STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 06/27/2015

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GOLDEN LIVINGCENTER - ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

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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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to notify a family representative of a change in physician's orders for a medication that	F 157	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. **F 157** DNS reviewed with Resident 40's responsible party all medication changes, discontinued and active orders since resident admitted to facility with an emphasis on Effexor and Buspar.. 7-25-15 All residents have the potential to be affected. The Director of Nursing/Designee will complete an audit of orders written in the past 30 days for notification. Notification will be completed as required.	

BISR NHL & C Black Mountain WRO
Received
AUG 05 2015
by: SKH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elene N Elliott — TITLE: Executive Director — (X6) DATE: 7-21-15

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 had been discontinued for 1 of 3 residents reviewed (Resident # 40). The findings included: Resident # 40 was admitted to the facility on 01/19/12 with diagnoses of diabetes, anxiety, acute venous embolism, dementia, and depressive disorder. A review of the Minimum Data Set (MDS) Quarterly Assessment dated 06/04/15 revealed Resident #40 had been identified as unable to complete the interview and had been receiving an anti-depressant. A review of a care plan dated 06/11/15 revealed a problem identified for Resident # 40 of often times refused care and medications. Interventions included: notify my physician if my behaviors interfere with my functioning and give meds as ordered. Review of a policy regarding Notification of Change in Resident Health Status dated 11/12/14 revealed a guideline statement: To ensure that proper notifications are made when a resident has a change in health status. An interview with Resident # 40's health care representative on 06/23/15 at 11:59 AM revealed she had found out in January of this year that Resident # 40's Effexor had been discontinued sometime last July. Further interview revealed she had not been notified of the medication change on the date it happened. Review of a physician's order dated 07/29/14 revealed Effexor discontinued. A telephone interview with the Nurse Practitioner	F 157	. The DNS/designee will re-educate licensed nurses on notifying responsible party or resident of any changes. The DNS/designee will review orders during clinical start up 5 X/week and notification will be made as required. DNS/Designee will report the results of the audits in the monthly Quality Assurance Committee meeting for 3 months to ensure quality care and compliance. Audits will continue until the QAPI committee has deemed that it is no longer necessary Date of Compliance: July 25, 2015	

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F 157	Continued From page 2 on 06/26/15 at 12:12 PM revealed Resident # 40 had a gradual dose reduction of Effexor, and it was discontinued in July of 2014. Review of Nurses Notes for the month of July, 2014 revealed no documentation had been found regarding notification the Effexor had been discontinued to Resident # 40's health care representative. An interview with the Director of Nursing on 06/26/15 at 7:00 PM verified that it was her expectation that nurses follow the facility policy and notify the resident's family representative of all medication changes.	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interviews, the facility failed to: dress a resident in personal clothing, interact with a resident during a meal, keep nails clean, provide incontinence care, and maintain cleanliness to prevent odors for 3 of 11 residents (Residents #44, #52, #11). Findings include: 1a. Resident # 44 was admitted on 07/05/13 from home to the facility with the diagnoses of aphasia, cerebrovascular accident, and dysphagia. The annual minimum data set (MDS)	F 241	F 241 Resident #44 is engaged in conversation with staff members during mealtimes. Resident #44 is allowed to wear her own night clothes at night. Resident #52 is resistive to care, Showers and partial baths given as resident allows. Nails cleaned and trimmed and clothing changed as resident allows. Resident responds to male caregivers better then to female caregivers. Family is contacted to assist with promoting cooperation with care. Resident # 11 has been showered and shaved and nails have been cleaned and trimmed.	7-25-15

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F 241	Continued From page 3 dated 06/16/15 noted resident required extensive assistance with all activities of daily living; cognition was intact, a significant aspiration risk, and communication deficits related to speech. The care plan dated 06/16/15 identified the resident was at risk for aspiration and provided interventions including feeding resident slowly while sitting at a 45 degree angle in order to prevent aspiration. A continuous observation on 06/22/15 at 6:10 PM to 06/22/15 at 6:17 PM noted Resident #44 being served a supper tray while lying in bed at approximately a 30 degree angle. Nurse Aide (NA) #8 moved the electric wheelchair belonging to Resident #44 next to the bed facing the foot of the bed. NA #8 then sat in the wheelchair facing the foot of the bed, turned on the television and proceeded to open containers on Resident #44's food tray while she watched television. NA #8 then began to spoon food from the tray with her left hand backwards into Resident #44's mouth while she watched television. During the seven minute feeding of four bowls of pureed food and three glasses of thickened liquids, NA #8 had not verbally interacted once with Resident #44. Prior to the meal resident was bright and attentive. After this meal, she appeared sullen and closed her eyes and looked like she was going to cry. In an interview on 06/24/15 at 4:45 PM with the Director of Nursing (DON), she shared her expectations for staff to interact with their residents to maintain dignity and treat them with respect. In a staff interview on 06/26/15 at 5:20 PM NA #8 explained she usually sat beside the resident to feed them and talk with them while they were being fed. She admitted that while feeding Resident #44 on 06/22/15 at 6:10 PM she did not follow proper feeding technique and aspiration	F 241	All residents have the potential to be affected. The center will complete a 100% audit of resident bathing and clothing preferences. Preferences will be incorporated into plan of care. 100% of resident's nails will be assessed for cleanliness and length. Nail care will be performed as indicated during audit. Newly admitted residents will have their preference of bathing showers, and getting out of bed documented by Social Service Director/Designee. The information will then be added to the resident care card, shower list and care plan. The DNS/designee educated nursing staff on bathing residents as scheduled, dressing residents in their choice of clothing and cleaning nails with each bath on July 9, 2015. Staff	

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F 241	Continued From page 4 precautions. 1 b. Resident #44 was admitted on 07/05/13 from home to this facility with the diagnoses of aphasia, cerebrovascular accident, and dysphagia. The annual minimum data set (MDS) dated 06/16/15 noted resident required extensive assistance with all activities of daily living (ADLs); cognition was intact, a significant aspiration risk, and communication deficits related to speech. The care plan dated 06/16/15 identified the resident required extensive assistance with all ADLS including dressing. On 06/22/15 at 6:10 PM an observation noted Resident #44 dressed in a facility gown instead of her personal clothing and lying in bed and looking out of her window. On 06/23/15 at 8:44 AM an observation noted Resident #44 dressed in a facility gown instead of her personal clothing and lying in bed looking out into hallway. On 06/24/15 at 3:51 PM an observation noted Resident #44 dressed in a facility gown instead of her personal clothing and lying in bed looking out of her window. In an interview on 06/24/15 at 4:45 PM with the Director of Nursing (DON), she shared her expectations for staff to interact with their residents to maintain dignity and treat them with respect. She also stated residents should be dressed in their own personal clothing unless unavailable. Upon interview with Resident #44 on 06/26/15 at 8:49 AM when asked if she preferred to wear her own night gowns in place of facility gowns, Resident #44 began to vigorously nod her head up and down while saying yes. Then when asked if she preferred to wear the facility gowns instead of her own personal clothes, Resident #44 began shaking her head back and forth while saying no. On 06/26/15 at 12:31 PM an interview with the	F 241	was educated on July 9, 2015 regarding engaging residents in conversation during mealtimes. The DNS/designee will audit 6 residents for bathing, dressing, personal hygiene, clothing, nail care, and engagement during mealtime weekly x 4 weeks, then monthly thereafter until no longer deemed necessary by the QAPI committee. The results of the audits will be reported in the monthly Quality Assurance Committee meeting for 3 months to ensure quality care and compliance. Date of Compliance: July 25, 2015	

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F 241	Continued From page 5 Laundry Supervisor revealed the NAs place all of the residents' soiled clothing in a designated linen bag in their rooms. The Laundry Supervisor stated he picked up soiled laundry several times per day and took it to the laundry, and returned it to the resident's closet within hours. He said it was rare that a resident was out of their own clothes to wear. In a staff interview with Nurse Aide (NA) #8 on 06/26/15 at 5:20 PM NA #8 explained she usually dressed Resident #44 in facility gowns because that was what the resident liked. NA #8 stated the resident didn't care what she slept in and would even sleep in her pants sometimes. 2. Resident #52 was admitted to the facility on 02/11/10 with diagnoses including dementia, cerebrovascular accident, hypertension, diabetes, anxiety, and depression. His most recent Minimum Data Set (MDS) assessment dated 06/12/15 revealed severely impaired cognition but able to be understood and to understand. Resident #52 required extensive 1-2 person assistance with personal hygiene. On 06/23/15 at 2:04 PM, Resident #52 was observed lying in bed with only a dirty white t-shirt and brief on and the sheet pulled halfway over him. He had an overwhelming odor of urine, feces, and body odor. The finger nails on both hands were long with approximately ¼ inch length past end of finger and had dark debris noted underneath them. On 06/24/15 at 4:45 PM, an interview with the Director of Nursing (DON) revealed her expectations of staff were for residents to be treated with dignity and respect. The DON also said she expected staff to interact with the resident while providing care. While accompanied by the DON, toured the four bed room next to room of Resident #52 which was fresh and clean	F 241		

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F 241	Continued From page 6 and neat: Residents located in this room were cognitively intact. When we came to the four bed room of Resident #52 at the doorway the malodorous scent of body odor, urine, and feces combined were first noted. All of the residents of this room, including Resident #52 were cognitively impaired. 3. Resident #11 was admitted to the facility on 5/11/11 with diagnoses including dementia, psychosis, and encephalopathy. His most recent Minimum Data Set (MDS) assessment dated 5/11/15 revealed severely impaired cognition but able to be understood and to understand others. The MDS also noted activities of daily living (ADLs) functional deficits with needs for extensive assistance with personal hygiene and limited assistance with toileting. The care plan dated 5/18/15 identified Resident #11 with needs for ADLs functional rehabilitation which required partial to extensive assistance with bathing and personal hygiene. On 6/22/15 at 5:15 PM Resident #11 observed ambulating in room and hallway. His appearance was disheveled with unshaven beard of between approximately 1/4-1/2 inches length. Resident #11 also noted with long fingernails approximately ¼ inches off of end of fingers with dark brown debris under them. Resident #11 an overwhelming odor of urine and body odor. At one point Resident #11 was noted to enter bathroom (without a sink) and return to room and hallway without washing hands. On 06/24/15 at 4:45 PM, an interview with the Director of Nursing (DON) revealed her expectations of staff were for residents to be treated with dignity and respect. The DON also said she expected staff to interact with the resident while providing care. While accompanied by the DON, toured the four bed room next to	F 241		

