			Managers that gastrostomy tubes are t	0	
		ke sure that they were placed			be checked for placement prior to		
		he stated that she would also			intermittent feedings and periodically		
		ut on gloves, and add water to			during continuous feedings and prior to		
		efore giving via the G tube.			flushes and or medication administration		
		ne placement of the feeding ere was no residual and then			and that residents with gastrostomy tubes	es	
	1 '	dication. She would flush			irrigated with 30 to 60 ml of water before	~	
	_	e medications. She stated that			and after administration of medications		
		isten for the "swoosh" sound			and 5 to 10 ml in between administration		
		the feeding tube. She stated			of multiple medications or as ordered b		
		mistakes and stated that she			the physician before initiating a feeding		
	was nervous when medications.				when there is an interruption of feeding		
		rmacist was interviewed on			The Staff Development Coordinator an	d	
	1	. He stated that a medication			or the Director of Nursing and or the U		
		as completed on Tuesday of			Managers will observe five resident		
	·	cility by the pharmacy. He			gastrostomy tubes checks for placeme	nt	
		d expect that the feeding tube			prior to intermittent feedings and		
		and after medications were			periodically during continuous feedings	j,	
	given through a fee	eding tube and for the			and prior to flushes and or medication		
		eding tube was checked			administration and that residents with		
	according to the fac	cility's policy.			gastrostomy tubes are to have their		
	The Director of Nur	rsing (DON) was interviewed			gastrostomy tubes irrigated with 30 to 6	30	
	on 9/14/17 at 2:57	PM. She stated that she would			ml of water before and after		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	
		345116	B. WING _			09/ <sup>-</sup>	14/2017
NAME OF P	ROVIDER OR SUPPLIER	•	,	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CTA DMOI	JNT HEALTH AND REH	AD CENTED		109	9 S HOLDEN ROAD		
STARWO	DNI HEALIH AND KEN	AD CENTER		GF	REENSBORO, NC 27407		
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F 332	be checked before of the feeding tube was b. During medication 9/13/17 8:23 AM, remove Docusate Somedication cart, crust 15 ml of water. The to resident #92 via the Physician's orders reorders (9/2017) for a liquid form to be given Nurse #2 interviewes stated that the Docubeen switched from form in the order sindocusate sodium. The consultant phare 9/14/17 at 1:33 PM. not typically supply tocunter stocked medithe Docusate Sodium exception. The DON was interviewed that she in the appropriate or resident.  2. Resident #122 Itube). A gastrostomy inserted through the nutrition directly to the Resident #122 had to orders for 9/2017: Ziprasidone 20mg came Metoprolol Tartrate 2 Valproic Acid liquid Nurse #2 was observed.	int of the feeding tube would giving medications and that is flushed. In administration observation in the server of the server	F3	332	administration of medications and 5 to ml in between administration of multiple medications or as ordered by the physician before initiating a feeding or when there is an interruption of feeding. The results of the audits will be present by the Director of Nursing to the center Quality Assurance and Performance Improvement Committee for review and recommendation. The audits will be conducted weekly for a minimum of twelve weeks or until the Quality Assurance and Performance Improvement Committee determines the audits remain necessary to sustain compliance ongoing. The audits will be presented by the Director of Nursing monthly, for a minimum of three months in the Quality Assurance and Performa Improvement Committee Meeting to determine recommendations and further actions indicated. At the end of the three months, the Quality Assurance and Performance Improvement Committee determine any further actions needed to sustain compliance ongoing. The Administrator is ultimately responsible to the plan of correction and ensuring compliance ongoing.	e ded s s ded e e e e e e e e e e e e e	

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345116	B. WING		C <b>09/14/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE	03/14/2017
CTADMOL	INT HEALTH AND DEH	AD CENTED		109 S HOLDEN ROAD	
STARWOO	JNT HEALTH AND REH	AB CENTER		GREENSBORO, NC 27407	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 332	Continued From pag	ge 34	F 33	2	
F 332	the Ziprasidone cap medication into its or medication with 15 in placement of the feet administration and at the G tube without fin between each mewere given, nurse # with water.  Nurse #2 interviewer stated that she wout the medication cart, individually and makin their own cup. She would check the tube, make sure the would give the medication be she would give the medication after the she would usually lie when auscultating that she knew her medications.  The consultant phare 9/14/17 at 1:33 PM. pass observation was this week at the facilitation in the state of the she would usually lie when auscultating that she knew her medications.	sules. She separated each win cup. She mixed each mill of water. She did not check eding tube prior to administered medications via lushing the G tube before or ediation. After all medications 2 flushed the feeding tube and on 9/13/16 at 2:30 PM. She are likely before on crush all the medications from crush all the medication was sure that they were placed e stated that she would also to on gloves, and add water to fore giving via the G tube. The placement of the feeding was no residual and then dication. She would flush medications. She stated that sten for the "swoosh" sound the feeding tube. She stated histakes and stated that she administrating the stated that a medication as completed on Tuesday of lity by the pharmacy. He diexpect that the feeding tube	F 33	2	
