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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 A recertification, and complaint survey was conducted from 10/14/18 through 10/19/18. An extended survey was conducted. Immediate Jeopardy was identified at: CFR 483.12 for tag F600 at a scope and severity J CFR 483.24 for tag F678. at a scope and severity J Tags F600 and F678 constituted Substandard Quality of Care. Immediate Jeopardy began on 9/30/18 and was removed on 10/19/18. There were no deficiencies as a result of the complaint investigations. Event #910211 11/7/18 Management review resulted in deletion of F600 and F678	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) for 1 out of 5 residents (Resident #62) reviewed for unnecessary medications and 1 out of 3 residents (Resident #16) reviewed for pressure ulcers. Findings include: 1. Resident #62 was admitted to the facility on	F 641	0641 483.20(g) Accuracy of Assessments Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared solely because it is required by the provision of the Federal and State Law.	11/15/18

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

Electronically Signed | 11/12/2018

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 641	Continued From page 1 9/24/18 with diagnoses that included fracture of the femur, and Diabetes. Resident #62's most recent MDS was coded as an admission assessment and dated 10/1/18. The resident's active diagnoses included Diabetes Mellitus, hip fracture, and hypertension. The medication 7 day look back for Resident #62 was coded as having an anticoagulant 2 out of 7 days and no injections for the past 7 days in the look back period. Resident #62's most current care plan dated 10/1/18 revealed the resident was not care planned for anticoagulant therapy. A review of Resident #62's MAR (Medication Administration Record) revealed that the resident received Lovenox 30mg subcutaneous every 12 hours from 9/25/18 through 10/1/18. An interview with the MDS nurse was conducted on 10/18/18 at 4:50pm. The MDS nurse reported it is her responsibility to accurately code the MDS assessments. She reported the Medication section of the MDS should have been coded to reflect Resident #62 received an injection for 7 out of 7 days in the look back period of the admission assessment. She also reported the MDS should have been coded to reveal the resident was on an anticoagulant 7 out of 7 days in the look back period. An interview was conducted on 10/18/18 at 8:10pm with the DON (Director of Nursing). She reported it was the MDS nurse's responsibility to correctly code the MDS assessments. She reported it was her expectation that all MDS assessments be coded accurately with the 7 day	F 641	The Resident Care Management Director (RCMD) or designee will complete an audit of current residents receiving an Omnibus Budget Reconciliation Act Assessment during the last 14 days to verify accurate coding of Sections I and N of the Minimum Data Set (MDS) per the Resident Assessment Instrument (RAI) Manual guidelines. If needed, modifications will be completed by the RCMD and or MDS Designee per the RAI Manual guidelines. Resident #62 had modification of section N to reflect accurate medical diagnoses for Assessment Reference Date 10/01/2018. Resident #16 had a modification of section I to reflect accurate coding of the medications for Assessment Reference Date 07/30/2018. The process breakdown occurred when the coding of the Minimum Data Assessments did not correspond with the Resident Assessment Instrument Manual. District Director Care Management will provide education to the Interdisciplinary Team members who participate in MDS coding of sections I and N related to accurate coding of MDS according to the RAI Manual on November 8, 2018. The RCMD will randomly audit five completed MDSs weekly for 12 weeks and then five random MDSs monthly for an additional 3 months to verify accurate coding of Sections I and N of the MDS. One to one education will be provided if opportunities for corrections are as identified as a result of these audits. Modifications to the MDS	

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 641	Continued From page 2 look back of medications. 2. Resident #16 was admitted to the facility on 2/18/18 with diagnoses that included Multiple Sclerosis, paraplegia, neurogenic bladder, and multiple pressure ulcers. A review of Resident #16's most recent MDS coded as a quarterly assessment was completed on 10/8/18. Active diagnoses included Multiple Sclerosis, paraplegia, unspecified wound of buttocks, and pressure ulcer of the elbow. The skin section of Resident #16's MDS was coded as resident having 4 Stage IV pressure ulcers, 3 of which were present on admission. A review of Resident #16's care plan revealed the care plan was updated on 7/23/18 and 8/11/18 to include pressure ulcer care to pressure ulcers on the coccyx, left sacrum, left posterior thigh, left lateral foot, and right medial heel. A review of Resident #16's medical record revealed wound assessments dated 10/2/18 revealed the resident had a Stage IV pressure ulcer to the right ischium, a Stage IV pressure ulcer to the left lateral foot, a Stage IV pressure ulcer to the left ischium, and a Stage IV pressure ulcer to the coccyx area. An observation of Resident #16 receiving wound care was conducted on 10/17/18 at 10:15am. The treatment nurse performed wound care on all of the resident's pressure ulcers using aseptic technique. It was observed that Resident #16 had pressure ulcers of the left ankle, sacrum, left ischium, and right ischium. An interview was conducted with the	F 641	will be completed as needed. Audits will begin on 11/12/18. The results of these audits will be presented by the Resident Care Management Director monthly for 6 months at Facility Quality Assurance Performance Improvement (QAPI) Committee Meeting. The QAPI Committee will make changes or recommendations as indicated. The Resident Care Management Director is responsible for implementing and sustaining the plan of correction.	