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F 241	Continued From page 7 room of Resident #11 which was fresh and clean and neat. Residents located in this room were cognitively intact. When we came to the four bed room of Resident #11 at the doorway the malodorous scent of body odor, urine, and feces combined were first noted. All of the residents of this room, including Resident #11 were cognitively impaired. On 06/25/15 at 5:02 PM Resident #11 was observed ambulating in hall to his room to bathroom. Resident #11 had an overwhelming odor of urine and body odor. His appearance was disheveled with unshaven beard of between approximately 1/4-1/2 inches length. Resident #11 also noted with long fingernails approximately ¼ inches off of end of fingers with dark brown debris under them. He went to the bathroom and back out several times and then came to the hallway leaving the room without washing his hands. At this time when questioned about who makes sure the resident gets his hands cleaned after toileting, Nurse #8 took Resident #11 to the sink and washed his hands. 06/26/15 at 3:10 PM a resident observation was made accompanied by the DON of Resident #11's fingernails. The fingernails were noted approximately ¼ inches off of end of fingers with dark brown debris under them. When asked about her expectations of nail care, the DON stated the nails should be clipped and clean.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices	F 242		7-25-15

cont

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F 242	Continued From page 8 about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, staff and resident interviews, the facility failed to honor a resident's choice of the time for getting up in the mornings (Resident #68) and failed to honor resident's food preferences (Resident #41) for 2 of 12 sampled residents who were reviewed for choices. The findings included: 1. Resident #68 was admitted to the facility on 08/27/14 with diagnoses which included chronic airway obstruction, kidney failure, diabetes, depressive disorder and anemia. The quarterly Minimum Data Set (MDS) dated 04/27/15 coded Resident #68 with no cognitive deficits, capable of making her needs known and with no behaviors. This MDS also indicated Resident #68 required extensive assistance of one person for bed mobility, dressing, toilet use and personal hygiene and extensive assistance of 2 people for transfers. The care plan related to self-care impairment was last updated 05/06/15, and included interventions to anticipate and meet Resident #68 needs and to encourage choices with care. On 06/26/15 at 11:48 AM Resident #68 revealed she would like to get up at 8:30 AM in the morning, but she stated it was impossible for her to get up at that time because they just did not	F 242	F242. Resident #68's preference of time for assistance with getting out of bed will be honored and the Care plan and care card were updated. A 100% audit of resident preferences of time for assistance with getting out of bed was performed by the Social Service Director/Designee and the care plans and care cards were updated accordingly. Newly admitted residents will have their preference of bathing showers, and time for getting out of bed documented by Social Service Director/Designee. The information will then be added to the resident care card, shower list and care plan The nursing staff were re-educated on the importance of honoring residents preferences and to identify preferences on the resident care cards. The Director of Nursing/designee will interview 6 residents weekly x 4 weeks to determine if preferences are being met, then monthly thereafter until no longer deemed necessary by the QAPI committee. The results of the audits will be reported in the	7-25-15

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F 242	Continued From page 9 have enough help to assist her out of bed. Resident #68 further stated she was usually gotten up around 10:00 AM to 10:30 AM each morning. On 06/27/15 at 9:10 AM Resident #68 was observed in bed eating her breakfast. Interview with Nurse Aide #2 revealed she usually worked 3:00 PM to 11:00 PM. She stated she knew Resident #68 liked to get up into her wheelchair before breakfast in the morning. Nurse Aide #2 stated the breakfast trays arrived about 9:00 AM in the morning. Interview with Nurse Aide #1 revealed she worked 7:00 AM to 3:00 PM and she got Resident #68 up by 10:00 AM every morning. Nurse Aide #1 stated she was aware the resident wanted up around 8:30 AM but she didn't always have time to get the resident up at 9:00 AM. Interview with the Director of Nursing (DON) on 6/27/15 at 5:15 PM revealed she was not aware Resident #68 was not getting up at her preferred time of 8:30 each morning. She further stated she expected her staff to follow the wishes of the residents when it came to assisting residents out of bed in the morning. 2. Resident #41 was admitted to the facility on 05/18/15 with a diagnosis of Diabetes Mellitus. Review of Resident #41 Minimum Data Set (MDS) of 05/25/15 revealed she was cognitively intact, able to make herself understood, able to understand others and able to make her daily preferences known.	F 242	monthly QAPI meeting for 3 months to ensure quality care and compliance to determine if resident preferences are being followed. Resident #41 was interviewed and her tray card was corrected on 6/26/15. All residents, including new admissions, will be interviewed to determine their food preferences. Their tray cards will be updated after the interviews are completed. The dietary staff will be re-educated on the importance of honoring resident food preferences and the importance of carefully reading resident tray cards. The Dietary Manager/Designee will conduct audits of tray line meal service will be done 5 times a week for 1 month, then 3 times a week for 2 months.	7-25-15

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F 242	Continued From page 10 Resident #41 was interviewed on 06/26/15 at 10:15 AM. During the interview the resident voiced a concern that her food preferences were not honored by the facility. The resident specified she had previously informed staff that she wanted orange juice served at breakfast and salads, cottage cheese and fruit served at the lunch and evening meals, but she was not always served these items. The resident further specified that she had also informed staff that she did not want milk or water served on her meal trays, but continued to receive these beverages at meals. The resident stated that she was aggravated that staff did not provide her with the foods and beverages she requested at meals. Observations on 06/26/15 at 10:30 AM of Resident #41's breakfast tray revealed she was served cranberry juice, milk and water on her meal tray. The resident stated she did not like these beverages and would not drink them. Review of the resident's tray slip served with this meal revealed orange juice, water, milk and oatmeal with raisins were to be served. Observations of the oatmeal on the meal tray revealed no raisins were in the resident's oatmeal. The resident stated she preferred raisins to be served in her oatmeal, but staff often did not serve them with her oatmeal. Observations on 06/26/15 at 1:00 PM of Resident #41's lunch meal tray revealed she was served milk and water with this meal. The resident again stated that she had informed staff repeatedly that she did not like these beverages, but continued to receive them on her meal trays. Interview with the Dietary Manager (DM) on	F 242	The Dietary Manager/Designee will perform a QAPI and bring the results to the monthly QAPI meeting for the QAPI committee to review for 3 months. Compliance date July 25, 2015	

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F 242	Continued From page 11 06/26/15 at 4:35 PM revealed Resident #41's food and beverage preferences should be honored. The DM stated Resident #41's meal tray slip was updated on 06/26/15 to reflect her preferences to receive cottage cheese, fruit and tossed salad at lunch and evening meals and to not receive milk and water on her meal trays. The DM also stated that Resident #41 should have received raisins with her oatmeal during the breakfast meal of 06/26/15.	F 242		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and review of the resident council meeting minutes the facility failed to respond to resident council concerns of staffing and slow response to requests for assistance. The findings included: Review of the resident council meeting minutes from December 2014-June 2015 included the following: 12/30/14 meeting-Residents still state call lights aren't being answered in a timely manner. Not enough nursing assistants that are experienced all three shifts.	F 244	F 244 The Executive Director will educate the Department Management staff regarding Golden Living Grievance policy. Each grievance brought to the Resident Council Meeting minutes will be documented in the resident council meeting. A grievance form will be generated by the Activity Director/Designee and brought to the "Stand Up" meeting toe next business day. All Grievance forms are directed to the Social Service director who will log enter F244 Cont.	7-25-15

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F 244	Continued From page 12 01/27/15-Issue of call lights aren't being answered in a timely manner. Not enough nursing assistants or experienced nursing assistants. 02/25/15-Meeting was cancelled due to residents were sick. 03/31/15-Call lights aren't being answered in a timely manner. Not enough nursing assistants or experienced nursing assistants. 04/09/15-Call lights still problems. Staffing not enough. 05/22/15-Call lights gotten better. 06/19/15-Call light still taking too long. On 06/26/15 at 11:00 AM the president of the resident council stated residents bring up poor call response all the time in the resident council meetings. The president of the resident council stated it was not uncommon for residents to report waiting upwards to an hour for staff to respond to their request for assistance. The president of the resident council stated the issue was discussed at every meeting with resident reports of no improvement. Review of "Department Response Forms" noted the following responses to the resident council meeting concerns: 12/30/14-All nursing assistants are certified, but new to facility. Give new employees time to get oriented. Continue to hire staff. Remind all staff to answer call lights. Continue to monitor. 05/22/15-Although the resident council meeting minutes indicated, "call lights gotten better", the "Department Response Forms" dated 05/22/15 noted "Call lights not being answered timely. Sometimes it takes up to an hour, low staff." The response to this concern by the Director of Nursing on 06/02/15 was, Call light audits will be	F 244	F244 Cont. an expected resolution date on the form, distribute to the appropriate, on the form, distribute to the appropriate department head and follow up to verify timely resolution of the grievance. The director of that department will resolve the grievance within 5 business days unless there are extenuating circumstances preventing it from being resolved. The Social service director will follow up with resident council president within 1 week of the resolution. The Activity director/ designee will follow up during the next resident council meeting to ensure on going resolution. All grievances will be discussed at the "Stand Up" meeting until resolved. The Executive director will audit the Grievance Log daily during the work week to verify grievances are resolved. Social service director/designee will follow up with resident council president within 1 week of resolution and report findings to QAPI committee monthly x 3. Compliance Date 7-25-15	7-25-15

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F 244	Continued From page 13 randomly conducted. Staff with frequent call outs. Attendance being tracked. New staff hired, staff being monitored by Director Nursing Services/Assistant Director Nursing Services for resident care issues, including call lights, breaks, lunches. 06/19/15-Provide staff education regarding call lights utilizing an "all hands on deck" approach. Review of the resident council meeting book noted there was no response to concerns raised at the resident council meeting on 01/27/15, 03/31/15 and 04/09/15. On 06/26/15 at 4:45 PM the activity director noted the facility did not have an activity director from December, until she was hired April 2015. The activity director stated she was told there were other staff filling in until she was hired. The activity director stated she reviewed all paperwork left from the prior activity director and did not see responses to the 01/27/15, 03/31/15 and 04/09/15 resident council meetings. The activity director stated, since she started, she gave any concerns reported by residents in the resident council meeting to the appropriate department head to address the concern. On 06/27/15 at 10:15 AM the Director of Nursing (DON) stated she could not speak about resident council concerns prior to 05/15/15 because she was not working at the facility prior to that time. The DON stated she was in the process of getting the call light audits as referenced in the 05/22/15 response. The DON stated the staff member assisting with staffing was tracking staff attendance. The DON stated she visually audited staff responding to call lights when making rounds. The DON stated she had not started	F 244		

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F 244	Continued From page 14 staff education as indicated in the 06/19/15 response. On 6/27/15 at 11:40 AM the administrator stated she could not speak about resident council concerns prior to 04/09/15 because she was not working at the facility prior to that time. The administrator stated she was unaware of resident council responses prior to her employment at the facility. The administrator stated there had not been an activity director from the end of December-April; noting the activity director was the staff member providing oversight to the resident council. The administrator stated she began reviewing concerns from the resident council beginning with the 04/09/15 meeting. The administrator stated there should be a response to any concerns reported by residents in the resident council and the responses should be implemented. The administrator could not explain why there was no response to the 01/27/15, 03/31/15 and 04/09/15 resident council concerns or why the responses to the 05/22/15 and 06/19/15 meetings had not been implemented. The administrator stated she was aware of call light response concerns noting all staff try to answer resident requests for assistance. The administrator provided information from the staff member assigned to track staff attendance. The information was reviewed and, outside of listing employee names, there was no evidence there was a working system in place to track staff attendance (as referenced in the 05/22/15 response by the DON). The administrator stated that staff member was not available to be interviewed.	F 244		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		

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F 246	Continued From page 15 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to keep a call bell in reach of 1 of 1 residents. (Resident #69). The findings included: A record review revealed Resident #69 was admitted to the facility on 01/22/15 with diagnoses of bilateral ankle fractures, non-weight bearing due to the bilateral heel wounds, depressive disorder, diabetes, end stage renal failure, and peripheral vascular disease. A review of a quarterly Minimum Data Set (MDS) dated 04/20/15 revealed Resident #69 as having no cognitive deficits, was capable of making her needs known, no behaviors, and required extensive assistance of 1 person for bed mobility and personal hygiene. The MDS further revealed Resident #69 required extensive assistance of 2 staff for transfers, dressing and toilet use and she was frequently incontinence of bowel. Resident #69 was coded with 3 pressure ulcers. A review of Resident #69's plan of care dated 04/11/15 revealed resident was cognitively intact, was capable of making her needs know and no behaviors. She required extensive assistance	F 246	F 246 Resident # 69 has her call light within reach. All residents have the potential to be effected. A 100% audit of all residents in the facility were audited to ensure the call light is within reach. The Director of Nursing/Designee in-service on keeping resident call lights with in reach was held on July 9, 2015. Nursing staff will be re-educated on making sure the call light is within reach of the resident at all times.	7-25-15