	given through a feed placement of the feed according to the fact The Director of Nurs 9/14/17 at 2:57 PM. expect that placeme	sing was interviewed on She stated that she would ent of the feeding tube would giving medications and that			

AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	, ,	ATE SURVEY DMPLETED	
		345116	B. WING			C <b>09/14/2017</b>	
	OVIDER OR SUPPLIER	IAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
SS=E	CARE PLANS CFR(s): 483.35(a)(1) 483.35 Nursing Ser The facility must ha the appropriate com provide nursing and resident safety and practicable physical well-being of each r resident assessmer and considering the diagnoses of the fac accordance with the at §483.70(e). [As linked to Facility be implemented beg (Phase 2)]  (a) Sufficient Staff. (a)(1) The facility m sufficient numbers of personnel on a 2- nursing care to all re resident care plans: (i) Except when wai this section, license (ii) Other nursing per limited to nurse aide (a)(2) Except when this section, the facility the section, the facility means the section, the facility the section, the facility the section, the facility that the section that th	vices  ve sufficient nursing staff with inpetencies and skills sets to a related services to assure attain or maintain the highest it, mental, and psychosocial resident, as determined by into and individual plans of care anumber, acuity and cility's resident population in a facility assessment required at Assessment, §483.70(e), will ginning November 28, 2017  ust provide services by of each of the following types 4-hour basis to provide esidents in accordance with a ved under paragraph (e) of dinurses; and	F 35	3		10/12/17	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345116	B. WING				14/2017
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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STARWOO	INT REALTH AND REHA	AD CENTER		G	GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	sets necessary to car identified through residentified through residescribed in the plan.  (a)(4) Providing care assessing, evaluating resident care plans a needs.  This REQUIREMENT by: Based on record review resident and families failed to provide staff quality to provide inconcious, answer call prevent accidents for assistance. This affect (Resident #26, Resident #135). This tags F241, F242, F37  Finding included:  F 241: Based on obsideristing in comproming residents who require personal hygiene. The residents (Resident #111)  F242: Based on obsidinterviews the facility	cific competencies and skill re for residents' needs, as cident assessments, and of care.  includes but is not limited to g, planning and implementing and responding to resident's  is not met as evidenced  iews, interviews with staff, and observations the facility ing of sufficient quantity and continence care, toileting, bells and supervision to residents who required cated 4 out of 40 residents lent #111, Resident #113 and tag is cross referenced to 12 and F323.  ervations, record reviews, erviews the facility failed to care when requested,	F	353	Per review of concern log and interview with the surveyors Residents #26, #11: #111 stated their call bells were not answered timely. Per interview with the surveyors Residents #26, #113 and #1 were not provided care timely. Call be are being answered timely. Timely Incontinent care is being provided as requested and or as needed. Staff has been educated regarding timely completion of their assigned duties in order to anticipate and meet resident needs timely. Residents #26, #113 and #111 call bells are being answered time Incontinent care is being provided as requested with incontinent checks being provided approximately every two hour and or as needed. Residents #26, #113 and #111 call bells are being answered time Incontinent care is being provided as requested with incontinent checks being provided approximately every two hour and or as needed. Resident #135	3, e 11 ls g s oed nd ely. g	
	reviewed for choices	(Resident #135.)			requested to the Social Worker get up early. The Social Worker forgot to noti		

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NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	17/2017
					9 S HOLDEN ROAD		
STARMOL	INT HEALTH AND REHA	B CENTER					
				G	REENSBORO, NC 27407		
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F 353	Continued From page	e 37	F3	353			
