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 08/25/2016

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 8/25/16. Event ID# RWJH11.	F 000		
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 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:	F 278		9/19/16

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

Electronically Signed | 09/15/2016

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F 278	Continued From page 1 Based on record review, observations and staff interviews the facility failed accurately code the Minimum Data Set (MDS) to reflect the resident ' s dental status for 1 of 3 residents reviewed for dental status (Resident #66). Findings included: Resident # 66 was admitted on 7/16/15 with the current diagnoses of dementia, diabetes and depression. The resident ' s MDS significant change assessment dated 3/31/16 revealed the resident was cognitively intact. Section L of the MDS for the resident ' s dental status assessment did not reflect the resident had no natural teeth or tooth fragments. A review of the Admission clinical Health status dated 7/16/15 revealed the resident was edentulous. Unit Manager #1 was interviewed on 8/24/16 at 8:09 AM. She stated the resident usually ate 25%-50% of meals and also snacked often. The resident did not have any teeth. The resident had not had teeth since she came in. Resident #66 was observed on 8/24/16 at 8:14 AM. The resident was observed eating pancakes, eggs with milk and juice. The resident stated that she does not have any problems eating and eats pretty well. The resident was observed not to have any teeth or dentures. Resident #66 was interviewed on 8/24/16 at 1:56 PM. She stated she does not have teeth and has never had dentures. She stated she was able to chew with her gums. MDS Nurse #1 was interviewed on 8/25/16 at 11:15 AM. She stated she coded the significant change MDS assessment dated 3/31/16. The resident has never had any teeth and the way the MDS was coded was a mistake. The Director of Nursing was interviewed 8/25/16	F 278	"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 conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law" Corrective action affected resident Significant change MDS for resident #66 was completed 3/16/16 with coding inaccuracy for section L, dental status. MDS Significant change 3/16/16, modified 8/25/16 with section L reflecting accurately by MDS nurse. MDS nurse was re-educated by Director of Nursing Services regarding accurate coding of the MDS 8/24/16 Corrective action potential residents All other residents with the potential to be affected by this practice will be audited on or before 9/19/16 by MDS nurse to ensure comprehensive MDS is completed accurately. Any MDS found with inaccuracy will be modified by the MDS nurse on or before 9/19/16 to reflect accurately. Measures Director of Nursing Services and/or Assistant Director of Nursing in her absence will monitor a minimum of 5 MDS completed assessments weekly to ensure accurate coding reflected and 100% of significant change MDS assessments will be monitored by Director of Nursing	

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F 278	Continued From page 2 at 10:43 AM. She stated her expectation was for a thorough assessment to be conducted and the MDS to be coded correctly.	F 278	Services and or Assistant Director of Nursing Services in her absence to ensure accurate coding. The monitoring will begin on or before 9/19/16. Monitoring The Director of Nursing Services will bring results from the monitoring to the QAPI meeting monthly, for a minimum of 3 months and continue monthly thereafter, if deemed necessary. The QAPI committee will make recommendations based on the results of the monitoring to ensure compliance. Urgent QAPI meeting held 8/23/16 to discuss plan of correction regarding this practice and will continue with each monthly meeting beginning September 2016.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee	F 520		9/19/16

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F 520	Continued From page 3 except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and facility staff interviews, the facility ' s Quality Assurance Program (QA) failed to maintain procedures and monitor the interventions that the committee put into place in September 2015. This was evident for the recited deficiency originally cited on a recertification and complaint survey ending September 24, 2015. The deficiency was inaccurate coding on the Minimum Data Set (MDS). The continued failure of the facility during two recertification surveys showed a pattern of the facility inability to sustain an effective Quality Assurance (QA) Program. The findings included: F 278 tag -Accuracy of Assessment was cross referenced to F 520. Based on observations, record review, and staff interviews, the facility failed to accurately code the MDS to reflect the resident ' s dental status for 1 of 3 sample residents reviewed for dental status. F 278 tag was originally cited during the recertification and complaint ending September 24, 2015. Based on record review and staff interviews, the 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 sample reviewed for PASRR.	F 520	"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 conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law" Corrective action affected resident Urgent facility QAPI held 8/23/16 to discuss corrective action regarding F278. Facility will maintain quality assessment process improvement committee(QAPI), who will continue to meet monthly. Corrective action potential resident The QAPI Committee will meet more frequently than required quarterly meeting, assembling at least monthly. The monthly meeting will include focus on the requirements of the Plans of Correction for the cited alleged deficient practice and the committee will develop plans for process improvement and deficiency correction. QAPI meeting scheduled for 9/19/16 and will continue to meet monthly to ensure quality assurance	

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F 520	Continued From page 4 An interview was conducted on 8/25/2016 at 1PM with the Director of Nursing (DON) and Cooperate Representative (CR). The DON stated her expectation was the MDS assessment be coded accurately. The CR stated her expectation was staff code the MDS accurately and the facility would continue to work on the Quality Assurance (QA) Program.	F 520	and compliance. Adjustments will be made in the plan based on the outcomes of the monitoring to ensure compliance. The Executive Director and/or the Director of Nursing Services in their absence will ensure the monthly QAPI meetings are held with attendance for verification on file. Measures The Executive Director and/or the Director of Nursing Services in their absence will ensure all results from action items and improvement plans are discussed in detail each meeting for 6 months and existing action steps will be revised or added to ensure quality improvement. Monitoring The results of the monthly monitoring will be brought to the Quarterly QAPI committee monthly for a minimum of 6 months to ensure quality improvement and to track progress. The QAPI plan will be adjusted according to the results and success of the plan implemented and these activities will be recorded within the minutes maintained by the facility for QAPI. By monitoring the plan of correction for deficit practice for effectiveness, the committee will continually ensure that its goal of quality and performance improvement is accomplished. After 6 months the QAPI committee will recommend if there is a need to continue.	