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	**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 641	Continued From page 3 treatment nurse and NA #2 on 10/17/18 at 10:15am. The treatment nurse reported she had only been on staff for 2 weeks but during the 2 weeks, the resident had not had a pressure ulcer of the elbow. NA #2 reported she had assisted with dressing changes and care of Resident #16 for a couple of months and she had not had any pressure ulcer of the elbow during that time. An interview was conducted with the MDS nurse on 10/18/18 at 5:10pm. She reported it was her responsibility to accurately code the MDS. After reviewing Resident #16's wound assessments, she reported the MDS dated 10/8/18 had inaccurate coding of diagnoses. An interview was conducted on 10/18/18 at 8:10pm with the DON (Director of Nursing). She reported it was the MDS nurse's responsibility to correctly code the MDS assessments. She reported it was her expectation that all MDS assessments be coded accurately with correct diagnoses.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	F 655		11/15/18

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 655	Continued From page 4 necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews the facility failed to complete the baseline care plan within 48 hours of admission to include goals and interventions and failed to review the baseline care plan with the resident, resident responsible party and/or family member for 2 of 3 new admissions (Resident #136 and	F 655	F655 483.21(a)(1) - (3) BASELINE CARE PLAN Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth	

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 655	Continued From page 5 Resident #62) Finding include: 1. Resident #136 was admitted on October 10, 2018 with current diagnoses of microcytic, anemia, iron deficiency, and Diabetic ketoacidosis type 1. Resident # 136 admission Minimum Data Set was not due until October 18, 2018. However Resident #136 was able to make her needs know to staff. During a review of the baseline care plan for Resident #136 dated October 12, 2018 on October 17, 2018 at 4 pm revealed no diagnoses, no medications, no goals and no intervention for Resident #136. During an interview with Resident #136 on October 17, 2018 at 4:30 pm, revealed she does not recall any staff talking to her about her baseline care plan. Resident #136 indicated does not know what a baseline care plan was. Resident #136 also indicated she never signed the care plan nor received a copy of it. During an interview with the Assistant Director of Nurses (ADON) on October 18, 2018 at 8:30 am revealed that the baseline care plan are completed by the Registered Nurse and that her expectation were that the baseline care plan be completed per state regulation. During an interview with the Director of Nurses (DON) on October 18, 2018 at 9:15 am revealed that her expectation for the baseline care plan, was to address all the issues and concerns for	F 655	in the statement of deficiencies. This Plan of Correction is prepared solely because it is required by the provision of the Federal and State Law. The Resident Care Management Director (RCMD) or designee will complete an audit of current residents baseline care plans to ensure that they address necessary diagnosis and medications per the Resident Assessment Instrument manual guidelines. Resident #136 was identified as not having a baseline care plan completed within 48 hours after admission. Resident #62 was identified as not having anticoagulant therapy addressed in the baseline care plan. Resident Care Management Director ensured that Resident #62 currently has a care plan addressing anticoagulant therapy. District Director Care Management will provide education to the Interdisciplinary Team members who participate in the implementation of baseline care plans according to the RAI Manual on November 8, 2018. The Director of Nursing or Designee will review all new admissions baseline care plans in the Clinical Morning Meeting to ensure they are being completed within 48 hours following admission. The RCMD will randomly audit five residents baseline care plans weekly for 12 weeks to ensure that all pertinent diagnoses and medications are addressed and then five residents baseline care plans monthly for an additional 3 months to verify	

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 655	Continued From page 6 the resident. DON stated she was not able to complete this form with Resident #136 because her blood sugar got low. DON indicated she never completed this process with Resident #136. 2. Resident #62 was admitted to the facility on 9/24/18 with diagnoses that included fracture of the femur, Diabetes, and depression. Resident #62's most recent MDS (Minimum Data Set) was coded as an admission assessment and dated 10/1/18. The resident's active diagnoses included Diabetes Mellitus, hip fracture, and hypertension. The medication 7 day look back for Resident #62 was coded as having an anticoagulant 2 out of 7 days and no injections for the past 7 days in the look back period. Resident #62's baseline care plan dated 9/26/18 revealed the resident was not care planned for anticoagulant therapy. A review of Resident #62's MAR (Medication Administration Record) revealed that the resident received Lovenox 30mg subcutaneous every 12 hours from 9/25/18 through 10/1/18. An interview with the MDS nurse was conducted on 10/18/18 at 4:50pm. The MDS nurse reported it is her responsibility to accurately complete the residents' care plans. She reported that the baseline care plan was not completed with anticoagulant therapy or medications and goals listed. An interview was conducted on 10/18/18 at 8:10pm with the DON (Director of Nursing). She	F 655	appropriate diagnoses and medications are addressed. One to one education will be provided by the DON if opportunities for corrections are as identified as a result of these audits. Revisions to the baseline care plans will be completed by the DON, ADON or RCMD as needed. The results of these audits will be presented by the Resident Care Management Director monthly for 6 months at Facility Quality Assurance Performance Improvement (QAPI) Committee Meeting. The QAPI Committee will make changes or recommendations as indicated. The Resident Care Management Director is responsible for implementing and sustaining the plan of correction.	