F 353	staff and resident interprovide incontinence failed to provide show This was evident for a reviewed for activities (Resident #26, Resid #113).  F323: Based on obsestaff and resident interprovide two staff for for incontinence care provide supervision to f3 residents (Resident eviewed for accident During an interview w (DON) on 09/13/17 a her expectations for a within 3-5 minutes. Hall staff treat all resident During an interview w 09/14/17 at 1:30pm, was that there would attend to the resident	erviews the facility failed to care for 3 of 4 residents and vers for 1 of 4 residents.  3 of 4 residents that were sof daily living (ADL's). ent # 111 and Resident  ervations, record reviews, erviews the facility failed to transfer a resident to the bed and the facility failed to prevent repeated falls for 1 ent #113) sampled residents is.  With Director of Nursing to 3:45 PM, she indicated that all staff to answer a call bell er expectation would be that ents with respect and dignity.	F3	353	staying in bed longer than her preferent Resident #135 Care Plan was updated per her preference. Resident #135 is currently going to and getting up from the per her choice. There were no complications noted from Resident #11 being transferred via the assistance of one Certified Nursing Assistant on 9/12/17. Resident #113 is currently be transferred with the assistance of two smembers. NA #13 was provided a one one in-service by the Staff Developmer Coordinator regarding transferring residents per their care plan. Resident #113 call bell is being responded to time Resident #113 care plan interventions related to falls prevention are being followed in an effort to prevent further falls.  Staff members are to respond to call be in a timely manner and address the residents requests, if able, at that time if staff is unable to meet the residents request at the time the call bell is answered the request should be met as quickly as possible. Staff is to interact with residents in a respectable manner Staff members are to honor resident preferences for time of going to and getting out of bed. The Department Managers (including the Administrator, Director of Nursing, the Business Office Manager, the Maintenance Director, the Activities Director, the Social Services Director and the Scheduler) interviewed alert and oriented residents to determine residents.	ing staff eto int ells e. the e e dine	
					,	ne	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X	3) DATE SURVEY COMPLETED
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		345116	B. WING _			09/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
STADMOL	JNT HEALTH AND REHA	AR CENTER		109 S HOLDEN ROAD		
SIANWOO	ONT TICALITY AND INC.	AD CENTER		GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 353	Continued From pag	e 38	F3	Managers (including the Ad Director of Nursing, the Bu Manager, the Maintenance Activities Director, the Soc Director and the Scheduler family members, where aw residents who are not alert to determine resident times and getting out of bed. Sta are to respond to call bells manner and address the re requests, if able, at that tim unable to meet the resident the time the call bell is ans request should be met as a possible. Staff is to interact in a respectable manner. Were in-serviced by the Ad or Staff Development Coor the Director of Nursing and Managers on answering catimely manner and meeting able. Staff members were the Administrator and or Staff Development Coordinator Director of Nursing and or Managers that if staff is un the residents request at the bell is answered the requemet as quickly as possible. members were in-serviced Administrator and or Staff Coordinator and or the Director of Nursing staff were the Staff Development Coordinator and or the Director of Nursing and Managers that incontinent	siness Office Director, the ial Services i) interviewed ailable, for and oriented, is for going to aff members in a timely esidents ne. If staff is ts request at wered the quickly as at with residents Staff members ministrator and or the Unit all bells in a g the request if in-serviced by aff by the Development ector of Nursing that staff is to respectable in-serviced by ordinator and or d or the Unit all the time the cal st should be staff by the Development ector of Nursing that staff is to respectable in-serviced by ordinator and or d or the Unit	s i

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMF	SURVEY
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	20,4252 02 01 22 152	343110	B. W.NO			09/	14/2017
NAME OF PI	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
STARMOL	INT HEALTH AND REH	AB CENTER			9 S HOLDEN ROAD REENSBORO, NC 27407		
(VA) ID	STIWWYDA 6.	TATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		(VE)
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F 353		,		3353	provided as requested with incontinent checks being provided approximately every two hours and or as needed. Stamembers are to provide showers per the shower schedule and as requested by resident. Staff members were in-service by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers on providing showers per the schedule and as requested by the resident. Transfers are to be performed per the plan of care. Staff is to follow for prevention care plans. Director of Nursing, Staff Development Coordinator Unit Managers and or Nurse Supervisor will interview alert and orient residents post fall to assist in determining the roccause of the fall, then will address it accordingly and implement measures the assist in falls prevention.  Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursiand or the Unit Managers on answering call bells in a timely manner and meeting the request if able. Staff members were	aff ne the ced  alls or, ors ot o	