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F 246	Continued From page 16 with ADL including bed mobility, transfers, personal hygiene and toilet use. An interview with Resident #69 on 06/25/15 at 3:30 PM revealed there were several episodes when her call bed was under her bed for the entire 11:00 PM to 7:00 AM shift. She stated since she was non-weight bearing due to the ulcers on her bilateral feet she was unable to get up to get the call bell, if her call bell was out of reach and that she had to yell to get anyone to help her. Resident #69 revealed her family put a phone in her room because there was such a problem with her call bell not in reach. Resident #69 stated if her call bell was out of her reach she would call her family and they called the nurses station and staff would come to her room. An interview with Resident #69's family on 06/25/15 at 3:30 PM revealed they had on several occasions come to see the resident in the morning and found Resident #69's call bell out of the resident's reach. The family further stated they brought a phone into the room for Resident #69 to use when her call bell was out of reach. The family stated if Resident #69's call bell was out of reach the resident could use the phone to call her family and the family would call the nurses station to let them know Resident #69's call bell was out of her reach. An interview with Nurse #5 on 06/27/15 at 8:45 AM revealed she worked 11:00 PM to 7:00 AM shift and it was possible for the call bell to be under the bed during the 11:00 PM to 7:00 AM shift, due to Resident #69 calling out for help. Nurse #5 revealed Resident #69 was non-weight bearing and she required assistance for incontinent care. An interview with the Director of Nursing (DON) on 6/26/15 at 5:00 PM revealed she was not aware of a time when Resident #69 could not	F 246	Call lights are audited by supervisors and management staff to assure they are within reach of the resident using non-clinical rounds 5x/week for one month and then weekly thereafter. Auditing is reported at morning "start up" meeting. Weekly audits to assure call lights are within reach are completed by management staff and reported to monthly QAPI for 3 months Date of compliance: July 25, 2015	

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F 246	Continued From page 17 reach her call bell. She stated she expected her staff to always make sure the residents call bell could be reached by the resident before the staff member left the resident's room.	F 246		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F272 Resident's #15, #50, 58, and #101, MDS and Care Plans were updated to identify and describe problem, causes and contributing factors or related risk factors and findings. All CAA's will state description of problem, causes and contributing factors or related risks factors including analysis of findings. The MDS Coordinator is currently on an extended Leave of Absence and will be educated upon returning to work. All remaining care plan team members will be educated by the Clinical assessment and reimbursement coordinator.	7-25-15

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F 272	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete Care Area Assessments that addressed the underlying causes, contributing factors and risk factors for 3 of 24 sampled residents reviewed for the most recent comprehensive Minimum Data Set and the facility failed have a Minimum Data Set completed prior to the due date (Resident #15, #50, #58, and #101). The findings included: 1. Resident #15 was admitted to the facility on 05/11/09 with diagnoses of Alzheimer's disease, non-Alzheimer's dementia and reflux. The most recent Minimum Data Set (MDS) dated 04/08/15 revealed Resident #15 was severely cognitively impaired. Review of the Care Area Assessment (CAA) summary for nutrition dated 07/15/14 indicated Resident #15 triggered for nutrition due to being on a mechanically altered diet and a therapeutic diet. The summary further stated Resident #15 weighed 130 pounds, received a mechanical soft diet and usually had to be fed by staff. There was no description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for the CAA Summary. During an interview on 06/26/15 at 10:14 AM with the MDS Coordinator she confirmed she had	F 272	F272 cont. Interim MDS coordinator/designee will ensure MDS/CAA assessments will be completed timely and include problem, causes and contributing factors or related risk factors and findings. A weekly audit will be performed on the prior week's comprehensive Care Plans to ensure MDS/CAAs are completed timely and include problem, causes and contributing factors or related risk factors and findings x 3 months by the Clinical assessment and reimbursement coordinator. The Executive Director will report the results of the weekly audits will be reported to monthly QAPI committee X 3. Date of compliance 7-25-15	7-25-15

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F 272	Continued From page 19 completed Resident #15's CAA summary for nutrition. She stated she received training in MDS 3.0 when it was released. The MDS Coordinator stated her CAA summaries contained the areas that needed to be care planed but did not paint a picture of the resident's strengths and weaknesses. The MDS nurse stated the CAA summary should include the problem, causes, risks and expected outcomes for the resident. 2. Resident #50 was admitted to the facility on 06/25/14 with diagnoses of anemia, non-Alzheimer's dementia and cirrhosis. The significant change Minimum Data Set (MDS) dated 04/10/15 revealed Resident #50 was cognitively intact. Review of the Care Area Assessment (CAA) summary for nutrition dated 04/10/15 indicated Resident #50 triggered for nutrition due to having a recent gastrointestinal bleed and was a diabetic. The summary further stated Resident #50 received snacks at bedtime and would address recent weight loss and maintain nutritional values. There was no description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for the CAA summary. During an interview on 06/26/15 at 10:14 AM with the MDS Coordinator she confirmed she had completed Resident #50's CAA summary for nutrition. She stated she received training in MDS 3.0 when it was released. The MDS Coordinator stated her CAA summaries contained the areas that needed to be care planed but did not paint a picture of the resident's strengths and weaknesses. The MDS nurse stated the CAA summary should include the problem, causes,	F 272		

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F 272	Continued From page 20 risks and expected outcomes for the resident. 3. Resident #58 was admitted to the facility on 03/27/15 with diagnoses of paraplegia, seizure disorder and diabetes. The admission Minimum Data Set (MDS) dated 04/03/15 revealed Resident #58 was cognitively intact. Review of the Care Area Assessment (CAA) summary for pressure ulcers dated 04/03/15 indicated Resident #58 triggered for pressure ulcers with no reason noted. The summary further stated will proceed to care plan to improve skin/wound and avoid infections. Provide adequate nutrition to heal and monitor for pain. There was no description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for the CAA summary. During an interview on 06/26/15 at 10:14 AM with the MDS Coordinator she confirmed she had completed Resident #58's CAA summary for nutrition. She stated she received training in MDS 3.0 when it was released. The MDS Coordinator stated her CAA summaries contained the areas that needed to be care planed but did not paint a picture of the resident's strengths and weaknesses. The MDS nurse stated the CAA summary should include the problem, causes, risks and expected outcomes for the resident. 4. Resident #101 was admitted to the facility on 06/08/15 with diagnoses of chronic respiratory failure, anxiety, and ulcers of the heel and mid-foot. Review of Resident #101's medical record revealed the admission Minimum Data Set (MDS) was unavailable and per the MDS Coordinaotr it was overdue. The 5 day MDS indicated Resident	F 272		

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F 272	Continued From page 21 #101 was severely cognitively impaired. During an interview on 06/26/15 at 10:14 AM with the MDS Coordinator she confirmed the MDS for Resident #101 was not completed and was overdue. She stated she received training in MDS 3.0 when it was released. The MDS Coordinator stated her CAA summaries contained the areas that needed to be care planed but did not paint a picture of the resident's strengths and weaknesses. The MDS nurse stated the CAA summary should include the problem, causes, risks and expected outcomes for the resident.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 Resident #15's care plan was updated on 7/24/15. Resident # 32 expired in the facility on 7/14/15. All residents have the potential to be affected. cont.	7-25-15

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F 280	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update the care plan and failed to invite the resident's responsible party to the care plan meetings for 2 of 25 residents reviewed for care plans (Resident #15, #32). The findings included: 1. Resident #15 was admitted to the facility on 05/11/09 with diagnoses of hypertension, Alzheimer's disease, non-Alzheimer's dementia, anxiety, depression, psychotic disorder, mood disorder and glaucoma. The quarterly Minimum Data Set (MDS) dated 04/08/15 revealed Resident #15 was severely cognitively impaired and required extensive assistance with bed mobility, dressing, eating, toileting and personal hygiene. Review of Resident #15's care plan dated 01/2015 indicated the care plan was due to be reviewed/updated 04/2015. The care plan had not been reviewed or updated since 01/2015. During an interview on 06/26/15 at 10:14 AM with the MDS Coordinator she indicated she updated care plans for all residents. She stated she was on medical leave during the month of 04/2015 and a contract MDS nurse filled in for her while she was on leave. The MDS Coordinator stated the contract MDS nurse was to keep the MDS and care plans up to date. She further stated she had reviewed Resident #15's care plan and it had not been updated since 01/2015 and it should have been updated 04/2015 and as needed due to resident changes. During an interview on 06/26/15 at 4:36 PM with the Director of Nursing stated her expectation was for care plans to be up to date and reviewed as needed. She stated she was not aware the contract MDS nurse had not updated Resident	F 280	A 100% audit of all resident care plans will be conducted to ensure all care plans are updated and residents/RPs are invited to participate in the care plan meeting. The Interdisciplinary Care Plan team will be re-educated by the Golden Living Regional Nurse on process of inviting involved parties to Care Plan conferences and the timely updating of Care Plans. The Social Services Director/designee will notify involved parties to participate in the resident's upcoming quarterly care plan conference. Audits will be performed by the Clinical assessment and reimbursement coordinator weekly for 3 months to assure Care Plans are performed timely and responsible parties are invited. The clinical assessment and reimbursement coordinator/designee will bring the result of the audits to the monthly QAPI meeting for the	7-25-15

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F 280	Continued From page 23 #15's care plan. 2. Resident #32 was admitted to the facility on 02/09/2015 with the diagnoses of cerebrovascular accident, dementia, and metabolic encephalopathy. The most recent minimum data set (MDS) completed for a significant change dated 05/04/15 showed cognitive impairment. During an interview on 06/23/15 at 5:28 PM Resident #32's guardian stated she had not been invited to the facility to participate in the resident's quarterly care planning conference. She also stated she did not recall being invited to an initial care planning conference. In an interview on 06/25/15 at 1:33 PM with the Social Worker it was revealed the guardian had not been notified of or invited to previous care planning conferences. The Social Worker stated she was unable to determine the reason the guardian was not invited. She added the guardian must have been overlooked when notices were sent out. The Social Worker immediately contacted the guardian to invite her to Resident #32's upcoming care planning conference.	F 280	QAPI committee to review for 3 months to ensure ongoing compliance Compliance date 7/25/15	
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, physician, pharmacist, and staff interviews the facility failed to clarify the correct method of administration of medication for Resident #72 and failed to clarify	F 281		7-25-15

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F 281	Continued From page 24 the correct dose of medication to be administered for Resident #40. Findings included: 1. A record review of quarterly MDS dated 03/05/15 revealed Resident #40 was admitted to the facility on 11/25/14 and was moderately cognitively impaired. Resident #40 was diagnosed with non-Alzheimer's dementia and anemia. A record review of physician's order dated 09/14/12 revealed Resident #40 was to receive vitamin B12 tablet and give 2 tablets by mouth one time per day related to vitamin B12 deficiency anemia. On 06/24/15 at 11:58 AM an interview was conducted with Nurse #6 who stated she had not administered vitamin B12 to Resident #40 that morning because the physician's order was not complete and the specific dose of vitamin B12 was absent for Resident #40. Nurse #6 stated the medication cart had 2 available doses of vitamin B12 for administration one bottle contained vitamin B12 100 (micrograms) mcg and another bottle contained vitamin B12 500 mcg. Nurse #6 stated Resident #40's vitamin B12 order would need to be clarified with the physician. A record review of Resident #40's MAR for the Month of May 2015 and Month of June 2015 indicated physician's order for vitamin B12 tablet and give 2 tablets by mouth one time a day related to vitamin B12 deficiency anemia. Nurse's signatures on the MAR from May 1 to June 24, 2015 indicated Resident #40 received vitamin B12, 2 tablets. Documentation by nursing on the	F 281	F281 1AM F281 Resident # 72 and Resident #40 orders were reviewed and clarified by MD. The DNS/designee will review all resident medication orders and correct any errors. He/She will also review orders indicating chewable to ensure availability and if not call MD for alternative medication. The DNS/designee will reeducate all license nurses regarding transcription and clarification of physician orders. New hires permanent and temporary will receive education on transcription and clarification of physician orders during orientation and 1:1 training as indicated. All new orders will be reviewed by the DNS/designee 5x/week to assure ongoing compliance per Golden Living Clinical start up procedures. The audits will be reported monthly to QAPI x 3 months. Compliance date 7/25/15	7-25-15