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 655	Continued From page 7 reported the registered nurse from corporate was responsible for making sure the baseline care plan was completed. She reported it was her expectation that all new admissions have a completed baseline care plan within 48 hours of admission.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		11/15/18

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 656	Continued From page 8 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to develop and implement a comprehensive care plan for 1 out of 5 residents (Resident #62) whose care plans were reviewed for unnecessary medications. Findings include: Resident #62 was admitted to the facility on 9/24/18 with diagnoses that included fracture of the femur, and Diabetes. Resident #62's most current care plan dated 10/1/18 revealed the resident was not care planned for anticoagulant therapy. There was a care plan meeting to review Resident #62's care plan on 10/3/18 but there was no update to include anticoagulant therapy on the care plan. A review of Resident #62's MAR (Medication Administration Record) revealed that the resident received Lovenox 30mg subcutaneous every 12 hours from 9/25/18 through 10/18/18. An interview with the MDS nurse was conducted on 10/18/18 at 4:50pm. The MDS nurse reported it is her responsibility to develop the comprehensive care plans. She reported Resident #62 should have been care planned for anticoagulant therapy. An interview was conducted on 10/18/18 at	F 656	F656 483.21(b)(1) DEVELOP/IMPLEMENT COMPREHENSIVE CARE PLAN Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared solely because it is required by the provision of the Federal and State Law. The Resident Care Management Director (RCMD) or designee will complete an audit of current residents care plans who receive anti-coagulant therapy to ensure all risks are identified on an anti-coagulant therapy care plan per the Resident Assessment Instrument manual guidelines. Resident #62 was identified as not having an accurate anti-coagulant therapy care plan. The anti-coagulant therapy care plan was developed by the Resident Care Management Director or Minimum Data Set Coordinator (MDSC).	

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 656	Continued From page 9 8:10pm with the DON (Director of Nursing). She reported it was the MDS nurse's responsibility to develop comprehensive care plans for each resident. She reported it was her expectation that residents' care plans reflect all care areas.	F 656	District Director Care Management will provide education to the Interdisciplinary Team members who participate in the implementation of care plans according to the RAI Manual on November 8, 2018. The RCMD will randomly audit five residents care plans, receiving anti-coagulant therapy, weekly for 12 weeks and then five residents care plans, receiving anti-coagulant therapy, monthly for an additional 3 months to verify appropriate anti-coagulant therapy care plans. One to one education will be provided by the DON if opportunities for corrections are as identified as a result of these audits. Revisions to the care plans will be completed by the RCMD or MDSC as needed. The results of these audits will be presented by the Resident Care Management Director monthly for 6 months at Facility Quality Assurance Performance Improvement (QAPI) Committee Meeting. The QAPI Committee will make changes or recommendations as indicated. The Resident Care Management Director is responsible for implementing and sustaining the plan of correction.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		11/15/18

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 657	Continued From page 10 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to update the care plan on 1 out of 2 residents (Resident #84) reviewed for accidents, 1 out of 3 residents (Resident #72) reviewed for care plans, and 1 out of 3 (Resident #16) reviewed for pressure ulcers. Findings include: 1. Resident #84 was readmitted to the facility on 9/26/18 with diagnoses that included sepsis, cellulitis, urinary tract infection, and diabetes mellitus. A review of Resident #84's most recent MDS (Minimum Data Set) dated 10/5/18 was coded as	F 657	F657 483.21(b)(2)(i)-(iii)CARE PLAN TIMING AND REVISION Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared solely because it is required by the provision of the Federal and State Law. The Resident Care Management Director	

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 657	Continued From page 11 a 5-day admission assessment. Active diagnoses included sepsis, unspecified organism and diabetes mellitus. Under the Treatment section of the MDS, Resident #84 was coded as having IV (intravenous) infusions. A review of Resident #84's medical record revealed a physician's order dated 9/29/18 that read 'Vancomycin 750mg IV every 8 hours for cellulitis left lower extremity.' A review of Resident #84's most recent care plan dated 10/5/18 did not address IV antibiotics. An interview was conducted on 10/18/18 at 5:00pm with the MDS nurse. She reported it was her responsibility to develop and update care plans as residents' needs change. She reported Resident #84 should have been care planned for IV antibiotics. An interview was conducted on 10/18/18 at 6:10pm with the DON (Director of Nursing). She reported it was her expectation that all care plans are updated when a resident's needs change and that care plans reflected all care areas. 2. Resident #16 was admitted to the facility on 2/18/18 with diagnoses that included Multiple Sclerosis, paraplegia, neurogenic bladder, and multiple pressure ulcers. A review of Resident #16's most recent MDS coded as a quarterly assessment was completed on 10/8/18. Active diagnoses included Multiple Sclerosis, paraplegia, and neurogenic bladder. The bladder/bowel section of Resident #16's MDS was coded as appliances: ostomy with urinary continence not rated and bowel continence rated as always incontinent. A review of Resident #16's medical record revealed the resident was hospitalized 7/30/18 - 8/10/18 with surgery performed for an urostomy. A review of Resident #16's most current care plan dated 8/11/18 revealed the resident was care	F 657	(RCMD) or MDSC will complete an audit of current residents care plans receiving antibiotics to ensure all risks are identified on an antibiotic care plan per the Resident Assessment Instrument manual guidelines. Resident #84 was identified as not having an accurate antibiotic care plan. The antibiotic care plan was developed by the Resident Care Management Director or designee. The Resident Care Management Director or designee will complete an audit of current residents Fall Care Plans to ensure implemented interventions are addressed on the Fall Care Plan. Resident #84's Fall Care Plan did not address the replacement of the wheelchair cushion in the wheelchair following a fall. The Fall Care Plan was revised addressing the replacement of the wheelchair cushion in the wheelchair. The Resident Care Management Director or MDSC will complete an audit of current residents with an Ostomy to ensure all risks are identified on an Ostomy Care Plan. Resident #16 was identified as not having an accurate Ostomy care plan. An Ostomy Care Plan was developed by the Resident Care Management Director or MDSC on 10/18/18. District Director Care Management will provide education to the Interdisciplinary Team members who participate in the implementation of care plans according to the RAI Manual on November 8, 2018. The RCMD will randomly audit five residents care plans who are receiving anti-coagulant therapy, have an Ostomy	