					in-serviced by the Administrator and or Staff Development Coordinator and or Director of Nursing and or the Unit Managers that if staff is unable to meet the residents request at the time the bell is answered the request should be met as quickly as possible. Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursiand or the Unit Managers that staff is to	the call t sing	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	(XX	3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
STARMOL	JNT HEALTH AND REHA	AB CENTER		109 S HOLDEN ROAD		
				GREENSBORO, NC 27407		
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F 353	Continued From pag	e 40	F3		espectable in-serviced by dinator and or or the Unit are is being incontinent oximately eeded. d by the by if ind or the e Unit ent it to and ing resident in-serviced by if ind or the e Unit vers per the bers were elopment tor of Nursing at transfers olan of care ins are to be including the if Nursing, the e ctivities Director and ten residents rovision of strator, the	y g

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	TIPLE CONSTRUCTION	(X:	3) DATE SURVEY COMPLETED
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STARWOO	INT HEALTH AND KE	HAB CENTER		GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	Continued From pa	age 41	F	Supervisors will conduct ten raresident observations per wee call bells are responded to in a manner. The Department Mainterview ten residents per we validate residents are being the respectable manner. The Admill present the results of the cand the Director of Nursing withe results of the timely incontaudit to the center Suality And Performance Improvemer Committee. The Department (including the Administrator, the Director, the Social Services State Scheduler) will interview to per week to validate residents going to and getting out of bed being honored. The audits will presented by the Director of Services monthly, for a minimum onths, in the Quality Assurar Performance Improvement Committee and as requested. The Administrator, the Director of Nursing the nesidents per week to documentation of showers being per the shower schedule and a requested. The Director of Nursesent the results of the show as well as any trends from the interviews to the Quality Assurance Improvement Compresent the results of the show as well as any trends from the interviews to the Quality Assurance Improvement Compresent the results of the show as well as any trends from the interviews to the Quality Assurance Improvement Compresent Compresent Improvement Compresent	ek to validate a timely nagers will ek to eated in a ministrator call bell aud Il present inence care Assurance at Managers ne Director e Manager, Activities Director and en residents choices for dimes are Il be locial aum of three nagers will ek to ven per the The Nursing, ervisors will to validate ing given as ursing will wer audits a resident rance and	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE COMP	SURVEY
		345116	B. WING _			C <b>14/2017</b>
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  109 S HOLDEN ROAD  GREENSBORO, NC 27407	1 03/	14/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		BE	(X5) COMPLETION DATE
F 353	Continued From page	÷ 42	F3	review and recommendation. The St Development Coordinator and or the Director of Nursing and or the Unit Managers will observe five resident transfers per week to validate compli with the care plan. The Staff Development Coordinator and or the Director of Nursing and or Unit Mana and or Nurse Supervisor will interview alert and oriented residents post fall assist in determining the root cause; they will address it accordingly and implement measures to assist in falls prevention. The Director of Nursing present the results of the transfer awas well as any trends from the reside interviews to the Quality Assurance and Performance Improvement Committer review and recommendation. The awill be conducted weekly for a minimal twelve weeks or until the Quality Assurance and Performance Improvement Committee determines audits remain necessary to sustain compliance ongoing. The Administra ultimately responsible for the plan of correction and ensuring compliance ongoing.	gers o o then vill dits nt nd e for dits um of	
F 431 SS=E	BIOLOGICALS CFR(s): 483.45(b)(2)(1) The facility must prov	ide routine and emergency	F4	431		10/12/17
	them under an agree §483.70(g) of this par	t. The facility may permit to administer drugs if State				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG	` '	OATE SURVEY OMPLETED
		345116	B. WING _			C <b>09/14/2017</b>
	ROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 109 S HOLDEN ROAD GREENSBORO, NC 27407	E	03/14/2011
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 431	Continued From pa	<u> </u>	F 4	31		
