STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENDERSONVILLE	1510 HEBRON ST HENDERSONVILLE, NC 28739

(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 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to follow up and clarify visitation arrangements (Resident #13) and investigate a resident's complaint of a missing wheel chair (Resident #6) for 2 of 2 sampled residents reviewed for resolution of grievances. The findings included: 1. Resident #13 was admitted to the facility on 03/26/14 with diagnoses of chronic pain. The most recent Minimum Data Set (MDS) dated 04/02/14 indicated that Resident #13 was assessed as cognitively intact and totally dependent on staff for most activities of daily living (ADL). During an interview on 04/15/14 at 2:08 PM with Resident #13 she revealed she had moved to this facility from another facility so her family member could come and see her and he was not allowed to visit when the facility found out about his past legal issues. During a follow up interview on 04/16/14 at 1:38 PM with Resident #13 she was crying and stated she was upset because she could not visit her family member and she was lonely. She said she	F 166	F 166 The Social Service Director has met with patient # 13 to assure she understands the reason for the visitation schedule and the details of the visitation schedule. The Social Service Director has been aware of resident #13's visitation arrangements from initiation however, the legal petition remains in the Executive Director's office. Resident #13 has received a psychiatry consultation for depression. Resident #6's wheelchair has been located and returned to the responsible party. The staff will be re-educated on Golden Living's Grievance policy including; anyone can facilitate a grievance, grievance forms. grievance forms go to the Social Service Department. The Social Service Director will forward the grievance to the department where the grievance is initiated. The director of that department will resolve the grievance with in 5 business days unless extenuating circumstance prevent it from being resolved, then the expected date of resolution will be placed on the	5-9-14

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

Adm | 5/12/14

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Original Signature Date: 5-6-14

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F 166	Continued From page 1 had moved to the facility to be closer to her family member and she felt awful that he was unable to visit. During an interview on 04/16/14 at 2:29 PM with the Executive Director (ED) she revealed on 04/07/14 the county DSS worker provided information to the facility about the family members past previous legal issues. The ED reported she met with Resident #13 s family member on 04/07/14 and he shared that he needed reasonable visits with Resident #13 and wanted to be allowed to visit her. The ED revealed she told the family member she needed to be informed when he wanted to visit because he would need to visit her in a public place in the facility. The ED revealed another meeting occurred on 04/11/14 with both Resident #13 and her family member. The ED said she told the family member and resident that when the status of his legal issues changed he could come and visit Resident #13 from 9:00 AM to 5:00 PM in a public place in the facility. The ED stated she had not followed up or clarified any visitation arrangements with Resident #13 and had no knowledge the resident was upset. During an interview with the Director of Social Services she revealed she had not received a copy of any letter or petition related to Resident #13's family member's legal issues. She stated Resident #13's family member had been visiting the resident in her room prior to 04/11/14 with no problems. The Director of Social Services revealed she had been in attendance at the 04/11/14 meeting but had not followed up or clarified with Resident #13 what she understood about visitation arrangements with her family member.	F 166	grievance form. All grievances will be discussed at the "Stand Up" meeting, and grievances brought to the Resident Council will be discussed in the next business days "Stand-up" until resolved. The Executive Director/designee will audit the Grievance Log daily during the work week, on an ongoing QAPI will be performed and reported at the monthly QA meeting by the Social Service Director/designee for 3 months.	5-9-14