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 657	Continued From page 12	F 657		

planned for a urinary catheter and a colostomy.

An interview was conducted on 10/18/18 at 5:10pm with the MDS nurse. She reported it was her responsibility to update care plans according to a resident's changing needs. She reported Resident #16's care plan was incorrectly updated.

An interview was conducted at 6:10pm with the DON on 10/18/18. She reported it was her expectation that a resident's care plan reflected all care areas.

3. Resident #84 was admitted to the facility 5/8/14 and diagnoses included osteomyelitis, muscle weakness, cerebral vascular accident, chronic pain syndrome, mood affective disorder, failure to thrive and stage 4 pressure ulcer to right hip. Resident #84 was re-admitted to the facility on 9/22/18 with a diagnosis of left femur fracture.

Review of an incident report dated 9/27/18 for Resident #84, provided by the Director of Nursing (DON), revealed the resident was found lying on her right side in the dining room. The resident had a small skin tear on top of her right hand and right upper arm with swelling. First aide was provided. The wheelchair cushion was replaced in the resident ' s wheelchair.

A comprehensive minimum data set (MDS) dated 9/29/18 for Resident #84 revealed the resident had a fall with a fracture, required extensive, two person assist with bed mobility and transfers, had an impairment in range of motion to both lower extremities and her cognition was intact.

A care plan dated 10/1/18 for Resident #84 stated the resident had falls related to weakness and the need for assistance with activities of daily living (ADLs). Diagnoses of cerebral vascular accident,

and have a Fall Care plan, weekly for 12 weeks and then five residents care plans who are receiving anti-coagulant therapy, have an Ostomy and have a Fall Care plan, monthly for an additional 3 months to verify appropriate anti-coagulant therapy, Ostomy and Fall care plans. One to one education will be provided by the DON if opportunities for corrections are as identified as a result of these audits. Revisions to the care plans will be completed as needed by the RCMD or MDSC.

The results of these audits will be presented by the Resident Care Management Director monthly for 6 months at Facility Quality Assurance Performance Improvement (QAPI) Committee Meeting. The QAPI Committee will make changes or recommendations as indicated.

The Resident Care Management Director is responsible for implementing and sustaining the plan of correction.

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 657	Continued From page 13 dementia and depression. Continued risk for falls related to falls in the past and antidepressant / opiate medication. Noncompliant with calling for staff assistance with transfers. Interventions included call light and personal items within reach, remind her frequently to call for assistance with transfers, mats beside her bed, apply antilock brakes and extended brake handle to wheelchair, medication review, provide reacher to increase safety when reaching for items, de-clutter room and frequent rounding during the night shift. There was no intervention for the wheelchair cushion. An interview on 10/18/18 at 9:47 am with the Director of Nursing (DON) revealed all resident falls were reviewed in the daily clinical and weekly at-risk meetings. She stated Resident #84 ' s most recent fall was on 9/27/18 and a new intervention to replace her wheelchair cushion with one that had a slight indent in the seat was implemented. The DON added it was her expectation that new fall interventions were updated on the resident ' s care plans. An interview on 10/18/18 at 4:28 pm with the MDS Nurse revealed that falls were reviewed in the daily clinical and weekly at-risk meetings. She stated she did attend these meetings. The MDS nurse explained she did not recall the new fall intervention of changing the wheelchair cushion for Resident #84 and hadn ' t added it to the resident ' s care plan.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		11/15/18

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 689	Continued From page 14 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide fall mats that were identified as a safety intervention for a resident that had re-current falls with injuries. This was evident for 1 of 3 residents reviewed for accidents (Resident #84). Findings Included: Resident #84 was admitted to the facility 5/8/14 and diagnoses included osteomyelitis, muscle weakness, cerebral vascular accident, chronic pain syndrome, mood affective disorder, failure to thrive and stage 4 pressure ulcer to right hip. Resident #84 was re-admitted to the facility on 9/22/18 with a diagnosis of left femur fracture. Review of the incident reports for the past 2 months, provided by the Director of Nursing (DON), for Resident #84 revealed the following: - On 8/22/18 the resident attempted to self-transfer from the bed to the wheelchair and hit her left arm on the bedside table. The resident obtained a skin tear on her left arm which was treated. The bedside table was replaced with one that had rounded edges. - On 8/28/18 the resident was found sitting on the floor in her room. The resident stated she was trying to get a pillowcase. No injuries were identified. The resident ' s labs and medications	F 689	F689 483.25(d)(1)(2) FREE OF ACCIDENT/HAZARDS/SUPERVISION/DEVICES Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared solely because it is required by the provision of the Federal and State Law. The DON provided Resident #84 with a bedside fall mat per the care plan on 10/18/18. The process breakdown was due to housekeeping staff not educated on moving equipment and devices including fall mats when they perform a room move. Housekeeping staff will be in-serviced on ensuring devices and equipment are moved when a room change occurs. Nursing Staff will be in-serviced on validating devices and equipment are in place post room change. This will be completed on 11/12/18. The ADON will inservice all nurses and certified nursing assistants on accessing the cardex to determine what interventions to prevent	