	(a) Procedures. A pharmaceutical ser that assure the acc dispensing, and ad biologicals) to mee (b) Service Consult employ or obtain the pharmacist who  (2) Establishes a sydisposition of all codetail to enable an (3) Determines that that an account of a maintained and per (g) Labeling of Drug Drugs and biological abeled in accordar professional principappropriate access instructions, and the applicable.  (h) Storage of Drug (1) In accordance with facility must stolocked compartmer controls, and permit have access to the (2) The facility must permanently affixed	facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and it the needs of each resident.  ation. The facility must e services of a licensed  ystem of records of receipt and introlled drugs in sufficient accurate reconciliation; and all controlled drugs is riodically reconciled.  gs and Biologicals. als used in the facility must be nee with currently accepted alles, and include the ory and cautionary e expiration date when  as and Biologicals. with State and Federal laws, re all drugs and biologicals in ints under proper temperature t only authorized personnel to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345116	B. WING		C <b>09/14/2017</b>
NAME OF PROVIDER OR SUPPLIER  STARMOUNT HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE  109 S HOLDEN ROAD  GREENSBORO, NC 27407	09/14/2017
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
package drug distribution quantity stored is minimal be readily detected. This REQUIREMENT by:  Based on record review observations the facility medications according instructions and failed to medications for 2 of 2 modification carts (1 medication room and 2 medication room and 2 findings included:  1. Manufactures Instraction 500 Milligrams (mg) of resulting in a concomposition (ml) stated "do not refrisolutions, otherwise presultions, otherwise presulting in a concomposition (ml) stated and medication certain observed on 9/14/17 at the following:  a. A 500 milligrams (modification (5mg/ml) hor 1/25/17 and was back of the injection barefrigerate".  b. There were 2 Intraction bag of medication certain of medication of medication of medication dispersion of medication dispersion bag of medication dispersion of medication dispersion bag of medication dispersion bag of medication dispersion dispersion bag of medication dispersion dis	abuse Prevention and dother drugs subject to de facility uses single unit on systems in which the hal and a missing dose can dis not met as evidenced wy, staff interviews and y failed to store to the manufactures do discard of expired medication rooms and for 1 100 medication room, 200 00 north medication cart).  Tructions dated 6/2013 for Metronidazole injection entration of 5mg/milliliter gerate neutralized decipitation may occur."  Intral storage room was and 10:30 AM and revealed medication date of stored in the refrigerator. The grated "do not wenous medicine balls (a cation) of Nafcillin 2 grams et (NS) stored in the	F 43	On 9/14/17 per the surveyor s and L Managers observations medications were not stored per manufacturer sinstructions and failed to discard expir medications in two of two medication rooms and for one of four medication carts. Medications are currently being stored according to the manufacturer instructions. There are currently no expired medications in the medication rooms or on the medication carts.  Medication Carts and Medication Stor Rooms have been audited to ensure medications are stored per manufacturer sinstructions and that medications are not expired. Prior to administration Licensed Nurses are to verify medication expiration dates and medication are stored per manufacturer sinstructions.  Licensed Nurses were in-serviced by Staff Development Coordinator and or Director of Nursing and or the Unit Managers and or the Nurse Supervisor verification of medication expiration dated and to store medications per manufacturer instructions.  The Director of Nursing, Unit Manager	ed  Inside the the or on lates

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		DATE SURVEY COMPLETED
		345116	B. WING _			C <b>09/14/2017</b>
	ROVIDER OR SUPPLIER  JNT HEALTH AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  109 S HOLDEN ROAD  GREENSBORO, NC 27407	<u>'</u>	00.1.1120.11
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 431	Solumedrol 60 mg in with an expiration d  2.) The 200 medica was observed on 9/1 revealed the following a. One Pneumocod (ml) vile was stored in expiration date of b. 6 intravenous min NS were stored in expiration date of c. 1 bag of 20 million Potassium Chloride in normal saline injection 6/2017.  d. 2 bags of 5% De expiration date of 6/2 e. 2 boxes of Influed dose 0.5 milliliters (mbox had an expiration total).  3.) The Package insophthalmic solution of unopened bottle degrees Fahrenheit. can be stored at room weeks.  a. The 200 North medication of 8/27/18 was a medication cart at room weelication cart at room w	ntravenous medicine ball of NS stored in the refrigerator ate of 2/4/17.  