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F 166	Continued From page 2 During a follow up interview on 04/17/14 at 10:22 AM with Resident #13 she revealed she had attended the 04/11/14 meeting with the ED, Director of Social Services and her family member. She stated she had not recalled any discussion during the meeting of visitation arrangements. Resident #13 said neither the ED nor Social Worker followed up or clarified visitation arrangements with her family member. 2. A review of Grievance Procedures document revised October 2009 revealed investigation and resolution of grievances shall be completed within five working days of receipt. If the investigation and resolution process cannot be completed within five working days, it should be documented on the Grievance Form along with the reason resolution was not completed and when resolution was expected. Resident #6 was admitted to the facility 02/08/13 with diagnoses which included chronic pain, congestive heart failure, and osteoarthritis. A quarterly MDS dated 02/04/14 indicated Resident #6's cognition was severely impaired. The MDS coded the resident required extensive staff assistance with bed mobility and transfers and did not walk during the assessment period. A review of a facility Grievance Tracking Log revealed a grievance dated 03/08/14 filed by Resident #6. "Search for wheelchair" was documented on the log. The resolution was dated 03/10/14 and did not contain any information regarding the missing wheelchair.	F 166		5-9-14

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F 166	Continued From page 3 Review was conducted of a note documented by Social Worker (SW) #1 and dated 03/11/14. The note did not address searching for the resident's wheelchair. An interview was conducted with SW #2 on 04/16/14 at 8:17 AM. SW #2 stated SW #1 was no longer employed at this facility. She stated she did recall SW #1 looked for Resident #6's wheelchair and was unable to find it. An interview with Physical Therapist (PT) #1 on 04/16/14 at 12:48 PM confirmed Resident #6's personal wheelchair was brought in by a family member in October of 2013. The PT stated she was attempting to increase the resident's time out of bed. She stated she asked a family member to bring in the wheelchair from home because she thought it would be more comfortable for the resident. The PT stated she had made a name band with Resident #6's name on it and attached it underneath the seat of the wheelchair. An interview with the Administrator was conducted on 04/17/14 at 8:20 AM. At this time a wheelchair with a thick black pressure reducing cushion in the seat was observed in the Administrator's office. The Administrator stated staff had found the wheelchair last evening, 04/16/14, in a back hall near a room Resident #6 had moved out of in February of 2014. Further interview with the Administrator on this date at 11:31 AM revealed she expected the concern for the wheelchair be addressed as any other grievance.	F 166		5-9-14

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F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview and staff interview, the facility failed to replace missing padding on a rigid cervical collar (Resident #7) and to perform ordered weekly weight checks for wound healing (Resident #3) for 2 of 2 residents reviewed for meeting professional standards. Findings included: 1. Resident #7 was admitted to the facility on 03/20/14 with diagnoses including a closed fracture and repair of fractured cervical vertebrae. The most recent Minimum Data Set (MDS) dated 03/28/14 coded the resident as having moderately impaired cognition, a depressed mood, no behaviors and no rejection of care. Resident #7 required extensive 2 person physical assistance with activities of daily living (ADL), including dressing and personal hygiene, and total 2 person assistance with bathing. His MDS coded him with range of motion limitations on both sides of this body and with both upper and lower extremities. Documented skin conditions included one unhealed stage I ulcer and 3 unhealed stage II ulcers, all present upon admission. Review of Resident #7's record revealed a medical order dated 03/25/14 directing the cervical collar (c-collar)to remain in place at all times but may be removed for bathing and care if	F 281	F281 A new cervical collar and additional padding for Resident #7's cervical collar were ordered 4/17/14. Resident #7's cervical collar has since been discharged and is no longer in use, due to resident #7's refusal to wear it. No other residents have cervical collars or immobilizers. All nurses will be educated on reviewing consultant recommendations received from outside providers and contacting the primary physician for physician orders. A skin assessment will be done on all new residents with immobilizers and collars to ensure they have the proper padding and accessoriness ensuring the safe utilization of the device weekly, for as long as the devise is in use. This will be performed by the Director of Nursing or designee. The Director or Designee will audit all patients with the above devices weekly for 1 month and then 3 patients weekly for two months. All consultations with outside providers will be reviewed within one working	5-9-14

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

Adm — 5/12/14

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Original Signature Date: 5-6-14