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 689	Continued From page 15 were reviewed. - On 9/9/18 the resident was found sitting on the floor in her room beside her wheelchair. The resident had taken off one of her shoes off. The resident complained of left hip pain. Multiple x-rays were obtained, and a fracture of the left greater trochanter was identified on 9/18/18. The resident was educated on using her call light and to wait for staff assistance to get back into bed. - On 9/27/18 the resident was found lying on her right side in the dining room. The resident had a small skin tear on top of her right hand and right upper arm with swelling. First aide was provided. The wheelchair cushion was replaced in the resident ' s wheelchair. A comprehensive minimum data set (MDS) dated 9/29/18 for Resident #84 revealed the resident had a fall with a fracture, required extensive, two person assist with bed mobility and transfers, had an impairment in range of motion to both lower extremities and her cognition was intact. A care plan dated 10/1/18 for Resident #84 stated the resident had falls related to weakness and the need for assistance with activities of daily living (ADLs). Diagnoses of cerebral vascular accident, dementia and depression. Continued risk for falls related to falls in the past and antidepressant / opiate medication. Noncompliant with calling for staff assistance with transfers. Interventions included call light and personal items within reach, remind her frequently to call for assistance with transfers and mats beside her bed. An observation of Resident #84 on 10/16/18 at 9:31 am revealed she was lying in bed asleep. The bed was in a low position and there were no fall mats present next to her bed.	F 689	falls are in place for the residents. This was completed on 11/12/18. The DON, ADON, and/or the Unit Managers will conduct observation audits to ensure that devices and equipment are in place for residents identified at High Risk for Falls on 11/12/18. Three times weekly the Housekeeping Supervisor, DON, ADON or Unit Managers will conducted an observation audit to validate equipment and devices are moved post room change for 4 weeks, then 2 X a week for 4 weeks, then weekly for one month. Audit results will be reviewed by the QAPI committee to determine the effectiveness and duration of the audit. The DON is responsible for execution of this plan.	

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 689	Continued From page 16	F 689		

An interview on 10/17/18 at 11:51 am with Nursing Assistant (NA) #3 revealed Resident #84 stayed in bed most of the time because she believed the resident had some falls. She stated she wasn ' t exactly sure what fall precautions were in place for the resident.

An interview on 10/17/18 at 12:06 pm with Nurse #3 revealed Resident #84 had frequent falls. She stated the staff needed to check on her frequently and she believed they kept her bed in a low position.

An observation of Resident #84 on 10/17/18 at 12:25 pm revealed she was awake and lying in bed. Her bed was noted to be in a low position. There were no fall mats present next to her bed.

An interview on 10/17/18 at 3:54 pm with NA #4 revealed he wasn ' t sure what fall interventions were in place for Resident #84. He stated he would need to check. He was observed to speak with Nurse #2 and then returned with a form that identified safety needs for Resident #64 included to have mats beside her bed.

An interview on 10/17/18 at 4:00 pm with Nurse #2 revealed Resident #84 was supposed to have fall mats next to her bed and she would need to locate them.

An interview on 10/18/18 at 9:47 am with the DON revealed Resident #84 was supposed to have fall mats next to her bed due to her multiple falls. She stated the resident had a room change and she believed the fall mats were not brought to her new room. The DON stated it was her expectation that the fall mats were in place as a

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 689	Continued From page 17 safety intervention for Resident #84. Review of the medical record revealed Resident #84 had changed rooms on 9/13/18.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to restrict the fluid intake as ordered by the physician for 1 of 1 sampled residents with a physician ' s order for a fluid restriction (Resident #386). Findings Included:	F 692	F692 483.25(g)(1)-(3) NUTRITION/HYDRATION STATUS MAINTENANCE Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth	11/15/18