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F 281	Continued From page 25 MAR indicated vitamin B12, 2 tablets was administered. On 06/25/15 at 10:15 AM an interview was conducted with Nurse #7 who stated Resident #40's order for vitamin B12 had been current since 09/14/12. Nurse #7 stated the medication cart had two types of vitamin B12 available for dispensing 100 mcg and 500 mcg. Nurse #7 stated she administered vitamin B12 500 mcg x 2 tablets to Resident #40 when she was assigned to administer medications to Resident #40. Nurse #7 stated there was no way to determine since 2012 which dose of vitamin B12 Resident #40 received. Nurse #7 stated she would have to clarify Resident #40's vitamin B12 order with the physician and determine the correct dose to administer. On 06/25/15 at 10:50 AM a phone interview was conducted with the physician who stated it was a concern that he was not aware that Resident #40's vitamin B12 dose was never clarified with him from pharmacy or nursing staff. The physician stated it was a concern that an accurate dose of vitamin B12 was not clarified with him prior to administration to Resident #40. The physician stated he felt there was no significant clinical issue for Resident #40 if received 100 mcg versus 500 mcg or 1000mcg. Physician stated the standard dose of vitamin B12 for administration was 1000mcg. On 06/25/15 Nurse #7 obtained for Resident #40 a physician's order for vitamin B12 which stated give 1000 mcg by mouth one time a day related to vitamin B12 deficiency. On 06/25/15 at 12:35 PM an interview was	F 281		

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F 281	Continued From page 26 conducted with the DON who stated she had reconciled Resident #40's MAR with physician orders for the month of June 2015. DON stated she must have overlooked that the dose of vitamin B12 was missing from the physician's order for Resident #40. DON stated she could not verify which dose of vitamin B12 that Resident #40 had been receiving from nursing staff because the medication cart contained 2 different doses of vitamin B12 100 mcg and 500 mcg. DON stated her expectations were for nurses who were administering medications to obtain clarification from physician of any order that did not contain a specific dose prior to administration of medication to the resident. On 06/26/15 at 3:00 PM an interview was conducted with Nurse #1 who stated even though the physician's order did not provide a specific dose of vitamin B12 for Resident #40 and she had not clarified the specific dose, she administered vitamin B12 500 mcg x 2 tablets on 06/24/15 to Resident #40. 2. A record review of quarterly Minimum Data Set (MDS) dated 5/20/15 revealed Resident #72 was admitted to the facility on 03/24/15 and was cognitively intact. Resident #72 was diagnosed with hypertension, diabetes mellitus, hyperkalemia, and anxiety disorder. A record review of physician's order dated 10/04/14 revealed Resident #72 was to receive vitamin B 12 active tablet chewable 1000 mcg by mouth one time per day. A record review of Resident # 72's Medication Administration Record (MAR) for the Month of May 2015 and Month of June 2015 indicated a	F 281		

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F 281	Continued From page 27 physician's order for vitamin B12-active tablet chewable and give 1000 mcg by mouth one time a day related to chronic kidney disease. Nurse's signatures on the MAR from May 1 to June 24, 2015 indicated Resident #72 received chewable vitamin B12. Documentation by nursing on the MAR indicated medication was administered. On 06/24/15 at 11:06 AM an interview was conducted with Nurse #6 who stated she clarified with the physician Resident #72's order for vitamin B 12 active table chewable. Nurse #6 stated chewable vitamin B12 medication was not available on the medication cart or in the facility stock medications for administration to Resident #72. Nurse #6 revealed she obtained a telephone order from the physician 06/24/15 for a new order for vitamin B12 which indicated administer vitamin B12 tablet 500 mcg and give 2 tablets by mouth one time a day related to chronic kidney disease. On 06/25/15 at 10:15 AM an interview with Nurse #7 revealed she had worked at the facility for 3 years and the facility did not have chewable vitamin B12 available for medication administration. Nurse #7 stated she had administered over the counter B12 500 mcg tablets x2 rather than chewable tablets to Resident #72. Nurse #7 stated the physician's order was probably placed in the computer as a chewable tablet because the computer system did not have an option to pick regular over the counter vitamin B12 as a choice. Nurse #7 stated the physician rarely ordered chewable tablets with any medication for residents. On 06/25/15 at 12:11 AM an interview was conducted with the pharmacist who stated he did	F 281		

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F 281	Continued From page 28 not have time to review all physician's orders on resident's chart for accuracy. Pharmacist stated if he found a discrepancy then he would spot check the medication to verify if it was available for administration. Pharmacist stated vitamin B12 could come in chewable form but pharmacy did not dispense over the counter vitamin B12 to the facility. Pharmacist stated the facility would be responsible to provide chewable vitamin B12 for administration to Resident #72. On 06/25/15 at 12:35 PM an interview was conducted with the DON who stated chewable vitamin B12 would have been obtained by nursing from central supply for administration to Resident #72. DON stated she was aware vitamin B12 chewable was not available on the medication cart or in the facility to be administered to Resident #72. DON stated her expectation were for nursing to have clarified with pharmacy the medication order and assure medication was available in the facility for administration to Resident #72. On 06/25/15 at 3:36 PM an interview was conducted with the head of central supply who revealed she had not ordered chewable vitamin B12 in over a year at least for the facility. The head of central supply stated chewable vitamin B12 was not available for order on the facility drug formulary. On 6/26/2015 at 8:06 AM an interview was conducted with Nurse #2 who stated the facility did not have chewable vitamin B12 on the medication cart or in the facility. Nurse #2 stated she administered vitamin B12 500 mcg x2 tablets from stock medication bottle labeled optimum B12 500 mcg dietary supplement prior to new	F 281		

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F 281	Continued From page 29 physician's order obtained on 06/24/15 for Resident #72.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to address 1 of 6 residents that went an extended time without a bowel movement. Residents #5 The findings included: Resident #5 was admitted to the facility 08/30/13 with diagnoses which included encephalopathy, episodic mood disorder, anxiety, personality disorder, depression and hemiplegia. A significant change Minimum Data Set (MDS) dated 06/05/15 noted Resident #5 was always incontinent of bowel and required extensive assistance of two staff for toilet use. The Care Area Assessment (CAA) associated with the significant change MDS dated 06/05/15 for the area of Activities of Daily Living (ADLs) included, Triggered due to dependence in almost	F 309	F309 Resident #5 bowel movements have been monitored since 6/13 by the DNS and have been regular since that day. An audit of all residents' bowel movements will be performed by the DNS/designee. If a resident has not had a bowel movement in three days, the Golden Living bowel procedure will be followed. cont.	7-25-15

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F 309	Continued From page 30 all ADLs. Resident has femur fracture and cast, is bedfast right now. She is able to shift weight a little and can feed herself after her tray is set up. Staff continues to anticipate needs and assists as needed. The care plan for Resident #5 was updated 05/13/15 and 06/18/15 and included the following problem area: Alteration in elimination, history of bowel and bladder incontinence, history of constipation. Approaches to this problem area included: -bowel medication as ordered -encourage fluids The nursing assistant care guide was observed in a book at the nursing station and was identified by the administrator on 06/22/15 at 4:00 PM as the source for nursing assistants to reference individual resident care needs. The care guide was noted as last updated 06/22/15 and indicated Resident #5 required assistance with all activities of daily living (ADLs). Review of the medical record noted Resident #5 had a physician's order for two doses of Senokot (a laxative) on a daily basis and had been on this medication prior to 06/01/15. Resident #5 did not have any other physician orders for scheduled or as needed (PRN) laxative medications. Review of the medical record of Resident #5 noted a physician's order for a nectar thick diet. Review of the nursing progress notes in the medical record of Resident #5 noted a fall out of bed on 06/01/15 which resulted in a femur fracture with a physician's order dated 06/03/15 for non weight bearing restrictions. As a result of the fracture on 06/01/15, Resident #5 had	F 309	Cont. F309 All nursing staff will be re-educated on bowel movement documentation utilizing the caretracker tool. All license nurses will be re-educated on Golden Living bowel procedures by DNS/designee. New hires, permanent and temporary will be educated on bowel movement documentation and Golden Living bowel procedures during orientation. The DNS/designee will review bowel movement tracking (no BM x 3 days) per Golden Living start up procedures. Residents with no BM x 72 hours will be administered prune juice or milk of magnesia per standing orders. The DNS/designee will bring the audits and report the finding to the monthly QAPI x 3 months then QAPI will determine if further actions to be taken. compliance date	7-25-15 7-25-15

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F 309	Continued From page 31 physician orders in the medical record for Norco (a narcotic pain medication) on a PRN basis. Review of the Medication Administration Record for Resident #5 for June 2015 noted Norco was initialed as given on the following dates: 06/02/15-2 doses 06/04/15-4 doses 06/05/15-1 dose 06/07/15-1 dose 06/08/15-1 dose 06/10/15-2 doses 06/12/15-1 dose The facility standing orders in the medical record of Resident #5 were signed by the Medical Director on 04/29/15 and included the following: Constipation (no bowel movement for 3 days). Give four ounces of warm prune juice as needed or Milk of Magnesium 30 cc by mouth X one dose On 06/22/15 at 4:00 PM the administrator stated bowel records were recorded by nursing assistants in the electronic data system. The bowel records from April 2015 to June 2015 for Resident #5 were reviewed and there were no issues from 04/10/15-05/31/15. After the 06/01/15 fall with fracture and implementation of non weight bearing status and narcotics there were extended times Resident #5 went without a bowel movement and were noted as follows: 05/31/15 third shift-06/05/15 second shift no bowel movement for a 5 day period 06/05/15 second shift-06/13/15 second shift no bowel movement for an 8 day period On 06/25/15 at 4:30 PM Nurse #2 (that worked the 7AM-3PM shift on 06/25/15) stated the day shift nurse usually got a list from management staff that referenced residents that had not had a	F 309		

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F 309	Continued From page 32 bowel movement in 3 days. Nurse #2 stated she usually talked to the nursing assistants to see if they could have missed documenting a bowel movement before implementing the standing orders. Nurse #2 stated the nurse documented what steps were taken on the report and gave it back to the Director of Nursing (DON). Nurse #2 noted she had not received the report during her shift that day. On 06/25/15 at 4:35 PM the DON stated bowel movements can be checked on line every day by nursing staff. The DON stated the "no bowel movement" in 3 day list was generated every day by management nursing staff and reviewed in the morning meeting. The DON stated this information was passed on to the nurse responsible for the resident. The DON stated her expectation was the nurse would look at the resident's record to see if they had any PRN laxative orders and, if not, implement the standing orders. The DON stated if the PRN or standing orders were implemented and not effective she expected the residents physician to be notified. The DON stated nurses should document on the "no bowel movement" list or the 24 hour nursing report information related to the "no bowel movement" and what steps were taken and the effects. The DON reviewed the "no bowel movement" reports and 24 hours nursing reports for Resident #5 from 05/31/15-06/13/15 and noted on 06/04/15 a laxative was given to Resident #5 (though this wasn't indicated on the resident's June 2015 MAR) and Resident #5 had a bowel movement. The DON could not find anything in the no bowel movement reports or 24 hour reports that indicated staff was aware of the 8 day period of time Resident #5 went without a bowel movement from 06/05/15-06/13/15. The	F 309		