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F 281	Continued From page 1 needed. An undated patient handbook filed in the medical record, printed by the manufacturer of the c-collar, revealed "cleaning the [brand name] cervical collar requires at least one extra set of pad" with a toll free phone number for ordering and "you should also purchase an extra pad set as replacements." The handbook also noted the pads were attached to the cervical collar with small circles of hook and loop type fastener and "adjust the pads as needed to make sure no plastic touches the skin." Review of a referral form from Resident #7's spine/neurosurgery clinic dated 04/09/14 and signed by a physician's assistant revealed the handwritten request for replacement pads for the cervical collar. His care plan initiated 04/15/14 included the problem of being at risk for and with the presence of a pressure ulcer to his right heel. One intervention noted to monitor skin under braces, prosthetics and splint casts for skin breakdown. An observation on 04/15/14 at 10:32 AM revealed Resident #7 wearing a rigid c-collar. An observation on 04/16/14 at 6:40 AM revealed Resident #7 wearing a rigid c-collar. An observation on 04/17/14 at 10:05 AM revealed Resident #7 wearing a rigid c-collar. On closer inspection, gray foam padding was observed on all surfaces of the c-collar in contact with the resident's skin except for the plastic chin piece of the c-collar. An approximate 1 inch diameter circle of hook and loop fastener was observed glued to the middle and inside of the chin piece. An interview on 04/17/14 at 10:05 AM with Resident #7 revealed his c-collar had been last removed a week prior at which time they cleansed his skin under the collar. He stated the c-collar was "falling apart" with a foam pad completely missing from the chin piece of the c-collar. He stated someone prior to the interview	F 281	day of receipt of the consult and any recommendations to be followed and they will be discussed at the "Stand Up" meeting. The Director of Nursing/designee will audit up to 3 residents a week, who have outside provider consults to assure ongoing compliance. A QAPI will be initiated and reported at the monthly QA meeting for three months. Patient#3's weekly weights are now being done effective, 4-22-2014 and obtained weekly since. weekly weight order was changed, per the physician's request, to reflect, secondary to edema. Resident #3 has not had a negative outcome, his weight has been stable. All resident's with weekly weights are discussed at the weekly "At Risk" meeting. A 100% audit of all resident's charts was conducted to assure all weekly weights were being completed per physician orders. The Director of Nursing/designee will provide the list of residents who are on the weekly weight list to the "Stand Up" meeting	

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F 281	Continued From page 2 had come into his room and cleansed his body but they said they were told not to remove the c-collar. An interview on 04/17/14 at 11:50 AM with Nurse Aide (NA) #1 revealed she was permanently assigned to the unit where Resident #7 resided and was assigned to his care. She stated Resident #7 received a bed bath at least twice a week on evenings but was not sure if it was more frequent. NA #1 stated she could pull a t-shirt over the c-collar or change it when the c-collar was off. She stated the c-collar had not been off that day, a nurse had to remove it and staff had to be as gentle and careful as possible. An interview on 04/10/14 at 12:04 PM with Nurse #1 revealed he was permitted to remove the c-collar any time the resident wanted him to clean the c-collar or his neck, for which there was no specific order. He stated he wanted to say he looked at the c-collar the day prior but he had not looked at it the day of the interview. Nurse #1 stated all c-collars were a risk factor for skin breakdown and he was not sure if the need to order pads was passed onto the supply department. An observation on 04/17/14 at 12:41 PM of Resident #7 revealed his c-collar was off and Nurse #1 was checking the resident's skin that had come in contact with the c-collar and the skin under the resident's t-shirt. All skin areas were observed as intact and blanchable. The plastic chin piece of the c-collar was observed as soiled and missing its pad. The interim Director of Nursing Services (DNS) was observed in the room and stated the surgeon was to have ordered a new c-collar. An interview on 04/17/14 at 1:33 PM with the interim DNS revealed placing any device on a resident was a potential risk for skin breakdown,	F 281	to discuss any new residents to be added or removed for the weekly weights list for 2 months. Audit results will be reviewed at the monthly QA meeting on an ongoing basis.	