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 692	Continued From page 18 Resident #386 was admitted to the facility on 2/3/15 and diagnoses included end stage renal failure, congestive heart failure, diabetes and dementia. A quarterly minimum data set (MDS) dated 10/3/18 for Resident #386 revealed she received dialysis, was on a therapeutic diet, was independent with eating and had moderately impaired cognition. A care plan with a review date of 10/6/18 for Resident #386 stated she was at risk for nutritional problems related to dietary restrictions for diabetes and additional diagnoses of end stage renal disease and congestive heart failure. An intervention dated 1/16/18 stated to continue a 1200 milliliter (ml) fluid restriction. A care plan with a review date of 10/6/18 for Resident #386 stated she required hemodialysis related to renal failure three times a week. An intervention included to monitor intake and output. Review of the physician ' s orders for Resident #386 identified an order dated 1/16/18 for a consistent carbohydrate, renal diet with a 1200 ml fluid restriction. Review of the meal card, provided by the Dietary Manager (DM), for Resident #386 revealed a consistent carbohydrate, renal diet. The card identified fluid restriction with 4 ounces of fluid at breakfast and 8 ounces of fluid at lunch and supper. Review of the Kardex (a document the facility used to identify care needs for the resident),	F 692	in the statement of deficiencies. This Plan of Correction is prepared solely because it is required by the provision of the Federal and State Law. Resident #386 had her water pitcher removed to ensure compliance to the fluid restriction. This was completed on 10/19/18. Resident #386's Kardex has been updated by the Unit Manager to reflect no water pitcher due to fluid restrictions. This occurred on 11/2/18. An intake sheet was implemented by the Unit Manager for the direct care staff to measure fluid intake per shift to be totaled by the last shift of the day. This was implemented 11/12/18. The breakdown in the process occurred when the Kardex was not updated to reflect the resident's fluid restriction as well as the intake sheet not being implemented. Nursing staff has been in-serviced by the DON, ADON or Unit Managers on fluid restrictions to include no water pitcher at bedside, updating and following the Kardex and completing intake sheets. This was completed on 11/12/18. The DON, ADON, and Unit Managers will complete an audit on fluid intake sheets and observation audits for water pitchers at bedside for residents on fluid restrictions 3 X a week for 4 weeks, then weekly X 4 weeks to ensure completion of the fluid intake sheet for any resident with fluid restrictions. This will begin 11/12/18.	

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 692	Continued From page 19 provided by Nurse #2, for Resident #386 stated under the eating / nutrition section to provide a consistent carbohydrate, renal diet and to observe intake and output. Review of the meal intake records for 10/1/18 through 10/16/18, provided by Nurse #2, for Resident #386 revealed fluid intake was not consistently recorded for meals, between meals or totaled for the day. Review of the October 2018 medication administration record (MAR) for Resident #386 revealed no documentation related to the 1200 ml fluid restriction. An observation on 10/17/18 at 11:45 am of Resident #386 revealed a 32-ounce water pitcher that was approximately half full was present on the resident ' s bedside table. An interview on 10/17/18 at 11:49 am with Nursing Assistant (NA) #2 revealed she was familiar with Resident #386. She stated the resident was on a renal diet and she believed the resident was also on a fluid restriction. NA #2 added the resident could have a water pitcher in her room and the amount of fluids she consumed was documented on the MAR. An interview on 10/17/18 at 11:51 am with NA #3 revealed Resident #386 went to dialysis and she wasn ' t sure if the resident was on any type of special diet. She stated the resident was provided with a water pitcher in her room and she also liked to drink unsweetened tea. NA #3 added she wasn ' t aware of the resident being on a fluid restriction.	F 692	Audits will be reviewed monthly by the QAPI committee to determine duration and effectiveness of the audits. The DON is responsible for execution of the plan.	

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 692	Continued From page 20	F 692		

An interview on 10/17/18 at 12:09 pm with Nurse #3 revealed Resident #386 went to dialysis 3 days a week and was on a fluid restriction. She stated the NAs kept track of how much fluid the resident drank.

An interview on 10/17/18 at 3:47 pm with NA #4 revealed he was familiar with Resident #386 and she went to dialysis. He stated the resident drank well, she liked unsweetened tea and they kept a water pitcher in her room. NA #4 added he didn ' t believe the resident was on a fluid restriction and the NAs documented how much residents ate and drank each shift for meals and snacks.

An observation on 10/17/18 at 4:01 pm of Resident #386 revealed a 32-ounce water pitcher that was full was present on her bedside table.

An interview on 10/18/18 at 10:40 am with the Registered Dietitian (RD) revealed the dietary staff had a chart that broke down how much fluid was provided by dietary and by nursing for residents on fluid restrictions. She stated fluid restriction orders should be clarified to reflect this breakdown. The RD added residents on fluid restrictions should not have water pitchers in their rooms.

An interview on 10/18/18 at 10:50 am with the Director of Nursing (DON) revealed residents on fluid restrictions should not have water pitchers in their rooms. She stated the NAs should document how much fluid the resident consumed on their Activity of Daily Living (ADL) record and the nurses should also document in the system what fluids the resident consumed. The DON stated she expected residents on fluid restrictions to have the total fluids consumed documented

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 692	Continued From page 21 and totaled for the day.	F 692		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews the facility failed to offer or deliver bedtime snacks to 3 of 3 residents (Resident #32, Resident #286 and Resident #287). Finding included: 1. During an interview with Resident #32 on October 16, 2018 at 2:30pm Resident #32 also indicated that bedtime snacks were never passed out or offered to her, she did not know she could get a bedtime snack.	F 809	F809 483.60(f)(1)-(3) FREQUENCY OF MEALS/SNACKS AT BEDTIME Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared solely because it is required by the provision of the Federal and State Law.	11/15/18

