STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345168	A. BUILDING _____ B. WING _____	C 04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREENVILLE	2910 MACGREGOR DOWNS GREENVILLE, NC 27834

(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 4/17/14. Event ID# 2ZTG11.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		5/15/14

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

Electronically Signed | 05/02/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews the facility failed to notify the physician of 7 missed doses of an antihypertensive medication for 1 of 6 (Resident #299) sampled residents whose medications were reviewed. Findings included: Resident #299 was admitted to the facility on 01/22/14 with cumulative diagnoses of hypertension, reflux, and muscle weakness. Resident #299's Admission Minimum Data Set (MDS), dated 01/29/14, showed that Resident #299 was cognitively aware. Review of the Medication Administration Record (MAR) for March 2014 showed that from 03/05/14-03/08/14 seven doses of Terazosin 1 milligram had a code of 7. Per the legend on the MAR, 7 = Other / See Nurse Notes. Review of the Physician Telephone Orders, dated 03/03/14, showed an order to start Amlodipine (an antihypertensive) 5 milligrams daily. Review of the Physician Telephone Orders, dated 03/04/14, showed an order to discontinue the Amlodipine and start Terazosin 1 milligram twice daily. Review of the Progress Notes, dated 03/05/14 at 8:36 AM, showed the Terazosin was a new medication and was not in from the pharmacy yet. Review of the Progress Notes, dated 03/05/14 at 5:41 PM, showed the medication was not in from	F 157	Preparation and/or execution of this plan of correction 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 solely because the provision of Federal and state law requires it. F157 Notifcation of Changes The facility will continue to notify the physician and the resident's legal representative when there is a change in condition or a change to the treatment plan. 1. Unable to correct alleged deficient practice for resident #299 because she was discharged home on 3/19/2014. Home Health services arranged, and discharge instructions were provided to the resident. 2.All residents have the potential to be affected by alleged deficient practice therefore nurses will be educated on notifying the doctor and family whenever they are unable to follow through on an order as given, especially as it relates to medication unavailability. They will also be educated on the importance of follow-up assessment of residents when started on new medications. Nurses will also be instructed to notify DNS, Unit Manager or designee if they are having a problem	

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F 157	Continued From page 2 the pharmacy yet. Review of the Progress Notes, dated 03/06/14 at 10:22 AM, showed the Terazosin was not in from the pharmacy yet. Review of the Progress Notes, dated 03/06/14 at 4:23 PM, showed the medication was not in from the pharmacy yet. Review of the Progress Notes, dated 03/07/14 at 9:50 AM, showed the Terazosin was not in from the pharmacy yet. Review of the Progress Notes, dated 03/07/14 at 5:57 PM, showed the medication was not in from the pharmacy yet. Review of the Progress Notes, dated 03/08/14 at 10:33 AM, showed the pharmacy was called and the order for the medication was faxed again and should arrive during the 7-3 shift. In an interview on 04/16/14 at 3:20 PM, Nurse #1 stated a code of 7 on the MAR meant the explanation could be found in the nursing notes. After reviewing the MAR and the progress notes she indicated Resident #299 had not received the Terazosin seven times. She stated that by not getting the antihypertensive medication Resident #299's blood pressure could have increased causing a stroke. In an interview on 04/16/14 at 5:10 PM, Nurse #2 stated several calls were made to the pharmacy for the missing Terazosin but it did not come in. The pharmacy was also faxed several times. No call was made to Resident #299's physician regarding the missing medication.	F 157	getting medications from pharmacy. In-service to stress the importance of not to document medication not available without follow-up and notification of the doctor. 3. The DNS, ADNS, DCE and or designees will review medication audit reports daily to determine if the code 7 is being documented on EMAR. Follow-up wil be done as needed. This audit will be done 5 times a week x 1 month then 3 x a week x 1 month then twice a week. 4. DNS, ADNS, DCE, UM and or designee will report any unresolved concerns in the scheduled Quality Assurance Performance Improvement Meetings until substantial compliance is achieved and or committee recommeds to discontinue monitoring.	