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F 281	Continued From page 3 including a c-collar. In reference to the referral sheet from Resident #7's spine/neurosurgery clinic dated 04/09/14, she stated when residents returned from a specialty appointment with recommendations, she expected the nurse assigned to the resident to follow through and let the facility know if something needed ordering. 2. Resident #3 was admitted to the facility on 11/14/12 with diagnoses including dementia and peripheral vascular disease. His most recent Minimum Data Set (MDS) dated 01/06/14 assessed him with severely impaired cognition, physical behavioral symptoms not directed towards others and rejection of care for 1 to 3 days of the assessment period. Resident #3 required extensive 1 to 2 person assistance for all activities of daily living except eating. His height was noted as 78 inches and his weight as 243 pounds with a therapeutic diet checked. The MDS assessed him to have an unhealed stage 3 pressure ulcer that was present upon admission with an intervention noted as nutrition or hydration to manage skin problems. Review of Resident #3's medical record revealed a registered dietician (RD) note dated 03/25/14 documenting a wound on the resident's left heel, a regular diet, average oral intake of 77% of his meals and a then current body weight of 245 pounds. This RD note further documented weight changes at 30 days and 90 days of less than 1% and to continue protein supplementation as needed. An active medical order for March and April 2014 directed weekly weights "r/t [related to] wound." A weight dated 04/03/14 was 255 pounds and another recorded weight dated 04/07/14 was 256.6 pounds. Prior to the weight of 04/03/14, there was one recorded weight done on 03/04/14 of 245 pounds. Review of medical orders dated 04/07/14 directed wound care for	F 281		

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F 281	Continued From page 4 the resident's right lateral lower leg. Review of wound doctor notes dated 04/07/14 revealed assessments of a left heel pressure ulcer and a left lower lateral leg venous wound. Review of doctor notes dated 04/11/14 revealed follow up of cellulitis and edema to a wound on Resident #3's left lower extremity for which he received antibiotics. An interview on 04/16/14 at 12:03 PM with the wound care nurse revealed she reviewed all resident records for wound care and prevention orders, orders were typed into the electronic record and referral recommendations were made to the wound care doctor for those residents not in his care. An interview on 04/17/14 at 12:38 PM with the RD revealed she had been monitoring Resident #3 but she was not aware of his active order for weekly weights for his wounds. An interview on 04/17/14 at 1:33 PM with the interim Director of Nursing Services (DNS) revealed that an at-risk book was reviewed every week for wounds to determine areas of decline and need for adaptive equipment that prevented pressure ulcers or promoted healing. She stated weekly weights were to be tracked by the DNS and dietary manager. She stated restorative aides were provided a list of weekly weights who then obtained them and provided them to the dietary manager. She stated the dietary manager entered the weights into the computer and then she would check them. She stated these weights were discussed at the weekly at-risk meeting. The interim DNS stated Resident #3 was missing weekly weights and the RD was made aware.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	Continued From page 5 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview and staff interview, the facility failed to change a shirt for 1 of 5 residents (Resident #7) requiring assistance with activities of daily living. Findings included: Resident #7 was admitted to the facility on 03/20/14 with diagnoses including a closed fracture and repair of fractured cervical vertebrae. The most recent Minimum Data Set (MDS) dated 03/28/14 coded the resident as having moderately impaired cognition, a depressed mood, no behaviors and no rejection of care. Resident #7 required extensive 2 person physical assistance with activities of daily living (ADL), including dressing and personal hygiene, and total 2 person assistance with bathing. His MDS coded him with range of motion limitations on both sides of this body and with both upper and lower extremities. His care plan initiated 04/15/14 included the problem of self-care impairment. Review of Resident #7's record revealed a medical order dated 03/25/14 directing the cervical collar (c-collar) to remain in place at all times but may be removed for bathing and care if needed. An observation on 04/15/14 at 10:32 AM revealed Resident #7 lying on an air mattress in his bed, wearing a rigid c-collar and a grey t-shirt. Another observation on 04/15/14 at 11:03 AM revealed him wearing a grey t-shirt during wound care.	F 312	F312 Social Service director audited resident #7's wardrobe and the result of the audit was the resident did not have enough clothes The Health care center purchased the resident several clothes. The Director Nursing or Designee reviewed residents requiring ADL's and dertermined no other residents were affected. The charge nurse must sign an audit sheet daily acknowledging the residents clothes has been changed for 2 months. The nursing staff will be re-educated on proper ADL's for residents who require care including, changing residents clothes daily, unless residents refused then it must be documented and placed in the resident s care plan. The Director of Nursing/designee will audit 3 patients daily who require ADL assistance to assure residents clothes are being changed and clean for one month. Then the Director of Nursing will audit 3 residents a week for one month and then 1 residents a week for another	