tion central storage room 4/17 at 10:30 AM and g: ccal Vaccine Polyvalent 0.5 in the refrigerator and had an 4/30/17. edicine balls of Ancef 2 gms the refrigerator with an 8/2/17. equivalents (meq) of in 5% dextrose and 0.45% in had an expiration date of extrose for injection had an expiration date of extrose for injection had an expiration date of extrose for injection had an expiration date of 4/1/17 (20 syringes on date of 4/1/17 (20 syringes in the refrigerator at 36 to 46 once the bottle is opened, it in temperature for 6 extrosed on the complex of the plastic had a sticker on it, which	F 4.	and Nurse Supervisors will corrandom observation audit of ormedication cart and one medic per week to validate medication currently being stored according manufacturer is instructions and expired medications. The Director of Nursing will present the results audits to the Quality Assurance Performance Improvement Correview and recommendation. Will be conducted weekly for an twelve weeks or until the Qual Assurance and Performance Improvement Committee deternated by the Director of Nursing will presented by the Director of Nursing	ne cation room ons are ng to the nd no ector of s of the e and ommittee for The audits minimum of ity  rmines the stain lits will be lursing ee months, Performance ting to and further of the three e and ommittee will needed to The consible for	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		345116	B. WING	B. WING		C 09/14/2017	
	ROVIDER OR SUPPLIER		<u> </u>	,	STREET ADDRESS, CITY, STATE, ZIP CODE  109 S HOLDEN ROAD  GREENSBORO, NC 27407	1 09/	14/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	at least 3 times a wee medication rooms an medication dispensin some of the medication in the medications roo had been discharged night shift nurses wer for expired medication. The consultant pharm 9/14/17 at 1:33 PM. If check the medication observations of medication observations of medications administration. He stapharmacy report reverpulling discontinued in medication carts. He checked the medication carts. He checked the medication stated that the staff was special type of solu expired, or if a reside stated the administration.	as interviewed on 9/14/17 at a that the pharmacy came in ek and would check the d would stock the automatic g machine. She stated that cons that were found expired for were for residents that and she stated she thought the responsible for checking ins.  The stated that he would carts and make cation administration at the months, there were concerns age and medication atted the August, 2017 caled the staff were not medication from the stated the pharmacy on carts and medication  The stated that she would stated the pharmacy on carts and medication in the stated that she would is to be stored properly. She has to destroy medications in tion when a medication in twas discharged. She tive staff were trying to figure his to be completed because	F	431			
F 441 SS=D		OL, PREVENT SPREAD,	F	441			10/12/17

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G		ATE SURVEY MPLETED
		345116	B. WING		١,	C 09/14/2017
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	<u> </u>	7571-72017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	Continued From pag	e 47 on and control program.	F 44	11		
		ablish an infection prevention (IPCP) that must include, at wing elements:				
	investigating, and co communicable disea volunteers, visitors, a providing services ur arrangement based u conducted according	nder a contractual upon the facility assessment to §483.70(e) and following andards (facility assessment				
	1 7 7	s, policies, and procedures ch must include, but are not				
	possible communical	illance designed to identify ble diseases or infections ad to other persons in the				
	` '	m possible incidents of se or infections should be				
		nsmission-based precautions vent spread of infections;				
	(iv) When and how is resident; including bu	solation should be used for a ut not limited to:				
	(A) The type and dur depending upon the involved, and	ation of the isolation, infectious agent or organism				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345116	B. WING_		_	C 09/14/2017
	ROVIDER OR SUPPLIER	AB CENTER	•	STREET ADDRESS, CITY, ST. 109 S HOLDEN ROAD GREENSBORO, NC 274		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BI		
F 441	Continued From pag	e 48	F4	41		
		at the isolation should be the ible for the resident under the				
	must prohibit employ disease or infected s	es under which the facility ees with a communicable kin lesions from direct s or their food, if direct the disease; and				
		e procedures to be followed irect resident contact.				
		rding incidents identified CP and the corrective facility.				
		el must handle, store, ort linens so as to prevent the				
	annual review of its I program, as necessa This REQUIREMEN by:	Γ is not met as evidenced				
	interviews the facility contact precautions a for 1 of 1 resident wh precautions due to e	on, record review and staff failed to fully implement as ordered by the physician no required contact xtended spectrum beta (ß) fection of the urine (Resident		precautions when E the laboratory. Res precautions were in	mplemented on #7 was being treated	ру
	Findings Included:	ed multi-drug resistant		laboratory result is	initiated by the the time the abnorma received by the center is not necessary to	er.