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F 157	Continued From page 3 In an interview on 04/17/14 at 9:50 AM, Nurse Supervisor #1 stated Resident #299's physician was an in-house physician. She indicated one of the nurses could have told the physician about the missing medications and had just not charted it. She stated she did not notify the physician of the missing medications. Nurse Supervisor #1 indicated that missing 7 doses of an antihypertensive medication was a problem. In a telephone interview on 04/17/14 at 11:08 AM, Resident #299's physician stated she had not been notified that Resident #299 had missed doses of her antihypertensive medication. She indicated someone at the facility should have informed her of the missing medications. She stated she saw this as a problem and that Resident #299 should not have missed any doses of medications that had been ordered. She indicated she had placed resident #299 on the antihypertensive because she wanted to reduce her blood pressure. Resident #299's physician stated again that she should have been notified when the medications were not given. In an interview on 04/17/14 at 11:51 AM, the Director of Nursing (DON) stated she expected the nurse to notify the physician and document in the medical record that notification was made when a medication was not given. She stated if the physician had known the medication was not being given a different medication may have been ordered.	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		5/15/14

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F 281	Continued From page 4 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews the facility failed to monitor blood pressures for 1 of 1 (Resident #299) sampled residents whose antihypertensive medications were not given. Findings included: Resident #299 was admitted to the facility on 01/22/14 with cumulative diagnoses of hypertension, reflux, and muscle weakness. Resident #299's Admission Minimum Data Set (MDS), dated 01/29/14, showed that Resident #299 was cognitively aware. Review of the Medication Administration Record (MAR) for March 2014 showed that from 03/05/14-03/08/14 seven doses of Terazosin 1 milligram were not given. Review of the Physician Telephone Orders, dated 03/03/14, showed an order to start Amlodipine (an antihypertensive) 5 milligrams daily. Review of the Physician Telephone Orders, dated 03/04/14, showed an order to discontinue the Amlodipine and start Terazosin 1 milligram twice daily. Review of the Progress Notes, dated 03/05/14 at 10:47 PM, showed Resident #299 had a blood pressure reading of 119/67. No other blood pressure readings were recorded in the progress notes during the times the Terazosin was not given.	F 281	Preparation and/or execution of this plan of correction 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 solely because the provision of Federal and State law requires it. F281 Services provided meet professional standards The facility will continue to ensure services are provided to meet professional standards of quality. 1. Unable to correct alleged deficient practice for resident #299 because she was discharged home from facility on 3-19-2014. Home health services were arranged and discharge instructions were provided to resident. Medication error report was done and doctor was notified. Medication error also discussed with Medical Director. 2. All residents have the potential to be affected deficient practice therefore nurses will be educated by DCE and or designee on the importance of follow-up documentation when there's a change in condition or change in treatment plan, especially as it relates to the	

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F 281	Continued From page 5 Review of the Weights and Vitals Summary showed no blood pressure readings between February 19 and March 12, 2014 for Resident #299. In an interview on 04/16/14 at 5:10 PM, Nurse #2 stated antihypertensives were very important medications to take. She indicated that not taking them could have caused Resident #299 to experience increased blood pressure or to have a stroke. In an interview on 04/17/14 at 11:08 AM, Resident #299's physician stated she had been unaware that Resident #299 had missed seven doses of her antihypertensive medication. The physician stated she considered it to be common sense for a nurse to monitor the blood pressure when antihypertensive medications were missed. She indicated it was a problem that the blood pressure was not monitored. In an interview on 04/17/14 at 11:22 AM, Nurse Supervisor #2 stated she considered not monitoring Resident #299's blood pressure to be a problem. In an interview on 04/17/14 at 11:51 AM, the Director of Nursing (DON) indicated that under standard nursing practice, Resident #299's blood pressure should have been monitored and documented in the medical record when the antihypertensive medications were not given.	F 281	documentation of vital signs on resident's medical record. 3. The DNS, DCE, ADNS, and or designees will review 24 hour reports and documentation review during morning start-up to determine if there are any acute change of conditions or medication orders which warrants monitoring of vital signs. Concerns will be addressed and corrected. This audit will be done 5 times a week x 1 month then 3 times a week x 1 month then twice a month. 4. DNS, ADNS, DCE, and Unit Managers will report any unresolved concerns in the scheduled Quality Assurance Performance Improvement Meeting until substantial compliance is achieved and or committee recommend to discontinue monitorng.	