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F 312	Continued From page 6 An observation on 04/16/14 at 6:40 AM revealed Resident #7 lying on an air mattress in his bed, wearing a rigid c-collar and a grey t-shirt. An observation on 04/17/14 at 10:05 AM revealed Resident #7 laying on an air mattress in his bed, wearing a rigid c-collar and a grey t-shirt. An interview on 04/17/14 at 10:05 AM with Resident #7 revealed his c-collar had been last removed a week prior and that although he could move his head just a little, there was no reason why it could not be removed. He stated someone prior to the interview had come into his room and cleansed his body but they said they were told not to remove the c-collar. Resident #7 stated he had been wearing the grey t-shirt for a couple of weeks, staff had not changed it and he would like to have it changed. An interview on 04/17/14 at 11:50 AM with Nurse Aide (NA) #1 revealed she was permanently assigned to the unit where Resident #7 resided and assigned to his care. She stated care assistance included brushing his teeth, repositioning in the bed, scratching him when requested, washing his face and feeding him. She stated Resident #7 received a bed bath at least twice a week on evenings but was not sure if it was more frequent. NA #1 stated his shirt was changed with bed baths and whenever it got dirty. She stated he had quite a few grey t-shirts and quite a few white t-shirts. She stated she had not changed it that day and could not tell the last time it was changed as they all were the same color, but she did think she put one on him the previous day when she repositioned him. NA #1 stated she could pull the t-shirt over the c-collar or change it when the c-collar was off. She stated the c-collar had not been off that day, a nurse had to remove it and staff had to be as gentle and careful as possible.	F 312	month. All audits results will be discussed at the Monthly QA meeting for 3 months.	

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F 312	Continued From page 7 An observation on 04/17/14 at 12:41 PM of Resident #7 revealed Resident #7 wearing a grey t-shirt. His c-collar was off and Nurse #1 was observed checking the resident's skin that had come in contact with the c-collar and under his t-shirt. Resident #7 was observed telling the DNS he preferred to wear a t-shirt and that his shirt was last changed about a week ago. The DNS was observed inspecting Resident #7's closet which revealed one long sleeved button-up shirt and no other t-shirts. An interview on 04/17/14 at 1:05 PM with the DNS revealed that a search of the laundry resulted in 2 unlabeled t-shirts. An interview on 04/17/14 at 1:33 PM with the DNS revealed her expectation that Resident #7's ADL care included changing his shirt.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview and staff interview, the facility failed to prevent a resident's foot from pressing against a bed foot board for 1 of 3 residents with a history of pressure ulcers (Resident #4) . Findings included:	F 314	F314 The Wound Physician has reclassified resident # 4's foot ulcer to a diabetic ulcer. Resident # 4's bed was changed for longer bed on 3/28/14. A review of residents beds was performed by the Director of Nursing or Designee and found no other residents were affected. The Director of Nursing/designee, during the work week, will review all physician orders of residents with ulcers to assure the health care center is following physician orders, for two months. The nursing staff will be reeducated to check patient's	

