STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345116	A. BUILDING _____ B. WING _____	C 09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - STARMOUNT	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 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain an odor free environment on 1 of 2 halls (100 hallway). The facility also failed to provide a sanitary interior in the multi-purpose conference room/restorative dining room by failing to clean the microwave oven, the stove, the dishwasher and the dual sinks. Findings included: 1. During all days of the survey from 09/20/15 through 09/24/15, there were lingering odors on the 100 hall and in the front lobby area near the elevators. Observations conducted on 09/20/15 at 9:40 PM revealed there was a very strong odor of urine at the entry of the facility directly in front of the elevators on the first floor. Observations conducted on 09/21/15 in rooms 104 D at 2:39 PM, 105 A at 3:59 PM,106 A at 2:49 PM, 107 A at 2:46 PM, 111 B at 3:37 PM, 113 A at 2:36 PM, and 114 A and 114 B at 2:51 PM revealed stale urine odors. Observations conducted on 09/23/15 at 8:10 AM revealed there was a very strong odor of urine at the entry of the facility directly in front of the	F 252	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed soley because it is required by the provisions of Federal and State Law. Rooms 104,105,106,107,111,113,and 114 were deep cleaned. The entry of the facility directly in front of the elevators was deep cleaned. The multi-purpose conference/restorative dining room was deep cleaned to include the microwave oven, the stove, the dishwasher and dual sinks. All residents have the potential to be effected. All resident rooms were inspected for stale urine odors on 10/15/15. No odors were present. All common areas were inspected on 10/15/15 for odors and none were present. The Environmental Services Director will audit 5 resident rooms and the	10/22/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/16/2015

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F 252	Continued From page 1 elevators on the first floor. The facility staff could not determine where the strong odor was coming from. An interview conducted with the Housekeeping Director on 09/24/15 at 1:15 PM regarding his expectations for eliminating odors indicated," I expect the housekeeping staff to detect where the odors are coming from and deep clean those rooms. We also use air fresheners and sanitizers. Each housekeeper has at least one room to deep clean everyday unless a room needs to be cleaned. Each morning I go around and check the rooms, and I identify which rooms need deep cleaning. I text it to my boss. I don't keep a record of it, I just keep it on my phone. " The Housekeeping Director indicated there was no other form of documentation for use by the facility to show which rooms had been deep cleaned and when the rooms were cleaned. 2. Observations conducted in the multi-purpose conference /restorative dining room on 09/20/15 at 9:30 PM, 09/21/15 at 12:00 PM and 3:00 PM, on 09/22/15 at 7:40 AM and 4:00 PM, 09/23/15 at 7:50 AM and 2:00 PM, and 09/24/15 at 7:30 AM and 10:30 AM, indicated the microwave oven turntable was covered with brown spills, the two compartment sink was observed with black debris inside the drain covers, and in both sinks. The inside upper door ledge of the dishwasher was observed with accumulated brown food debris. The inside door ledge of the stove was observed with black accumulated food debris. Interview conducted with the Food Service Director on 09/24/15 at 12:10 PM indicated it was," the responsibility of the Housekeeping staff to keep the multi-purpose conference	F 252	multi-purpose conference/restorative room 5 times a week for 4 weeks to address a sanitary interior and odors in all resident/common areas of the facility. The housekeeping staff will be inserviced by the Environment Services Director on identifying and addressing odors, deep cleaning of resident rooms, and deep cleaning of the multi-purpose conference room/restorative dining room. Results of the audits will be reported to the Exective Director daily in the Stand Up Meeting. Results from the audits will be discussed at the Quality Assurance and Performance Improvement Meeting monthly times 3 months. Additional education and monitoring will be initiated for any identified concerns.	

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F 252	Continued From page 2 room/restorative dining room area and equipment (including the stove and dishwasher) clean." A staff interview conducted on 09/24/15 at 12:20 PM with the Housekeeping Aide indicated, "We are responsible for cleaning the sinks and the microwave oven in the multi-purpose conference room/restorative dining room." A staff interview was conducted with the Environmental Services Director on 09/24/15 at 12:30 PM. When asked when the last time the equipment in the multi-purpose conference room/restorative dining room had been cleaned, the director stated, "The last time the equipment was cleaned was Saturday 09/19/15. The director was unable to provide documentation related to when the equipment/area was cleaned. When asked what his expectations was of the Housekeeping staff related to the concern, the Environmental Services Director indicated, "I expect the equipment and the area to be cleaned daily. "	F 252		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278		10/22/15