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F 309	Continued From page 33 DON stated it would have been her expectation the standing orders would have been implemented for Resident #5 during the time frame 06/05/15-06/13/15.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interviews, the facility failed to provide personal hygiene for dependent residents in need of showering, shaving, and finger nail care for 4 of 12 residents reviewed for activities of daily living (Residents #52, #11, #5, and #50). Findings included: 1. Resident #52 was admitted to the facility on 02/11/10 with diagnoses including dementia, cerebral vascular accident, hypertension, diabetes, anxiety, and depression. The most recent Minimum Data Set (MDS) assessment dated 06/12/15 revealed the resident's cognition was severely impaired and he was able to be understood and to understand others. Resident #52 required extensive 1-2 person assistance with personal hygiene. The care plan problems, dated 6/18/15, listed a functional deficit with all activities of daily living and interventions included extensive assistance to shower at least twice a week. On 06/22/15 at 4:04 PM, Resident #52 was	F 312	F312 Resident #52 is resistive to care, Showers and partial baths given as resident allows. Nails cleaned and trimmed and clothing changed as resident allows. Resident prefers male caregivers to female caregivers. He is given male caregivers when they are available. The family is very supportive and is contacted at times to assist with promoting cooperation with care. Resident #11 is receiving scheduled showers, grooming and ADL care, fingernails have been trimmed and cleaned regularly,. Resident #5 nails were cleaned, filed and polished on 6/25/15. Resident's hands and nails are being cleaned regularly. Resident # 50 hands and nails are being cleaned regularly. cont.	7-25-15

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F 312	Continued From page 34 observed lying in bed with only a dirty white t-shirt and brief on and the sheet pulled halfway over him. He had an overwhelming odor of urine, feces, and body odor. The finger nails on both hands were long and had dark debris noted underneath them. On 06/22/15 at 4:09 PM, in an interview with Nurse Aide #4 (NA), it was revealed Resident #52 usually required 2 staff to provide care because he was often combative. NA #4 was then observed to provide incontinence care for this resident with the assistance of NA #8. Resident #52 was initially resistant to care, but once the NAs engaged him in conversation the resident was calm and cooperative. When NA #4 was asked when Resident #52 was last bathed or showered, he said he would have to check the shower/bath log but he could tell it was time for resident to be showered again. On 06/23/15 at 2:04 PM, Resident #52 was observed lying in bed with only a dirty white t-shirt and brief on and the sheet pulled halfway over him. He continued with an overwhelming odor of urine, feces, and body odor. The finger nails on both hands were long and approximately ¼ inch past end of finger and had dark debris noted underneath them. On 06/24/15 at 8:16 AM in an interview with NA #5 it was revealed the NAs would chart they did showers or residents refused them noting, we just don't have enough staff to get it all done. On 06/24/15 at 1:20 PM Resident #52 was observed in bed wearing a hospital gown. The resident's finger nails remained long, approximately ¼ inch past the end of finger with dark matter under them. When asked about the cleaning and grooming of fingernails for residents, NA #5 replied resident fingernails were cleaned and trimmed when they gave residents	F 312	Cont. F312 All the residents have the potential to be effected 7-25-15 The DNS/designee educated nursing staff on bathing residents as scheduled, dressing residents in their choice of clothing and cleaning nails with each bath on July 9, 2015. The DNS/designee will audit 6 residents ADL care x week x 4 weeks, then monthly thereafter until no longer deemed necessary by the QAPI committee. The DNS will present results of the audits will be reported in the monthly Quality Assurance Committee meeting for 3 months to ensure quality care and compliance. Compliance date 7/25/15	

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F 312	Continued From page 35 showers. NA #5 also stated he wasn't sure when Resident #52 had his last shower and would have to look on the shower schedule. On 06/25/15 at 6:43 PM Resident #52 was observed asleep in bed wearing a hospital gown with an overpowering urine and body odors noted. The resident's fingernails remained long, approximately ¼ inch past end of finger with dark matter under them. On 6/26/15 at 3:10 PM observed finger nails of Resident #52 remained long and with dark matter under them. At this time the Director of Nursing went to the room and visualized Resident #52's finger nails and stated her expectations of nail hygiene were for them to be clipped and cleaned. 2. Resident #11 was admitted to the facility on 5/11/11 with diagnoses including dementia, psychosis, and encephalopathy. His most recent Minimum Data Set (MDS) assessment dated 5/11/15 revealed severely impaired cognition but able to be understood and to understand others. The MDS also noted activities of daily living (ADLs) functional deficits with needs for extensive assistance with personal hygiene and limited assistance with toileting. The care plan dated 5/18/15 identified Resident #11 required limited to extensive assistance with bathing and personal hygiene. The care plan also included a problem of urinary incontinence with the goal to remain free of UTI and have no urinary incontinence. Interventions for Resident #11 included assistance with toileting and provide incontinence care as needed. On 6/22/15 at 5:15 PM Resident #11 was observed ambulating in his room and in the hallway. His appearance was disheveled with unshaven beard of between approximately 1/4-1/2 inches length. Resident #11 was also noted with long fingernails approximately ¼	F 312		

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F 312	Continued From page 36 inches off of end of fingers with dark brown debris under them. Resident #11 displayed an overwhelming odor of urine and body odor. At one point Resident #11 was noted to enter a bathroom (without a sink) and return to room and hallway without washing hands. On 6/25/15 at 5:02 PM Resident #11 was observed ambulating in his room and on the unit. A facial beard with approximately ½ inch or more growth was noted. Finger nails were long and jagged and approximately ¼ inch past the end of his fingers with brown colored material under them. Resident #11 smelled of urine and body odor as he ambulated down the hall. An interview on 6/26/15 at 9:08 AM with Nurse Aide (NA) #5 revealed Resident #11 was not incontinent and could manage toileting independently most of the time. NA #5 stated it was when Resident #11 had a bowel movement that he needed assistance. When asked about the cleaning and grooming of fingernails for residents, NA #5 replied resident fingernails were cleaned and trimmed when the resident got showers. NA #5 also stated he wasn't sure when Resident #11 had his last shower and would have to look on the shower schedule. He also stated Resident #11 would be added to the shower list that morning since it was needed. On 6/26/15 at 3:12 PM an observation with the Director of Nursing (DON) of Resident #11's finger nails revealed the nails remained long and with dark matter under them. The DON stated her expectations of nail hygiene was for them to be clipped and cleaned. 3. Resident #5 was admitted to the facility 08/30/13 with diagnoses which included encephalopathy, episodic mood disorder, anxiety, personality disorder, depression and hemiplegia.	F 312		

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F 312	Continued From page 37 A significant change Minimum Data Set assessment completed 06/05/15 assessed Resident #5 as cognitively intact and required extensive assistance of one staff for personal hygiene. The Care Area Assessment for Activities of Daily Living (ADL) associated with this 06/05/15 assessment noted, "Triggered due to dependence in almost all ADLs. Resident has femur fracture and cast. Is bedfast right now. She is able to shift weight a little and can feed herself after her tray is set up. Staff continues to anticipate needs and assists as needed. Will care plan." The care plan for Resident #5 was last updated 06/18/15 and included the problem area, "I have a physical functioning deficit related to: Self care impairment, mobility impairment." Approaches to address this problem area included, anticipate needs and assist as needed and encourage choices with care. The nursing assistant care guide was observed in a book at the nursing station and was identified by the administrator on 06/22/15 at 4:00 PM as the source for nursing assistants to reference individual resident care needs. The care guide was noted as last updated 06/22/15 and indicated Resident #5 required assistance with all ADLs. Observations were made of Resident #5 the following days and times: 06/23/15 11:36 AM-Resident #5 was observed in bed. Noted the middle finger and ring finger on both hands had a noticeable amount of black matter embedded under the nail. 06/24/15 5:53 PM-Resident #5 was observed in bed. Noted the middle finger and ring finger on both hands had a noticeable amount of black matter embedded under the nail.	F 312		

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F 312	Continued From page 38 06/25/15 5:00 PM-Resident #5 was observed in bed. Noted the middle finger and ring finger on both hands had a noticeable amount of black matter embedded under the nail. The Director of Nursing (DON) was present at the time of the observation and, as the resident held out her hands, the resident stated, "will you clean them?". Resident #5 stated she liked to have her nails cleaned. At the time of the observation on 06/25/15 at 5:00 PM the DON stated she expected staff to clean nails when a shower or bed bath was given. The DON noted the resident's nails needed to be cleaned and requested staff working at that time to clean the nails of Resident #5. The DON provided documentation by nursing assistants when a bed bath or shower was given and this documentation noted the last bed bath for Resident #5 was 06/23/15 at 12:45 PM by Nurse Aide (NA) #3. On 06/26/15 at 2:55 PM NA #3 verified she did give a bed bath to Resident #5 on 06/23/15. NA #3 stated she typically checked residents' nails when providing a shower or bed bath and cuts and cleans them if there is an issue. NA #3 stated she didn't recall there being a problem with Resident #5's nails when she gave a bed bath on 06/23/15. 4. Resident #50 was admitted to the facility on 06/25/14 with diagnoses of chronic obstructive pulmonary disease, hypertension, cirrhosis and non-Alzheimer's dementia. The significant change Minimum Data Set (MDS) dated 04/10/15 revealed Resident #50 was moderately cognitively intact. She could understand and was	F 312		

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F 312	Continued From page 39 understood. The MDS further indicated Resident #50 needed extensive assistance with dressing, toileting, personal hygiene and bathing. Review of Resident #50's care plan dated 06/23/15 indicated she had a physical functioning deficit related to activities of daily living. Interventions included anticipate needs, assist as needed and encourage choices with care. Observations were made of Resident #50 on the following dates and times: · 06/24/15 at 1:16 PM Resident #50 was observed eating lunch. Resident #50's thumb and fingernails on both hands were observed to have black debris underneath and pink nail polish chipping off all fingernails. · 06/25/15 at 8:57 AM Resident #50 was observed eating breakfast. Resident #50's thumb and fingernails on both hands were observed to have black debris underneath and pink nail polish chipping off all fingernails. · 06/26/15 at 10:10 AM Resident #50 was observed sitting in her wheelchair in her room. Resident #50's thumb and fingernails on both hands were observed to have black debris underneath and pink nail polish chipping off all fingernails. During an interview on 06/25/15 at 9:35 AM with NA #7 she stated nail care should be provided during showers and as needed. NA #2 stated they had been short staffed and it was very difficult to even get showers done and nail care was being neglected. She further stated she did not recall the last time she provided nail care for Resident #50. At the time of the observation on 06/26/15 at 10:10 AM the Director of Nursing (DON) agreed Resident #50's nails needed to be cleaned and trimmed. The DON stated she expected fingernails to be cleaned and trimmed at the time	F 312		

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F 312	Continued From page 40 of the residents shower and as needed.	F 312		
F 314 SS=E	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 observations, record review, resident, staff, and physician interviews, the facility failed to provide dressing changes as ordered and/or complete weekly skin assessments as ordered for 6 out of 7 residents reviewed for pressure sores and failed to change a wound vacuum assisted closure device (promote healing through negative pressure wound therapy) for 1 of 1 resident reviewed for wound vacuum device to assist in pressure sore healing (Residents #23, #34, #53, #58, #69, #101, # 103). The findings included: 1. Resident #34 was admitted to the facility on 04/27/11 with diagnoses which included Alzheimer's disease, dysphagia, osteoporosis, below knee amputation, and cerebrovascular disease. The annual Minimum Data Set (MDS) dated	F 314	F314 Resident #34 treatment to wound has been changed per physician orders. Wound physician is following patient treatment and updating as needed. Resident # 23 blister area healed. Resident # 101has received wound treatments as ordered by physician. Resident #103 has received treatments as ordered. Improvement in wounds noted on Wound physicians weekly report dated 7/10/15. Resident #58 has received treatments as ordered. Resident # 53 has been discharged home. Resident # 69 has received treatments as ordered. Resident is being followed by wound doctor. cont.	7-25-15