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F 314	Continued From page 8 1. Resident #4 was admitted to the facility on 12/06/13 with diagnoses including dementia with behaviors and diabetes mellitus type II. Her most recent Minimum Data Set (MDS) dated 02/03/14 coded her as having moderately impaired cognition and requiring extensive 1 to 2 person assistance with activities of daily living, including bed mobility. Her MDS documented no pressure ulcers at the time of assessment but did code her as at risk with an intervention of the placement of a pressure reducing device for her chair. Her care plan last reviewed on 02/18/14 noted Resident #4 as at risk for pressure ulcers due to "slow mobilities" and incontinence with appropriate interventions. Review of Resident #4's active medical orders for March and April 2014 directed to avoid letting the resident's feet come into contact with the foot board of her bed, on every shift and related to diabetes. Review of the weekly skin condition form for 03/19/14 revealed intact skin and the statement "diabetic or foot problems" checked. Review of a nurse aide (NA) shower sheet and skin check dated 03/20/14 revealed intact skin with the statement "new open areas" checked no. Review of physician notes dated 03/21/14 revealed the presence of an ulcer on Resident #4's right foot that had been healed but had now reopened, characterized as a stage II with referral to the wound care physician and wound care orders. Review of a nursing note dated 03/28/14 revealed the facility changed the resident's bed out with one having an extension to the foot section. Review of a wound physician note dated 04/07/14 revealed the presence of an unstageable pressure wound to the right foot, lateral distal side, measuring 3.2 centimeters (cm) by 2 cm with an estimated depth of 0.3 cm. The wound was further described with excessive	F 314	positioning while in the bed. This will be audited weekly by the Director of Nursing/designee for 1 month. All new residents will be assessed upon admission for the correct bed size by the nursing supervisor or designee . The Director of Nursing/designee will monitor all new admissions within the first week to determine the accuracy of the bed size for two months. This will be done on an ongoing basis. An ongoing QA will be performed and discussed at the monthly QA meeting for 3 months.	

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F 314	Continued From page 9 necrotic tissue and black in color. This note documented the resident with an extension contracture with partial supination of the foot and having been in contact with the foot board of the bed, creating the wound. This note further documented removal of the foot board. An observation on 04/15/14 at 2:36 PM revealed daily wound care for Resident #4 performed by Nurse #2. After removing the old dressing, an ulceration approximately the size of a walnut was observed on the lateral side of Resident #4's right foot at the base of the fifth toe. Eschar covered approximately 75% of the wound, wound edges appeared pink and the surrounding skin was also pink. After cleansing the wound with normal saline solution, Nurse #2 applied hydrogel on gauze which she applied to the wound. Nurse #2 wrapped the gauze and right foot in cling gauze held in place with tape noting the date and the nurse's initials. An interview on 04/16/14 at 6:30 AM with Resident #4 revealed her foot wound was caused by her bed being too short. She stated she told someone but it was a long time before they gave her a longer bed. She stated that until the longer bed was provided, staff would prop her feet up on pillows, but sometimes with repositioning they would forget the pillows. An interview on 04/16/14 at 12:03 PM with the wound care nurse revealed she reviewed all resident records for wound care and prevention orders, orders were typed into the electronic record and referral recommendations were made to the wound care doctor for those residents not in his care. Concerning Resident #4, she stated she thought it was the foot board of her bed that affected the resident's skin integrity, the foot board was removed and she read this in the wound doctor's notes.	F 314		