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F 278	Continued From page 3 that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code on the Minimum Data Set (MDS) assessment to reflect PASRR (Preadmission Screening and Resident Review) level 2 (two) for 1 of 1 resident in the sample reviewed for PASRR. (Resident #68) Findings included: Resident #68 was admitted on 06/20/15 with cumulative diagnoses which included depression, anxiety and bipolar disorder. Review of PASRR (Preadmission Screening and Resident Review) Determination notification form revealed that Resident #68 was determined to be a PASRR level II since 6/23/14 with no expiration date. Review of the Significant Change Minimum Data Set (MDS) assessment dated 1/12/15 revealed Section A of the MDS was not coded to reflect PASRR determination. The MDS Nurse was interviewed on 09/24/15 at	F 278	The Minimum Data Set (MDS) for Resident #68 was corrected on 10/15/15 to reflect the correct PASRR determination. All residents have the potential to be affected. All current Minimum Data Sets were audited to ensure Section A of the MDS is coded to reflect the PASRR determination of the resident. No other incorrect coding of PASRR determinations were found. Social Services Director will audit Section A of the MDS to ensure the correct PASRR determination is coded for the resident. Social Services Director will audit the Comprehensive MDS prior to their completion date times 4 weeks.	

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F 278	Continued From page 4 9:53 AM who stated that the Social Worker was responsible for completing the PASRR section on the MDS assessment. The Social Worker was interviewed on 09/24/15 at 9:37 AM who stated that the resident was admitted on 6/23/14 with a level II PASRR with the B code. Continued interview with the social worker revealed the B code indicated a permanent PASRR II. The Social Worker was interviewed again on 09/24/15 at 09:57 AM and indicated she was responsible for coding the PASRR section of the MDS and that it was an oversight that it was not coded on the MDS Significant Change Assessment. The Administrator was interviewed on 09/24/15 at 11:56 AM who stated that the MDS assessment should be accurate and reflect the resident status.	F 278	Social Services Director inserviced by the Executive Director to ensure that each resident PASRR determination is coded accurately on Section A of the MDS. Results of the audits will be reported to the Executive Director daily in the Stand Up Meeting. Results from the audits will be discussed at the Quality Assurance and Performance Improvement Meeting monthly times 3 months. Additional education and monitoring will be initiated for any identified concerns.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279		10/22/15

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F 279	Continued From page 5 be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with facility staff, the facility failed to have a written care plan for activities of daily for a resident that was totally dependent for activities of daily living for 1 of 2 sampled residents. (Resident #66) The findings included: Record review of the Body Wash directions on the container revealed, either apply to damp cloth or add small amount to basin of warm water. Cleanse patient's face. Continue down the body. Rinse thoroughly and pat dry. Resident #66 was admitted to the facility 6/30/09. Her diagnoses included Alzheimer's Disease. Care Area Assessment dated 4/1/15 revealed that staff was to provide assistance with activities of daily living as needed, encourage self care to abilities and monitor for changes. Placement was expected to be long term. Record review of the most recent quarterly Minimum Data Set dated 9/8/15 revealed that the resident had problems with short and long term memory, Resident #66 was coded that she required total assistance with one person physical assist for dressing, personal hygiene and bathing.	F 279	All residents have the potential to be affected. Resident #66 Care Plan was updated on 9/24/15 to reflect total assistance with one person assist for dressing, personal hygiene, and bathing. CNA #2 inserviced on Body Wash directions and completed Bath Competency. Registered Nurse Assessment Coordinator (RNAC) audited all resident care plans to ensure it reflects the appropriate plan of care related to Activities of Daily Living. No other residents were affected. RNACs to audit any newly completed/updated Care Plans to ensure an Activities of Daily Living plan of care is correct and included times 4 weeks. Unit Coordinators will observe baths of 2 residents 5 times a week times 4 weeks to ensure appropriate bathing procedure is followed. Certified Nursing Assistants will be inserviced regarding proper bathing of resident with Body Wash.	

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F 279	Continued From page 6 There was no care plan for activities of daily living. Observation on 9/24/15 at 9:30 AM of NA #2 providing a bed bath to Resident #66 revealed that NA #2 applied soap to the top of the resident ' s legs and the peri area but did not rinse soap. She dried the resident with a towel. NA #2 continued and washed Resident #66's back on the resident ' s right side with soap, without rinsing off the soap before she dried the resident. NA #2 did not wash the resident's left side of her back and the back of her legs. Interview on 9/24/15 at 12:35 PM with NA #2 revealed "I forgot" when asked why she did not rinse the soap from Resident #66 while giving her the bed bath. Interview on 9/24/15 at 12:30 PM with the Director of Nursing revealed that her expectation was that the resident would be rinsed off. Interview on 09/24/2015 at 12:53 PM with the Director of Nursing revealed that the care plan for activities of daily living for Resident #66 had just been completed. She continued that it was dated 9/24/15.	F 279	Director of Nursing services will inservice RNACs regarding completion of Care Plan to reflect that each resident has a completed and accurate Activites of Daily Living plan of care. Results of the audits will be reported to the Executive Director daily in the Stand Up Meeting. Results from the audits will be discussed at the Quality Assurance and Performance Improvement Meeting monthly times 3 months. Additional education and monitoring will be initiated for any identified concerns.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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.	F 312		10/22/15