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 809	Continued From page 22 During an observation on Tuesday October 16, 2018 from 7:40pm until 9:23pm, no one was observed passing out or offering snacks to the residents that resided on the 200 hall. During a second interview with Resident #32 on October 16, 2018 at 9:25 pm, she revealed that snacks were not offered or passed out during the night. Resident #32 indicated no one came by her room tonight (October 16, 2018). An observation of Resident #32's room on October 16, 2018 at 9:05 pm revealed no snack had been left in her room. During an interview with Nurse Assistant #267 on October 16, 2018 at 9:30pm revealed that snacks were passed out between 8pm and 9pm. NA #267 revealed that only specific residents got snacks and she had not passed out a snack to resident #32 tonight. During an interview with the Assisted Director of Nursing on October 16, 2018 at 9:45pm she indicated that her expectation was all residents would be offered a bedtime snack every night. During an interview with the Director of Nursing on October 16, 2018 at 9:45pm revealed that her expectation was all residents who wanted a bedtime snack nightly would receive one. During an interview with the Dietary Manager on October 17, 2018 at 2:45pm, he revealed that labeled snacks were prepared daily for diabetic residents and bulk snacks were available for the other residents in the facility. He added the nursing assistants (NAs) on the halls were	F 809	The resident #386, #387, and #32 have been offered HS snack each evening beginning on 11/1/18. The process that led to the breakdown was a lack of education of the standard for offering of HS snacks by the nursing staff. Nursing staff has been in-serviced by the DON, ADON or Unit Managers on the offering of HS snacks each night. This was completed by the ADON on 11/1/18. An audit tool was developed to validate that HS snacks are being provided and offered in accordance with the regulation. The audit will be conducted by the Unit Manager, ADON, DON 5 X week for 4 weeks, then weekly X 4 weeks. The audits began on 11/12/18. All audits will be reviewed in the QAPI meeting to determine effectiveness and duration of the audits. The DON is responsible for the execution of this plan.	

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 809	Continued From page 23	F 809		

responsible for passing out the snacks between 8pm and 9pm.

2. During an interview with Resident #286 at 2:31 pm he also indicated he only been here two weeks and never had received any bedtime snack and never had been offer one.

During an observation on Tuesday October 16, 2018 from 7:40pm until 9:23pm, no one was observed passing out or offering snacks to the residents that resided on the 200 hall.

During a second interview with Resident #286 on October 16, 2018 at 9:27 pm, he revealed that snacks were not offered or passed out during the night. Resident #286 indicated no one came by his room tonight (October 16, 2018).

An observation of Resident # 286's room on October 16, 2018 at 9:08 pm revealed no snack had been left in his room.

During an interview with Nurse Assistant #267 on October 16, 2018 at 9:30pm revealed that snacks were passed out between 8pm and 9pm. NA #267 revealed that only specific residents got snacks and she had not passed out a snack to resident #286 tonight.

During an interview with the Assisted Director of Nursing on October 16, 2018 at 9:45pm she indicated that her expectation was all residents would be offered a bedtime snack every night.

During an interview with the Director of Nursing on October 16, 2018 at 9:45pm revealed that her expectation was all residents who wanted a bedtime snack nightly would receive one.

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 809	Continued From page 24	F 809		

During an interview with the Dietary Manager on October 17, 2018 at 2:45pm, he revealed that labeled snacks were prepared daily for diabetic residents and bulk snacks were available for the other residents in the facility. He added the nursing assistants (NAs) on the halls were responsible for passing out the snacks between 8pm and 9pm.

3. During an interview with Resident #287 at 2:33 pm she revealed that she had never been offer a bedtime snack and been here almost two year.

During an observation on Tuesday October 16, 2018 from 7:40pm until 9:23pm, no one was observed passing out or offering snacks to the residents that resided on the 200 hall.

During a second interview with Resident #287 on October 16, 2018 at 9:28 pm, she revealed that snacks were not offered or passed out during the night. Resident #287 indicated no one came by her room tonight (October 16, 2018).

An observation of Resident # 287's room on October 16, 2018 at 9:15 pm revealed no snack had been left in his room.

During an interview with Nurse Assistant #267 on October 16, 2018 at 9:30pm revealed that snacks were passed out between 8pm and 9pm. NA #267 revealed that only specific residents got snacks and she had not passed out a snack to resident #287 tonight.

During an interview with the Assisted Director of Nursing on October 16, 2018 at 9:45pm she indicated that her expectation was all residents

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 809	Continued From page 25 would be offered a bedtime snack every night. During an interview with the Director of Nursing on October 16, 2018 at 9:45pm revealed that her expectation was all residents who wanted a bedtime snack nightly would receive one. During an interview with the Dietary Manager on October 17, 2018 at 2:45pm, he revealed that labeled snacks were prepared daily for diabetic residents and bulk snacks were available for the other residents in the facility. He added the nursing assistants (NAs) on the halls were responsible for passing out the snacks between 8pm and 9pm.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		11/15/18