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F 314	Continued From page 41 06/25/15 indicated Resident #34 was severely impaired in cognition for daily decision making and was totally dependent on staff for activities of daily living (ADLs). The MDS also revealed Resident #34 had difficulty making self-understood and understanding others. Further review of the MDS coded Resident #34 with having a Stage II pressure sore of the sacral/coccyx area. A care plan was developed with a revised date of 06/17/15 revealed Resident #34 was at risk for pressure sores related to a history of pressure sores and a re-opened area to the coccyx. The goal indicated the resident would remain free from further skin breakdown. Interventions included weekly skin assessments, reposition resident frequently, provide pressure reducing wheelchair cushion, pressure reduction/relieving mattress (air mattress on bed), thorough skin care after incontinent episodes, and provide treatments as ordered. Review of a document titled "Skin Integrity Guideline/Skin Care Protocol" provided by the facility with no date read in part, Stage II pressure ulcer hydrocolloid dressing used for absorption of minimal to moderate amounts of drainage, use dressings for acute and chronic wounds that are partial or full thickness, granular or partially necrotic wounds. A review of the nurse's notes dated 06/17/15 indicated an opened area was observed on Resident #34's coccyx. The notes indicated the resident was incontinent of bowel and bladder, and required total assistance from staff with all ADLs. The open area on the coccyx measured 0.4 cm (centimeters) in length by 0.3 cm in width	F 314	All residents at risk for or with wounds have the potential to be affected. All residents will receive a skin assessment. The DNS/ designee will in-service all nursing staff to include turning and repositioning, frequency of turning and repositioning, skin care, following wound treatment plans per physician orders and performance of weekly skin assessments. New hires, permanent and temporary will be educated on turning and repositioning, frequency of turning and repositioning, skin care, following wound treatment plans per physician orders and performance of weekly skin assessments during orientation The DNS/designee will review 6 residents per week for wound treatments x 4 weeks. DNS/designee will audit 6 residents per week for weekly skin assessments x 4 weeks Then 3 residents weekly x 4 weeks Then 6 residents monthly x 1 month.	7-25-15

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F 314	Continued From page 42 by 0.1 cm in depth (0.4 cm x 0.3 cm x 0.1 cm). The nurse's notes indicated the physician was contacted and the treatment protocol was started and a tegaderm hydrocolloid dressing to the coccyx area was applied. Review of the Treatment Administration Record (TAR) and nurse's notes revealed Resident #34 obtained dressings to the coccyx area on 06/17/15 and on 06/22/15. There were no dressing changes documented as being completed to the coccyx area on 06/18/15, 06/19/15, 06/20/15, or 06/21/15. Review of a document titled "Wound evaluation flow sheet" dated 06/17/15 indicated the following entries by Nurse #7: 06/17/15: Stage II pressure ulcer, measurements 0.4 cm x 0.3 cm x 0.1 cm), no odor, no pain, no drainage, wound margins intact, treatment of tegaderm hydrocolloid dressing. 06/22/15: Stage II pressure ulcer, measurements 7.0 cm x 4.5 cm x 0.1 cm and no other documentation was indicated on the flow sheet. Review of a facility nurse/physician communication document dated 06/17/15 through 06/24/15 indicated Nurse #7 had written a communication note to the physician dated 06/17/15 which read in part, Resident #34 had a small open area to the coccyx and treatment was started. The document had the physician's initials and he had written "noted." Further review of the nurse/physician communication document indicated Nurse #7 had written a note to the physician dated 06/23/15 which read in part that Resident #34 had an opened wound which was much larger and for the physician to please see the resident on his next visit. The physician in	F 314	The results of the audits will be reported in the monthly Quality Assurance Committee meeting for 3 months to ensure quality care and compliance. Compliance Date 7-25-15	

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F 314	Continued From page 43 response (with no date indicated) wrote for Resident #34 to be referred to the wound staff. On 06/25/15 the wound care physician assessed Resident #34 and wrote an order to apply hydrocolloid dressing to the sacral wound every day on day shift due to a stage II pressure sore. On 06/26/15 at 2:18 PM, Resident #34 was observed lying in the bed on an air mattress on her back, with the head of her bed at a 40 degree angle, and her eyes closed. On 06/26/15 at 3:00 PM, Resident #34 was observed lying on her back in bed, her eyes closed, and the head of the bed at a 40 degree angle. On 06/26/15 at 4:25 PM, Resident #34 was observed lying on her back in bed, her eyes opened, and non-verbal. On 06/26/15 at 4:28 PM, an interview was conducted with Nurse #2. She stated she was unaware of Resident #34's coccyx wound and/or dressing changes until 06/23/15. She verified the skin assessment was done on 06/17/15 and 06/22/15 but there was nothing documented on the treatment record which would have indicated a treatment had been ordered and/or started. She further stated she had not completed any dressing changes for Resident #34 as ordered by the wound care physician due to the facility being so short staffed and she was too busy and did not have the time to get the dressing changes done during her shift on 06/26/15. On 06/26/15 at 4:53 PM, a telephone interview was conducted with the wound care physician. He	F 314	July 25, 2015	

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stated he was unable to advise very much related to Resident #34's sacral wound because he had just taken over the wound care of the residents at the facility on 06/25/15 and that was the first time he had assessed Resident #34.

On 06/26/15 at 6:05 PM, Resident #34 was observed lying on her back in bed with her eyes opened.

On 06/27/15 at 9:12 AM, Nurse #10 was asked if she would be doing a dressing change for Resident #34 on 06/27/15. Nurse #10 stated she was a contracted nurse and was hired to only administer the resident's medications and she was unaware of any dressing changes which needed to be done.

On 06/27/15 at 10:35 AM, Resident #34 was observed lying on her back, in her bed, with her eyes closed, and the head of the bed at a 35 degree angle.

On 06/27/15 at 10:45 AM a telephone interview was conducted with Nurse #7. She stated she was aware that Resident #34's pressure sore had increased in size in approximately 5 days. She indicated the month of June was very difficult related to a severe decline in staffing and she was unable to complete the dressing changes for Resident #34 every day as ordered. She further indicated if her initials were not documented on the TAR that meant she had not had the opportunity or time to do the dressing changes. She indicated "there were many days there was not enough staff and there just was not enough time to get everything done." She stated the Nurse Aides (NAs) were expected to turn and reposition the residents every 2 hours and keep

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them clean and dry but due to the nurse aide and nurse staffing shortage the residents were not being turned and/or repositioned and residents would have to wait for 2 to 3 hours to be cleaned and dried.

On 06/27/15 at 2:30 PM an interview was conducted with the Director of Nursing (DON). She stated she was aware the nurses were struggling to get their work done and that it was not acceptable or her expectation but the facility needed more staff because there was no way the nurses or the nurse aides could get it all done. She further stated Nurse #10 was a contracted nurse and was advised to only administer medications on 06/27/15 and that another nurse would do the dressing changes if there was time.

On 06/27/15 at 5:32 PM, Nurse #2 stated the dressing change was not completed on 1st shift and she was behind on administering medications and did not have the time to do the dressing change. No observation of the wound was done during the survey.

2. Resident #23 was admitted to the facility on 05/10/11 with diagnoses which included Parkinson's disease, depressive disorder, bilateral upper extremity contractures, hemiplegia, and hemiparesis, and chronic obstructive pulmonary disease.

The annual Minimum Data Set (MDS) dated 01/09/15 indicated Resident #23 was moderately impaired in cognition for daily decision making and requires extensive assistance for activities of daily living (ADLs). The MDS also revealed Resident #23 had difficulty making self-understood and at times understanding

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F 314	Continued From page 46 others. Further review of the MDS coded Resident #23 as having barrier cream applied to the sacral area as needed for incontinence care. A care plan was developed with a revised date of 01/22/15 noting Resident #23 was at risk for pressure sores. The goal indicated the resident's skin would remain intact. Interventions included weekly skin assessments, adult briefs at all times, incontinence care to be provided by staff, apply barrier cream with incontinent episodes, pressure reduction/relieving mattress (air mattress on bed), wheelchair cushion, and resident to lay down after meals to provide pressure relief to the buttocks and sacral area. A review of the nurse's notes dated 06/16/15 indicated Nurse #4 completed a weekly skin assessment and identified Resident #23 with blisters to the top of the sacral area and blisters to the bottom of the sacral area. The notes indicated the resident was incontinent of bowel and bladder and required total assistance from staff for incontinent needs. Review of a document titled "Wound evaluation flow sheet" dated 06/16/15 indicated the following entries by Nurse #7: 06/16/15: Wound, Blister-Top of Sacral Area: measurements 0.4 centimeters (cm) in length by 0.4 cm in width by 0.0 cm in depth; (0.4 x 0.4 x 0.0), no odor, pain as a 2 on a scale of 1 to 10 (1 as the little pain and 10 as the worst pain), with wound margins intact, intact surrounding tissue, and treatment of tegaderm hydrocolloid dressing. 06/22/15: Wound, Blister-Top of Sacral Area: measurements 0.8 cm in length by 0.1 cm in width by 0.1 cm in depth; (0.8 x 0.1 x 0.1), and no other documentation noted.	F 314		

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F 314	Continued From page 47 Review of another document titled "Wound evaluation flow sheet" dated the following entries by Nurse #7 for the Wound: Blister-Bottom of sacral area: 06/16/15: measurements of wound: blister to bottom of sacral area as 0.5 cm in length by 0.5 cm in width by 0.0 cm in depth, no odor, pain of 2 on a scale of 1 to 10, wound margins intact, and treatment of hydrocolloid dressing. 06/22/15: Wound: Blister Bottom of sacral area-healed with no other documentation noted on flow sheet signed by Nurse #7. A review of a physician's order dated 06/17/15 indicated cleanse blisters on sacral area with normal saline, apply tegaderm hydrocolloid dressing three times a week and as needed for soiling, every day shift every Monday, Wednesday, and Friday for wound care. Review of the Treatment Administration Record (TAR) and nurse's notes revealed Resident #23 obtained dressings and measurements of the wounds to the sacral area on 06/17/15 and measurements were obtained on 06/22/15 and no documentation of dressing changes. There were no dressing changes indicated as being completed to the sacral area on 06/19/15, 06/22/15, 06/24/15, or 06/26/15. Review of a facility nurse/physician communication document dated 06/17/15 through 06/24/15 indicated Nurse #7 had written a communication note to the physician dated 06/17/15 which read in part, Resident #23 had 2 blisters to the coccyx area and treatment was started. The document revealed the physician had acknowledged the written communication	F 314		

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F 314	Continued From page 48 note written by Nurse #7 with the physician's initials. On 06/26/15 at 2:20 PM, Resident #23 was observed lying in the bed on an air mattress, on her back with her eyes closed. On 06/26/15 at 3:10 PM, Resident #23 was observed lying on her back in bed with her eyes closed. On 06/26/15 at 4:32 PM, Resident #23 was observed lying on her back in bed, her eyes opened, her television playing, and incomprehensible words. On 06/26/15 at 4:42 PM, an interview was conducted with Nurse #2. She stated she was aware of the blisters on Resident #23's sacral area. She verified she was responsible for the dressing changes for Resident #23 on 06/19/15 and on 06/26/15. She stated she had not completed any dressing changes for Resident #23 as ordered from the physician due to the facility being short staffed and she was not able to get to the dressing changes. On 06/26/15 at 6:10 PM, Resident #23 was observed lying on her back in bed and her eyes closed. On 06/27/15 at 9:12 AM, Nurse #10 was asked if she would be doing a dressing change for Resident #34 on 06/27/15. Nurse #10 stated she was a contracted nurse and was hired to only administer the resident's medications and she was unaware of any dressing changes for which needed to be done.	F 314		