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F 312	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with residents and facility staff, the facility failed to provide urinary incontinent care for 5 hours and 10 minutes on 9/24/15 and provide proper technique for urinary incontinent care for 1 of 2 residents dependent on staff for care. (Resident #80) The facility failed to rinse the soap off the resident's body during a bed bath. This was evident in 1 of 2 sampled residents, dependent on staff for care. (Resident #66) The findings included: 1. Resident #80 was admitted to the facility on 9/24/13 with diagnoses of dementia, retention of urine and unspecified urinary incontinence. Care Plan dated 4/9/15 Focus: Potential for urinary tract infection or actual urinary tract infection due to history of urinary retention, urinary incontinence. Goal: Will remain free of urinary tract infections thru the next review. Interventions: Assist with toileting or incontinent care as needed. Encourage fluids unless contraindicated. Observe and report signs of urinary tract infection, change in color, odor or consistency of urine, dysuria, frequency, fever or pain. The most recent annual Minimum Data Set dated 6/18/15 coded Resident #80 as extensive assistance with one person physical assist for toilet use and personal hygiene. Resident #80	F 312	Resident #80 has BIMS score of 12. Resident is care planned to frequently refuse care. No other residents were affected by this practice. CNA #2 inserviced on Body Wash directions and completed Bath Competency. CNA #1 inserviced regarding timely incontinent care and to complete rounds at the beginning of the shift on all assigned residents. Unit Coordinators will observe baths of 2 residents 5 times a week times 4 weeks to ensure appropriate bathing procedure is followed. Director of Staff Education to audit 2 residents 5 times a week to ensure timeliness of incontinent care. Director of Staff education will inservice Certified Nursing Assistants regarding proper bathing of resident and Body Wash directions. Director of Staff Education will inservice Certified Nursing Assistants regarding timeliness of incontinent care and completion of rounds at the beginning of the shift on all assigned residents. Results of the audits will be reported to the Executive Director daily in the Stand	

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F 312	Continued From page 8 was always incontinent of bladder. Record review of the Care Area Assessment dated 7/6/15 revealed that Resident #80 required extensive to dependent assistance with toilet use. Resident #80 was at risk for complications such as urinary tract infection. Interview on 9/21/15 at 12:23 PM with Nurse #1 revealed that Resident #80 was considered to be interviewable. Observations on 9/24/15 at 10:55 AM of Resident #80's bath was performed by nurse aid #1 (NA #1)NA#1 took the wash cloth and then wiped between both sides of the skin between her legs then came back to the peri area and made one swipe from front to back, without rinsing the wash cloth. Resident #80 was then turned on her side. Her night gown was soaked with urine up her back, the incontinent brief was saturated and the bed sheet had a wet circle of about 30 inches of urine on it. Interview on 9/24/15 with NA #1 at 11:05 AM revealed that this was late for her to get up. Interview with Resident #80 on 9/24/15 at 11:08 AM revealed that she was last changed at 5:00 AM. The resident was considered to be interviewable. Interview on 9/24/15 with NA #1 at 11:10 AM revealed she did not do morning rounds when her shift began because breakfast came early and she was in the dining room. She had not gotten around to completing her incontinent rounds. Interview on 9/24/15 at 12:30 PM with the	F 312	Up Meeting. Results from the audits will be discussed at the Quality Assurance and Performance Improvement Meeting monthly times 3 months. Additional education and monitoring will be initiated for any identified concerns.	

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F 312	Continued From page 9	F 312		

Director of Nursing revealed that incontinent care was to be done in the morning when the NA arrived, after meals and as needed. The NA should provide care to the perineal area with a clean/rinsed wash cloth.

2. Record review of the Body Wash directions on the container revealed,
Either apply to damp cloth or add small amount to basin of warm water. Cleanse patient ' s face. Continue down the body. Rinse thoroughly and pat dry.

Resident #66 was admitted to the facility 6/30/09. Her diagnoses included Alzheimer's Disease.

Care Area Assessment dated 4/1/15 revealed that staff was to provide assistance with activities of daily living as needed, encourage self care to abilities and monitor for changes.

Record review of the most recent quarterly Minimum Data Set dated 9/8/15 revealed that the resident had problems with short and long term memory, Resident #66 was coded that she required total assistance with one person physical assist for personal hygiene and bathing.

There was no care plan for activities of daily living.

Observation 9/24/15 at 9:30 AM of NA #2 providing a bed bath to Resident #66 revealed that NA #2 applied soap to the top of the resident ' s legs and the peri area but did not rinse soap from her skin. She dried the resident with a towel. NA #2 continued and washed Resident #66 ' s back on the resident ' s right side with soap, without rinsing off the soap off of her skin, before

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F 312	Continued From page 10 she dried the resident. NA #2 did not wash the resident ' s left side of her back and the back of her legs. Interview on 9/24/15 at 12:30 PM with the Director of Nursing revealed that her expectation was that the resident was to be rinsed off. Interview on 9/24/15 at 12:35 PM with NA #2 revealed, " I forgot " when asked why she did not rinse Resident #66.	F 312		