

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/19/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - STARMOUNT	STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 431 483.60(b), (d), (e) DRUG RECORDS, SS=E LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

F 431 *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*

The identified medications were removed from storage and disposed of by the unit coordinator.

An audit of all facility designated areas for the storage of medications was completed by the Unit Coordinators and charge nurses on 4/20/12 to identify potentially expired medications and medications without an open date. No other medications were identified.

The Central Supply Clerk was educated on 4/26/12 by the Director of Clinical Education on the storage and supplying of over the counter medications. Licensed nursing staff will be inserviced by the Director of Clinical Education on the storage, dating, and expiration of medications and related processes.

The Director of Nursing Services, Assistant Director of Nursing Services, Director of Clinical Education and/or the Unit Coordinators will audit facility medications to ensure that all medications have open dates and that are no expired medications. This audit will be conducted three times per week for four weeks, then once weekly for four weeks.

5/14/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

*Nursing Home Administrator*

(X6) DATE

*5/10/12*

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/19/2012
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - STARMOUNT		STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 431	<p>Continued From page 1</p> <p>Based on observation and interview the facility failed to remove expired medications from 4 of 7 medication storage areas and document medication open dates for 1 medication.</p> <p>Example 1:</p> <p>04/18/2012 at 5:25 PM an observation was made with the facility's 2nd floor unit coordinator of the facility's over the counter medication storage room located on the second floor. Located on the wooden storage shelves 4 bottles of Oyster Calcium 250mg tablets were observed. The bottles had an expiration date of 11/2011 and lot# - 28432. On the same shelf 1 bottle of Oyster Calcium 250mg tablets was observed with an expiration date of 2/2012 and lot# 28433.</p> <p>An interview was conducted with the facility's second floor unit coordinator on 04/18/2012 at 5:35 p.m. The unit coordinator explained the process for stocking the medication carts to be that the medications would be taken from the over the counter stock storage room and placed on the medication carts when the carts stock was depleted. The second floor unit coordinator indicated the medications observed on the shelf were expired per the manufacturer's date on the bottles.</p> <p>2. During an observation on 4/19/2012 at 9:30 am the medication cart on the Two East hall had one bottle of Thera M multivitamins with an expiration date of 11/2011, one bottle of Vitamin D with an expiration date of 12/2011, one bottle of Bisacodyl with and expiration date or 9/2011, and</p>	F 431	<p>The results of this audit will be reviewed by and brought to the Quality Assessment and Assurance Committee Meeting by the Director of Nursing Services. Any issues or trends identified will be addressed by the Quality Assurance Committee as they arise and the plan will be revised as needed to ensure continued compliance.</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

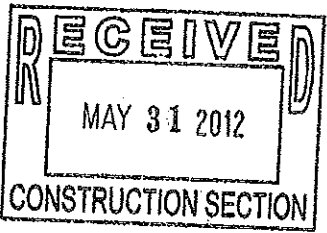
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/19/2012	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - STARMOUNT		STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 2</p> <p>a bottle of folic acid with an expiration date of 2/2012. When asked who was responsible for checking the carts for expired medications, Nurse #1 stated the nurses on the carts or sometimes the pharmacist.</p> <p>3. An observation of the medication cart on the One East hall on 4/19/12 at 9:50 am found one bottle of Thera M Vitamins with an expiration date of 11/2011. Nurse # 2 when asked stated that the nurses usually checked the carts for expired medications.</p> <p>4. On 4/19/2102 at 10:00 am an observation was made on the One North hall of an Advair diskus that was open in use with 23 does on the dial and no opened date on the diskus or the box in the medication cart. The box had a pharmacy delivery date of 3/29/12. Nurse # 3 stated I guess they forgot to date that one. The manufacturer ' s recommendation was for an Advair diskus to be discarded 30 days after removal from the foil pouch or when the dose read 0 whichever came first.</p>	F 431		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345116	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/01/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - STARMOUNT	STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	INITIAL COMMENTS  This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type II(2222) construction, two stories, with a complete automatic sprinkler system.	K 000		
K 052 SS=E	<p>The deficiencies determined during the survey are as follows: NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 5/1/2011 the primary and secondary phone line to the Fire Alarm Control Panel (FACP) could not be verified to have a visual or audible indicator. When the phone lines for the FACP were disconnected there was no visual or audible indication in an area where it was likely to be heard.</p>	K 052		<p>We will make sure all alarm systems are working properly when the telephone line is disconnected.</p> <p>All future alarm systems installed will be routinely checked to make sure that if the phone line is disconnected , the (FACP) fire alarm control panel will alarm us</p> <p>This will be monitored daily for 4 weeks, then monthly x3 weeks : then quarterly and as needed.</p> <p>This system will be monitored monthly x 3..then quarterly and as needed by the QA comltee.</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *W. K. L...* TITLE: *Administrative* (X6) DATE: *5/10/12*

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345118	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/01/2012
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - STARMOUNT			STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052  K 062 SS=E	Continued From page 1 CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 5/1/2012 The sprinkler heads installed at the charting room on the second floor. were a mix of a quick response head and a standard fused head. Interview with Maintenance Supervisor revealed that the facility was not aware that all sprinkler heads in a smoke compartment were required to be of the same type so that the sprinkler system in that space can work in unison. Actual NFPA Standard: NFPA 13,5-3.1.5.2  CFR#: 42 CFR 483.70 (a)	K 052  K 062	Dual sprinkler head will be replaced in Charting room  All sprinkler heads installed in the future will coincide with each other  This will be monitored to make sure additional sprinkler systems coincide with each other weekly x4, monthly x4 then quarterly and as needed.  This will be monitored by the QA committee weekly x4, monthly x4 and then quarterly and as needed	5/22/12

*WTC*