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F 314	Continued From page 49 On 06/27/15 at 10:40 AM, Resident #23 was observed lying on her back, in her bed, with her eyes closed, and the head of the bed at a 35 degree angle. On 06/27/15 at 10:45 AM a telephone interview was conducted with Nurse #7. She stated she was aware that Resident #23's blisters on the top of the sacral area had increased in size in approximately 5 days. She indicated the month of June was very difficult related to a severe decline in staffing and she was unable to complete the dressing changes for Resident #34 every day as ordered. She further indicated if her initials was not documented on the TAR that meant she had not had the opportunity or time to do the dressing changes. She indicated "there were many days there was not enough staff and there just was not enough time to get everything done." She stated the Nurse Aides (NAs) were expected to turn and reposition the residents every 2 hours, keep them clean and dry, and also assist with the showers but due to the nurse aide and nurse staffing shortage the residents were not being turned and/or repositioned, showers were not being given, and residents would have to wait for 2 to 3 hours to be cleaned and dried. She verified she was responsible for the dressing changes for Resident #23 on 06/22/15 and 06/24/15. She indicated she did not have time to do the dressing changes on those days. On 06/27/15 at 2:30 PM an interview was conducted with the Director of Nursing (DON). She stated she was aware the nurses were struggling to get their work done and that it was not acceptable or her expectation but the facility needed more staff because there was no way the nurses or the nurse aides could get it all done.	F 314		

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F 314	Continued From page 50 She further stated Nurse #10 was a contracted nurse and was advised to only administer medications on 06/27/15 and that another nurse would do the dressing changes if there was time. On 06/27/15 at 5:32 PM, Nurse #2 stated the dressing change was not completed on first shift and she was behind on administering medications and did not have the time to do the dressing change. No observation of the wound was done during the survey. 3. Resident #101 was admitted to the facility on 06/08/15 with diagnoses which included chronic respiratory failure, anxiety, and ulcers of the heel and mid-foot. The admission Minimum Data Set (MDS) was unavailable and per the MDS Coordinator it was overdue. The 5 day MDS indicated Resident #101 was severely cognitively impaired. There was no care plan available for review for Resident #101. A review of physician's orders dated 06/08/15 indicated: right lateral heel eschar, paint with betadine and wrap with kerlix every day shift related to ulcer of the heel and mid-foot. Further review indicated a physician's order dated 06/09/15 to have weekly skin assessments/review completed every evening shift every Wednesday. Review of the Treatment Administration Record (TAR) for the month of June 2015 revealed there were no nurse initials on the TAR to indicate dressing changes had been done to Resident #101's right lateral heel on 06/09/15, 06/11/15,	F 314		

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F 314	Continued From page 51 06/16/15, 06/19/15, 06/20/15, or 06/21/15. The TAR further revealed that the weekly skin assessments had not been completed for Resident #101 on 06/09/15, 06/17/15, or 06/23/15. Resident #101 was discharged to the hospital on 06/24/15 for a psychiatric evaluation and no observations were made during the time of the survey. On 06/26/15 at 4:38 PM an interview was conducted with Nurse #4. He stated he was aware of the physician's orders for dressing changes and weekly skin assessments for Resident #101. He indicated he was responsible for the weekly skin assessments for Resident #101 on 06/09/15, 06/17/15, and 06/23/15. Nurse #4 confirmed he had not completed the skin assessments for Resident #101 and indicated the weekly skin assessments were not completed due to the shortage of nursing staff. He further stated the weekly skin assessments and/or dressing changes were not done because he did not have time to do the skin assessments on those days. On 06/27/15 at 10:45 AM a telephone interview was conducted with Nurse #7. She stated she was aware that Resident #101 had orders for dressing changes to the right lateral heel every day on the shifts she had worked. She indicated the month of June was very difficult related to a severe decline in staffing and she was unable to complete the dressing changes for Resident #101 every day as ordered. She further indicated if her initials was not documented on the TAR that meant she had not had the opportunity or time to do the dressing changes. She indicated "there	F 314		

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were many days there was not enough staff and there just was not enough time to get everything done." She stated the Nurse Aides (NAs) was expected to turn and reposition the residents every 2 hours, keep them clean and dry, and also assist with the showers but due to the nurse aide and nurse staffing shortage the residents were not being turned and/or repositioned, showers were not being given, and residents would have to wait for 2 to 3 hours to be cleaned and dried. She verified she was responsible for the dressing changes for Resident #101 on 06/09/15, 06/11/15, 06/16/15, 06/19/15, 06/20/15, and 06/21/15. She indicated she did not have time to do the dressing changes on those days.

On 06/27/15 at 2:30 PM an interview was conducted with the Director of Nursing (DON). She stated she was aware the nurses were struggling to get their work done and that it was not acceptable or her expectation but the facility needed more staff because there was no way the nurses or the nurse aides could get it all done.

4. Resident # 103 was admitted to the facility on 06/17/15 with diagnoses which included traumatic brain injury, pressure wound to the left side of the head, and aphasia (inability to communicate).

An admission Minimum Data Set (MDS) for Resident #103 was not available. The MDS Coordinator stated she had not had an opportunity to complete the MDS.

There was no care plan available for review for Resident #103.

A review of physician's orders dated 06/17/15 indicated weekly skin assessments/review every

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F 314	Continued From page 53 evening shift every Wednesday and pressure wound to the left side of the head to be cleansed with normal saline moist gauze with each dressing change, apply silvadine on normal saline moist gauze twice daily. Review of the Treatment Administration Record (TAR) for the month of June 2015 revealed there were no nurse initials on the TAR to indicate dressing changes had been done to the left side of Resident #103's head on 06/20/15, 06/21/15, 06/24/15, or 06/25/15. The TAR further revealed that the weekly skin assessments had not been completed for Resident #103 on 06/24/15. On 06/26/15 at 2:25 PM, Resident #103 was observed lying in the bed on her back, her eyes opened, non-verbal, and her neck/head turned to the right side. On 06/26/15 at 2:30 PM, an interview was conducted with Resident #103's family member. She stated the pressure sore to the left side of the head was caused by the resident's Geri-chair she used when she lived at home. On 06/26/15 at 4:02 PM, Resident #103 was observed lying in the bed on her back, her eyes opened, non-verbal, and her neck/head turned to the right side. On 06/26/15 at 4:38 PM an interview was conducted with Nurse #4. He stated he was aware of the physician's orders for dressing changes and weekly skin assessments for Resident #103. He indicated he was responsible for the weekly skin assessment for Resident #103 on 06/24/15 and for the evening shift dressing changes to Resident #103's wound on the left	F 314		

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F 314	Continued From page 54 side of the head. Nurse #4 confirmed he had not completed the skin assessments for Resident #103 and/or the dressing change and indicated the weekly skin assessments or the dressing changes were not completed on those days due to the shortage of nursing staff. He further stated the weekly skin assessments and/or dressing changes were not done because he had not had the time to do the skin assessment or the dressing change on 06/24/15 or 06/25/15. On 06/26/15 at 6:12 PM, Resident #103 was observed lying on her back in bed, her neck/head turned to the right side, and her eyes closed. On 06/27/15 at 9:12 AM, Nurse #11 was asked if she would be doing a dressing change for Resident #103 on 06/27/15. Nurse #11 stated she was a contracted nurse and was hired to only administer the resident's medications and she was unaware of any dressing changes which needed to be done. On 06/27/15 at 10:15 AM, Resident #102 was observed lying on her back, in her bed, her eyes closed, and her neck/head remained turned to the right side. On 06/27/15 at 10:45 AM a telephone interview was conducted with Nurse #7. She stated she was aware that Resident #103 had orders for dressing changes to the left side of her head twice daily and the dressing changes were supposed to be done on first shift and second shift every day. She indicated the month of June was very difficult related to a severe decline in staffing and she was unable to complete the dressing changes for Resident #103 when she worked first shift every day as ordered. She	F 314		

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F 314	Continued From page 55 further indicated if her initials were not documented on the TAR that meant she had not had the opportunity or time to do the dressing changes. She indicated "there were many days there was not enough staff and there just was not enough time to get everything done." She stated the Nurse Aides (NAs) were expected to turn and reposition the residents every 2 hours, keep them clean and dry, and also assist with the showers but due to the nurse aide and nurse staffing shortage the residents were not being turned and/or repositioned. She verified she was responsible for the dressing changes for Resident #103 on 06/20/15 and 06/21/15. She indicated she did not have time to do the dressing changes on those days. On 06/27/15 at 2:30 PM an interview was conducted with the Director of Nursing (DON). She stated she was aware the nurses were struggling to get their work done and that it was not acceptable or her expectation but the facility needed more staff because there was no way the nurses or the nurse aides could get it all done. She further stated Nurse #11 was a contracted nurse and was advised to only administer medications on 06/27/15 and that another nurse would do the dressing changes if there was time. On 06/27/15 at 5:32 PM, Nurse #11 stated she was scheduled to work 7:00 AM until 7:00 PM and the dressing change had not completed and that she was behind on administering medications and did not have the time to do the dressing change. She further stated she was unaware of any dressing changes for the residents on the hall she was working on 06/27/15. No observation of the wound was done during the survey.	F 314		

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5. Resident #58 was admitted to the facility on 03/27/15 with diagnoses of neurogenic bladder, diabetes and a stage 3 pressure ulcer. The admission Minimum Data Set (MDS) dated 04/03/15 revealed Resident #58 was cognitively intact and required extensive assistance for bed mobility and personal hygiene and was dependent for transfers and bathing. The MDS further indicated Resident #58 had a stage 3 pressure ulcer.
Review of the care plan dated 04/23/15 revealed Resident #58 had a sacral ulcer and was at risk for further breakdown. The goal was for the pressure ulcer to heal without complication. Interventions included conduct weekly skin inspection, provide pressure reducing device to bed and wheelchair, provide thorough skin care after incontinent episodes and apply barrier cream, treatments as ordered, when resident is observed not off-loading remind him to reposition off wound and wound vacuum assisted closure (VAC), wound healing through negative pressure wound therapy as ordered.
Review of the Physician order dated 06/19/15 revealed Resident #58's wound VAC should be restarted at 150 millimeters of mercury (a measure of pressure). Change Monday, Wednesday and Friday and as needed if the seal breaks and if unable to trouble shoot and get a seal then call representative for assistance. If the seal is unable to be made then remove the wound VAC and apply adkins solution (wound healing solution) ¼ strength on fluffed bandage twice a day to the wound and reattempt wound VAC seal the next day.
An observation made on 06/24/15 at 10:19 AM of Resident #58 revealed his Wound VAC did not

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F 314	Continued From page 57 have a seal and was not working but in place over the wound. During an interview on 06/24/15 at 10:20 AM with Resident #58 he stated the wound VAC had lost its seal around 2:00 AM on 06/24/15. Resident #58 stated he reported the wound VAC not working to the 11:00 PM to 7:00 AM shift nurse and she told him she did not feel comfortable changing the wound VAC and would report to the oncoming shift the wound VAC needed to be changed. Resident #58 stated his wound VAC was still not working and the nurse should have taken it off and put a dressing over the wound until someone could get a new seal and reapply the wound VAC. An interview was attempted on 06/24/15 at 10:30 AM with the nurse that worked 06/23/15 11:00 PM to 7:00 AM shift but she was unavailable. During an interview on 06/24/15 at 3:44 PM with Nurse # 6 she stated she worked at the facility's sister facility and was asked to work at the Asheville facility on 06/24/15 due to short staffing. She stated she had worked in the facility before but never on the Medication or Treatment Carts. Nurse #6 stated Resident #58 asked her to change his wound VAC the first time she entered his room to give him his morning medications but she had not had time to change his wound VAC due to passing medications which took the entire shift. She further stated she had only completed one treatment during the eight hour shift and had passed that information on to the oncoming 3:00 PM to 11:00 PM nurse. A follow up interview conducted on 06/25/15 at 9:18 AM with Resident #58 revealed his wound VAC was changed on 06/24/15 at 11:55 PM by Nurse #1. During an interview conducted on 06/25/15 at 9:21 AM with the Wound Physician he explained	F 314		