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 812	Continued From page 26 by: Based on observation and staff interviews the facility failed to ensure pots and pans were clean and allowed to air-dry before being stored. This was evident in 1 of 1 kitchen observation. Findings Included: An observation of the kitchen on 10/14/18 at 4:05 pm with Cook #1 revealed 4 - 1/3 size steam table pans were stacked together wet, 4 -full size steam table pans were stacked together wet and 6 - full size sheet pans were stacked together wet with white, greasy substances on them. All pans were located on a storage rack designated for clean, ready to use pots and pans. An interview on 10/14/18 at 4:10 pm with Cook #1 revealed the steam table and sheet pans should have been left on the drying section of the pot sink before they were put away on the clean storage shelf. He stated all dishware should be clean and allowed to air-dry before being put away. An interview on 10/17/18 at 7:30 am with the Dietary Manager (DM) revealed all pots and pans should be clean and allowed to air-dry before being stored. An interview on 10/19/18 at 12:41 pm with the Administrator revealed he expected all pans to be clean and dry before being stored for use.	F 812	F812 483.60(i)(1)(2) FOOD PROCUREMENT, STORE/PREPARE/SERVE-SANITARY Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared solely because it is required by the provision of the Federal and State Law. The steam table pans were cleaned and air dried in accordance to the regulation. They were then stored after they had air dried on 10/19/18. The process breakdown that led to the deficiency was the Dietary manager failed to hold dietary staff accountable to the process. The dietary staff to include the Dietary Manager has been in-serviced by the District Director of Dietary Services on the standard for cleaning and storage of pots and pans to include air drying prior to storage. Dietary staff was in-serviced by 11/12/18. An audit tool was created to ensure compliance to the regulation. The audit will be conducted by the Dietary Manager 5 X a week for 4 weeks, then twice weekly for 4 weeks. The audits will begin on 11/12/18.	

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 812	Continued From page 27	F 812	Audit results will be reviewed by the QAPI committee to determine effectiveness and duration of the audits. The Dietary Manager is responsible for the execution of this plan.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews the facility ' s Quality Assessment and Performance Improvement Committee (QAPI) failed to maintain implemented procedures and monitor the interventions that were put in place following the annual recertification and complaint survey of 9/12/17. This was for 2 recited deficiencies in the area of supervision to prevent accidents (F-689) and development of comprehensive care plans (F-656). These deficiencies were re-cited during the annual recertification and complaint survey of 10/19/18. The continued failure of the facility during 2 federal surveys of record showed a pattern of the facility ' s inability to sustain and effective QAPI program. Findings Included: This tag was cross referenced to:	F 867	F867 483.75(g)(2)(ii) QAPI/QAA IMPROVEMENT ACTIVITIES Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared solely because it is required by the provision of the Federal and State Law. The facility Administrator will conduct a Quality Assurance and Improvement (QAPI) Committee meeting on November 12, 2018 to discuss the repeat deficiencies, F689 and F656, from our last two annual recertification surveys. The meeting consisted of reviewing the entire regulation and not just the specific deficient practice cited. During this	11/15/18

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 867	Continued From page 28 1a. F - 689 Adequate supervision and assistance devices to prevent accidents. Based on observations, record review and staff interviews the facility failed to provide fall mats that were identified as a safety intervention for a resident that had re-current falls with injuries. This was evident for 1 of 3 residents reviewed for accidents (Resident #84). During the recertification and complaint survey of 9/12/17 the facility was cited for failure to provide 2 staff members when transferring a resident to bed for incontinence care and failure to provide supervision to prevent repeated falls for 1 of 3 residents reviewed for accidents (Resident #113). b. F-656 Development and Implementation of Comprehensive Care Plans. Based on record reviews and staff interviews, the facility failed to develop and implement a comprehensive care plan for 1 of 5 residents (Resident #62) whose care plans were reviewed for unnecessary medications. During the recertification and complaint survey of 9/12/17 the facility was cited for failure to develop a comprehensive care plan for ADL (activities of daily living) care and incontinence care, specifically e-stem therapy and bowel regimen for 1 of 1 residents (Resident #165). An interview with the Administrator on 10/19/18 at 12:09 pm revealed he was the leader of the facility ' s QAPI committee. He stated the team met monthly and included all of the department managers. He added the medical director and consultant pharmacist attended the meetings quarterly. The Administrator stated they recently hired a new MDS nurse with many years of	F 867	meeting, initial audits were reviewed and determined to be effective and will continue as stated in the plans of correction. The QAPI committee determined the alleged process breakdown occurred when the facility completed the audits per the plan of correction from prior surveys, the audits were discontinued and that further random auditing needed to have occurred throughout the year at the QAPI Committee□s discretion. The Administrator will educate the QAPI Committee by November 13, 2018 regarding accurately reporting and revising current action plans as well as developing and implementing new action plans to assure compliance with state and federal regulations in the facility. The QAPI committee determined audits from the plan of correction will be conducted monthly throughout the year to validate sustained compliance ongoing. The QAPI Committee determined audits from the plan of correction will be reviewed in the QAPI Meeting monthly throughout the year to validate sustained compliance ongoing. Should any interdisciplinary team member find that the facility may need an Ad Hoc Quality Assurance and Performance Improvement meeting for a facility compliance issue, the Administrator will organize a meeting and notify all team members in order to revise any present action plan or determine the need for a new action plan in order to maintain compliance in the facility.	

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 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	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 867	Continued From page 29 experience that should help with the repeat deficiencies for development of comprehensive care plans. He added the staff made a mistake by not providing the falls mats for a resident with a history of falls. The Administrator explained the QAPI team would need to evaluate and develop action plans, including monitoring, for these areas.	F 867	Quality assurance monitoring will take place at each Quality Assurance Performance Improvement meeting monthly and any AD Hoc meetings held. This monitoring tool will be signed off by the responsible Interdisciplinary team member after each meeting accepting and acknowledging monitoring and revisions set forth by the QAPI Committee. The Vice President of Operations or District Director of Clinical Services will review the facility QAPI meeting minutes at least monthly X 3 months. The Administrator is responsible for implementing the plan of correction and to ensure the plan of correction is sustained ongoing.	