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F 314	Continued From page 10 An interview on 04/16/14 at 1:15 PM with Nurse Aide (NA) #2 revealed she recalled it had been a month prior that the decision was made about her bed. She stated at first they were going to remove the foot board but then they decided to get her a longer bed which she now has in place. She stated it was changed out either that day or the following day but it was real quick. An interview on 04/16/14 at 3:12 PM with Nurse #2 revealed she was the nurse who documented the weekly skin assessment for Resident #4 on 03/26/14 in reference to previous skin findings on 03/21/14, at which time Resident #4's foot had opened back up. She stated the physician was here on 03/21/14 who looked at the wound and gave new orders. She stated the wound was an old wound that at one time was healed. An interview on 04/17/14 at 10:47 AM with the Maintenance Director revealed that on 03/28/14 he was off but his assistant was called in that day. He stated he was told by his assistant that the Director of Nursing Services (DNS) told the assistant to extend Resident #4's bed, but the assistant had found another bed already extended and swapped out the beds. An interview on 04/17/14 at 1:33 PM with the interim DNS revealed that an at-risk book was reviewed every week for wounds to determine areas of decline and need for adaptive equipment that prevented pressure ulcers or promoted healing. She stated Resident #4's bed had been replaced and that it was discussed at a risk meeting. She stated she reviewed wound orders and reports in conjunction with the staff.	F 314		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520	F520 Refer to F-312 for compliance, monitoring, auditing and QAPI process for resident # 7. Refer to	

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F 520	Continued From page 11 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 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 observations, record reviews and resident and staff interviews the facility failed to effectively implement and monitor interventions put into place by the Quality Assessment and Assurance committee for 2 of 8 deficiencies cited on the CMS form 2567 dated 02/19/14 associated with activities of daily living (ADLs) and pressure ulcer prevention for Resident #7 and #4. The findings included: 1. On a complaint investigation dated 02/19/14,	F 520	F- 314 for the monitoring, auditing and compliance with the QAPI process for resident # 4 . The Director of Clinical Education reeducated the QAPI committee reviewed Golden Living QAPI policies on identifying issues and systems of care, root cause analysis, and the implementation of the plan of correction. The regional nurse consultant will audit all QAPI meetings for one year,	

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F 520	Continued From page 12 the facility was cited on the CMS Form 2567 for failure to provide incontinence care for a resident who required extensive assistance with ADLs at F 312. The requirement for F 312 says, "Based on a comprehensive assessment of a resident, the facility must ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene." On the revisit, F 312 was recited because the facility failed to change a shirt for 1 of 5 residents (Resident #7) who required extensive assistance with ADLs. See F 312. During an interview on 04/17/14 at 1:06 PM the Director of Nursing (DON) explained she was hired and started to work in the facility after the plans of correction were written and the in-services were done. She stated systems for auditing and monitoring were in place but they had not been followed in the past and she was still identifying areas of concern that needed to be fixed. She further stated they had focused on providing incontinence care to residents for the plan of correction but there had not been enough time to correct deficiencies related to ADLs regarding F 312. During an interview on 04/17/14 at 2:14 PM the Administrator explained Quality Assurance committee meetings were held monthly and there had been 2 meetings since the last survey on 02/19/14. She confirmed the committee had reviewed the plan of correction for F 312 in the meetings but the plan of correction was quite large and they were still monitoring and were still putting systems in place to correct the deficiencies	F 520		

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F 520	Continued From page 13 2. On a complaint investigation dated 02/19/14, the facility was cited on the CMS Form 2567 for failure to provide footwear to promote healing in a resident with a heel ulcer at F 314. The requirement for F 314 says, "Based on a comprehensive assessment of a resident, the facility must ensure that a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing." On the revisit, F 314 was recited because the facility failed to prevent a resident's foot from pressing against a bed foot board for 1 of 3 residents with a history of pressure ulcers. (Resident #4). See F 314. During an interview on 04/17/14 at 1:06 PM the Director of Nursing (DON) explained she was hired and started to work in the facility after the plans of correction were written and the in-services were done. She stated systems for auditing and monitoring were in place but they had not been followed in the past and she was still identifying areas of concern that needed to be fixed. She further stated there had not been enough time to correct the deficiencies identified in the plan of correction regarding F 314. During an interview on 04/17/14 at 2:14 PM the Administrator explained Quality Assurance committee meetings were held monthly and there had been 2 meetings since the last survey on 02/19/14. She confirmed the committee had reviewed the plan of correction for F 314 in the meetings but the plan of correction was quite large and they were still monitoring and were still putting systems in place to correct the deficiencies.	F 520		