	organisms (MDROS)	dated 2012 was provided by dig (DON). Section II titled		initiate contact isola	•	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345116	B. WING			1	С
NAME OF D	20//DED OD OUDDUED	345116	B. WING _		TREET ARRESTO CITY OTATE ZIR CORE	09/	/14/2017
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STARMOL	INT HEALTH AND REHA	AB CENTER		109 S HOLDEN ROAD			
				G	REENSBORO, NC 27407		
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE
F 441	Continued From pag	e 49	F 4	141			
F 441	Continued From page 49 isolation precautions stated "Contact Precautions shall be considered for residents infected or colonized with an MDRO. A case by case decision will be made." Section titled note stated "Other organisms, not as well-known are capable of causing severe infection and death in infected individuals, especially the immunocompromised host. These include extended spectrum beta-lactamase producers."  Resident #7 was admitted to the facility on 8/23/17 and diagnoses included septicemia, urinary retention, diabetes and heart failure.  An admission minimum data set (MDS) dated 8/30/17 for Resident #7 revealed she had a indwelling Foley catheter for urine elimination, required extensive assistance with her activities of daily living (ADL 's) and had not received any antibiotics during the 7 day look back period.  A review of the urinalysis dated 9/9/17 at 6:57 am for Resident #7 identified a urinary tract infection (UTI) was present with >100,000 colony forming units per milliliter (CFU/mI) lactose fermenting gram negative rods. The isolate was an ESBL producing microorganism.  A review of the physician orders for Resident #7		F 4	signage should be placed on the resident so door and the appropria Personal Protective Equipment show made readily available outside the resident soor. Licensed Nurses communicate in shift to shift report are any residents on Isolation Precautions.  Licensed Nurses were in-serviced Staff Development Coordinator and Director of Nursing and or the Unit Managers and or the Nurse Supern that Contact Isolation is initiated by Licensed Nurse at the time the abrilaboratory result is received by the a physician sorder is not necessal initiate contact isolation; at the time contact isolation is initiated, appropriately soor and the appropriate Personal Protective Equipment show made readily available outside the resident door.  The Director of Nursing, Unit Managend Nurse Supervisors will conduct random observation of residents woon isolation precautions once weel validate the signage is posted and		ould ere  ne the	
	order to administer II intramuscular (IM) fo tract infection (UTI) a isolation for ESBL U  An observation on 9/	for 7 days. On 9/11/17 an envanz 1 gram (gm) or 10 days for ESBL urinary and an order for contact TI until antibiotic completed.			available outside the resident □s door. The Director of Nursing will present the results of the audits to the Quality Assurance and Performance Improvement Committee for review an recommendation. The audits will be conducted weekly for a minimum of twelve weeks or until the Quality		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345116	B. WING			C 9/14/2017	
NAME OF PROVIDER OR SUPPLIER  STARMOUNT HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  109 S HOLDEN ROAD  GREENSBORO, NC 27407			3/14/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 441	personal protective of outside of the reside.  An observation on 9, #7 's room revealed on the door to her roavailable. A staff me resident 's room we PPE.  The staff member we Resident #7 's room identified herself as therapy assistant (C seen the contact iso had asked the nurse know why the sign we that she did put on gresident and washed room, but did not us there was none outs.  An observation on 9, #7 's room revealed on the door to her roavailable in a cart in Red barrels were location.  An interview on 9/12 Nursing Assistant #1 resident was on isola why. She stated this worked with the resigloves and a gown wadded that when she	r to her room. There was no equipment (PPE) available int's room.  //11/17 at 3:19 pm of Resident a contact isolation sign was som. There was no PPE inber was observed in the aring gloves, but no other as interviewed when she left in on 9/11/17 at 3:19 pm. She the certified occupational OTA #1). She stated she had lation sign on the door and a about it but the nurse didn't was on the door. She added alloves while working with the did her hands in the resident's eany other PPE because	F 44	Assurance and Performance Improvement Committee dete audits remain necessary to su compliance ongoing. The authorisement by the Director of Monthly, for a minimum of three in the Quality Assurance and Improvement Committee Meedetermine recommendations actions indicated. At the end months, the Quality Assurance Performance Improvement Condetermine any further actions sustain compliance ongoing. Administrator is ultimately rest the plan of correction and enscompliance ongoing.	ustain dits will be Nursing ree months, Performance eting to and further of the three ce and ommittee will a needed to The sponsible for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  B	COMPLETED	
		345116	B. WING		C 09/14/2017	
NAME OF PROVIDER OR SUPPLIER  STARMOUNT HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  109 S HOLDEN ROAD  GREENSBORO, NC 27407		09/14/2017	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 441	Continued From pa	ge 51	F 44	11		
	revealed she was the stated she was an affirst time she had we #3 stated that she was an affirst time she had we #3 stated that she was on contact is the resident yet on Resident #7 's Sepadministration recollike she was on iso in her urine and that 9/11/17 to start conditions and the she was on iso in her urine and that 9/11/17 to start conditions in the resident #7 's root isolation sign remain There was a cart we and a red barrel instant An interview on 9/1 Manager for Resident a bacterial infection was confoley catheter. The had just returned to days but if the physisolation anyone er gown and gloves.	9/13/17 at 10:19 am of m revealed the contact ined on the door of her room. ith PPE outside of her room				
	#4 revealed on 9/11 physician was at th urinalysis results for the morning of 9/12 on contact precauti physician had writte	1/17 Resident #7 's primary e facility and reviewed the om 9/9/17. Nurse #4 added on 2/17 she started Resident #7 ons when she realized the en the order but, other than the door the other required				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345116	B. WING		C 09/14/2017	
NAME OF PROVIDER OR SUPPLIER  STARMOUNT HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODI  109 S HOLDEN ROAD  GREENSBORO, NC 27407		·	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION	
F 441	administration recordidentified an order for UTI until antibiotic is dated 9/11/17 at 4:3 was initialed for this 9/12/17 at 7:00 pm.  An interview on 9/14 DON revealed she was a the land ESBL in her unisupervisor had cont 09/09/17 when she for Resident #7. The telephone order dat Macro crystal 100 m added that Residen reviewed the lab resident was also be and the Invanz wou she was not sure whot ordered contact the primary physicial precautions on 9/11 facility would not im without a physician  A phone interview on Nurse #5 revealed is supervisor on 9/9/17.	per 2017 medication d (MAR) for Resident #7 or contact isolation for ESBL s completed. This order was 6 pm. The first time the MAR order being completed was  4/17 at 11:30 am with the was aware that Resident #7 ne. She stated the weekend acted the on-call physician on received the urinalysis results e on-call physician provided a ed 09/09/17 for Nirtofuantoin ng every 12 hours. The DON t #7 's primary physician sults on 9/11/17 and she tic to the Invanz because the eing treated for pneumonia ld cover both. She explained by the on-call physician had isolation on 9/9/17 and that an ordered contact f/17. The DON stated the plement contact isolation	F 44	,		
	on-call physician ord didn't think she had Nurse #5 stated she	alysis. She added that the dered an antibiotic, but she d ordered contact isolation. e couldn ' t remember the physician she spoke with.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		3/5/16	B. WING		С		
NAME OF P	ROVIDER OR SUPPLIER	343110	B. WING _	STREET ADDRESS, CITY, STATE, ZIP COD		9/14/2017	
TO THE OT T	NOVIDER OR OUT FIELD			109 S HOLDEN ROAD	_		
STARMOUNT HEALTH AND REHAB CENTER			GREENSBORO, NC 27407				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 441	Continued From pag	ge 53	F 4	41			
	A phone interview of the primary physicial she had reviewed the and had started the was a more appropring ESBL UTI and her palso started her on obecause of the ESB contamination and significant to be started the resident 's urine was unfortunate that isolation to be started soon as she reviewed added that she had day on 9/11/17 and she had ordered the physician provided the physician that covers A phone interview of the on-call physician coverage for the faction coverage for the faction should be added that she could them an order for counter the facility would know this type of infection.  An interview on 9/14 revealed it was her existed it was her e	n 9/14/17 at 12:25 pm with n for Resident #7 revealed e urinalysis results on 9/11/17 resident on Invanz because it iate antibiotic to treat both her neumonia. She stated she contact isolation on 9/11/17 L and the risk for preading from contact with the tit took 2 days for the contact d, but she had ordered it as ead the urinalysis results. She been in the facility most of the she could not recall what time to contact precautions. The he name of the on-call ed for her on 9/9/17.  In 9/14/17 at 12:58 pm with a prevealed she had provided ility on 9/9/17. She stated that build have been started with a UTI. The on-call physician d not recall if she had given entact isolation but assumed bow that this was required with a UTI. The the that this was required with a utility of the she had given entact isolation but assumed by that this was required with a utility of the she had given entact isolation but assumed by that this was required with a utility of the she had given entact isolation but assumed by that this was required with a utility of the provision of the sident's room when					