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F 314	Continued From page 58 if the wound VAC lost the seal it should be removed and the wound should be covered with a dressing until the wound VAC can be reapplied with a good seal. He stated he was concerned that the wound VAC had remained in place with no seal and not working from 2:00 AM to 11:55 PM on 06/24/15. He further stated the fluid has nowhere to go when the wound VAC isn't working and that the old sponge is sitting in the fluid and could cause an infection to occur. During an interview conducted on 06/25/15 at 9:30 AM with Nurse #1 she confirmed she changed Resident #58's wound VAC on 06/24/15 around 12:00 AM. An interview conducted on 06/25/15 at 11:45 AM with the Director of Nursing (DON) revealed all facility nurses had been trained on the use of the wound VAC and it was her expectation that if the seal was broken or the wound VAC needed to be changed the nurse on duty should change it. 6. A record review revealed Resident #53 was admitted to the facility on 04/28/15 with diagnoses of cancer of the lung, diabetes, pressure ulcer to right buttock and below knee amputation. A record review of an admission Minimum Data Set (MDS) dated 05/05/15 revealed Resident #53 as having no cognitive deficits, no behaviors, and required supervision with bed mobility, transfers, toilet use and personal hygiene. Resident #53 was coded with a Stage II pressure ulcer present on admission as well as having lower impairment of right extremity related to below knee amputation. A record review of Resident #53's plan of care dated 05/06/15 revealed the resident was cognitively intact, at risk for pressure ulcers, required supervision with one person with activities of daily living (ADL). The goal was the resident would not have any additional pressure	F 314		

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F 314	Continued From page 59 ulcers and healing of current pressure ulcer. Interventions included incontinence care and provide assist with ADL's, weekly skin assessments, a pressure reducing mattress and cushion for wheelchair. On 04/28/15 a physician's order was written to cleanse area to left and right buttock with normal saline, cover with Tegaderm foam, change Monday, Wednesday and Fridays. A record review of the Treatment Administration Record (TAR) and nurse's notes revealed there was no documentation on the 7:00 AM to 3:00 PM shift that Resident #53 dressing changes for 06/10/15, 06/15/15 and 06/22/15 were completed. Dressings were documented on 06/01/15, 06/03/15, 06/05/15, 06/08/15, 06/12/15, 06/17/15, 06/19/15 and 06/25/15 on 7:00 AM to 3:00 PM as being completed. Interview with Nurse #7 on 06/25/15 at 8:00 AM revealed Resident #53 pressure ulcer to the right and left buttock were healed and needed no further dressing changes and had been discontinued. A record review for Resident #53 revealed there was no physician order to discontinue the dressing changes to the right and left buttock. On 06/26/15 at 4:30 PM the Director of Nursing revealed there was no physician order to discontinue Resident #53 dressing changes to the left and right buttock. On 06/26/15 at 4:45 PM observations were made of Resident #53 with the DON and revealed there were 2 dressings to the right and left buttock and there were no dates on the two dressings. The area under the dressing to the left buttock revealed no skin breakdown. The area under the dressing to the right buttock revealed an open area measuring 2.5 cm by 1 cm, Stage II wound. The area was cleaned with	F 314		

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F 314	Continued From page 60	F 314		

normal saline. The area was dried well and Mepliex was applied to cover the wound by Nurse #1. The DON stated she was going to reinstate the dressing changes. She further stated she did not know how the order for dressing changes was stopped. Nurse #1 stated she was going to call the physician and let him know the dressing had not been completed as ordered and to get a new order for dressing changes to the left buttock.

7. A record review revealed Resident #69 was admitted to the facility on 01/22/15 with diagnoses of bilateral ankle fractures, bilateral heel wounds, depressive disorder, diabetes, end stage renal failure, and peripheral vascular disease.

A record review of a quarterly MDS dated 04/20/15 revealed Resident #69 as having no cognitive deficits, no behaviors, and required extensive assist of 1 person for bed mobility and personal hygiene. The MDS further revealed Resident #69 required extensive assist of 2 staff for transfers, dressing and toilet use and she was frequently incontinent of bowel. Resident #69 was coded with 3 unstageable pressure ulcers with 2 of these unstageable pressure ulcers present on admission.

A review of Resident #69's plan of care dated 04/11/15 revealed resident was cognitively intact, had pressure ulcers on her left and right heel on admission and acquired a pressure ulcer to her buttock. She required extensive assistance with ADL including bed mobility, transfers, personal hygiene and toilet use.

On 06/23/15 a physician's order was written to apply Silvadene wet to moist dressing twice a day to left heel and ankle ulcers, and to apply Mepilex to right heel ulcer Monday, Wednesday and Friday every shift.

A review of the weekly skin assessment on 05/04/15 revealed Resident #69 had non healing

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F 314	Continued From page 61 wounds on bilateral heels, buttock red with open area treated with Duoderm which originated on 04/22/15. Observations were made on 06/25/15 at 8:20 AM of Nurse #3 changing the dressing to the left heel of Resident #69. The old dressing to the left heel was removed by Nurse #3. She used normal saline to loosen the dry areas on the wound. Nurse #3 cleaned the area covering the entire left heel and the right side of the ankle with normal saline and patted the wound dry with a sterile gauze. She applied Silvadene cream to 2 sterile gauze and applied the gauzes to the heel and the ankle. She wrapped the entire foot with a roll of gauze and applied the date and her initials to tape on the dressing. A record review of the TAR and nursing notes revealed Resident #69 Silvadene wet to dry wound dressing changes were not documented for 06/24/15 and 06/25/15 at 8:00 PM to left heel and ankle. There was documentation the dressing changes were done on 06/23/15 at 8:00 PM and 06/24/15, 06/25/15 and 06/26/15 at 8:00 AM. In an interview on 6/26/15 at 5:00 PM Nurse #4 revealed he did not complete the dressing for Resident #69 as ordered for 6/24/15 and 06/25/15 due to the facility being short staffed and he was not able to get to the dressing changes. On 06/26/15 at 5:00 PM the Director of Nursing revealed Nurse #4 did not change the dressing for Resident #69 due to there were not enough staff available. She stated she was aware there were staffing shortages causing care not to be completed as ordered.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	cont.	

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F 323	Continued From page 62 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews the facility failed to analyze the circumstances of 2 falls and failed to place an alarm on the bed of 1 of 7 residents reviewed for falls. (Resident #5) The findings included: Resident #5 was admitted to the facility 08/30/13 with diagnoses which included encephalopathy, episodic mood disorder, anxiety, personality disorder, depression and hemiplegia. A significant change Minimum Data Set (MDS) dated 06/05/15 noted Resident #5 required extensive assistance of two staff for transfers and bed mobility, had a history of falls with injuries including a fracture. The care plan for Resident #5 dated 12/04/14 included a problem area, At risk for falls. Approaches to this problem area to prevent falls included: -anticipate needs; assist as needed -bed alarm, chair alarm -call light or personal items available and in easy reach	F 323	F 323 A bed alarm was placed on Resident #5's bed on 6/25/15. All residents at risk for and have falls have the potential to be affected. The DNS/designee will review all care plans and update care cards accordingly to make sure all interventions are in place and identified on the care card. The DNS/designee will audit all residents to ensure fall interventions are in place. The DNS/designee will re-educate nursing staff on checking placement and function of fall interventions. The Interdisciplinary team reviews the fall- post fall analysis/plan and makes additional recommendations within 72 hours of the fall. Falls are reviewed weekly during "at risk" meetings.	7-25-15

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F 323	Continued From page 63 -fall mats at bedside -keep call bell within reach at all times while in bed -keep environment well lit and free of clutter Review of the medical record of Resident #5 noted a fall out of bed on 03/14/15. The investigation report related to this fall was provided by the Director of Nursing (DON) on 06/25/15. The investigation included the following: Found resident sitting on floor at bedside. Stated she fell out of bed. Stated she did not hit her head. No apparent injuries noted. Pupils equal and react equally. Neuro status at baseline for resident. The post fall analysis/plan indicated Resident #5 rolled out of bed, had impaired safety awareness and was reaching for something. The investigation did not include any additional information. The care plan for Resident #5 was updated 05/13/15 and included the problem area, At risk for falls. Approaches to this problem area to prevent falls included: -anticipate needs; assist as needed -bed alarm, chair alarm -call light or personal items available and in easy reach -fall mats at bedside -keep call bell within reach at all times while in bed -keep environment well lit and free of clutter Review of the medical record of Resident #5 noted a nursing progress note dated 06/01/15 at 8:22 AM which read, Resident was observed lying on her right side in the floor, next to her bed at 5:20 AM. She stated she fell out of her bed. She was complaining of severe pain in her left knee.	F 323	The DNS/designee will audit 6 residents with fall interventions weekly x 4 weeks then 3 residents weekly x 4 weeks, then 6 residents monthly x 1 month. The results of the audits will be reported in the monthly Quality Assurance Committee meeting for 3 months to ensure quality care and compliance. Compliance Date 7-25-15	

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F 323	Continued From page 64 Has normally very stiff joints and normally confused. Is incontinent of urine. She has a history of cerebrovascular accident with hemiparesis. Resident is on Coumadin. Possible injury to left knee. Increased pain to left knee with range of motion. Both upper extremities are strong and no pain on range of motion. Family Nurse Practitioner notified. Resident transported to hospital emergency room via emergency medical services at 5:55 AM 06/01/15. At 10:47 AM a nurses progress note in the medical record of Resident #5 read, Per physician's assistant at emergency room, resident sustained a right distal femur fracture. Physician orders after the fall included no weight bearing on Resident #5's left lower leg and Norco (a narcotic) for pain management. The nursing assistant care guide was observed in a book at the nursing station and was identified by the administrator on 06/22/15 at 4:00 PM as the source for nursing assistants to reference individual resident care needs. The care guide was noted as last updated 06/22/15 and indicated Resident #5 was at risk for falls but did not include any specific interventions. On 06/24/15 at 7:15 PM Resident #5 was observed in bed. A bed alarm was not in place on the resident's bed. Fall mats were beside both sides of the resident's bed. On 06/25/15 at 5:06 PM Resident #5 was observed in bed. A bed alarm was not in place on the resident's bed. Fall mats were beside both sides of the resident's bed. On 06/25/15 at 4:35 PM the DON stated falls investigations were completed by the nurse on duty at the time of the fall. The DON stated fall	F 323		

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F 323	Continued From page 65	F 323		

investigation were reviewed the day after a fall during the staff morning meeting. The DON stated when the investigation was reviewed at morning meeting staff checked to see what the circumstances surrounding the fall were, if there were injuries, if the resident was interviewed (if appropriate) and measures to prevent another incident. At the time of the interview the DON provided the facility investigation into the 06/01/15 fall out of bed for Resident #5. The investigation included the same information as contained in the 06/01/15 nursing progress note (referenced above). Additional information in the investigation included, Resident was too confused to state how the fall happened, resident was last toileted at 3:00 AM and the diaper, at the time she fell, was minimally wet. The Summary and Outcome of investigative findings included, "needs fall mats on both sides of bed." The investigation did not indicate if fall mats were in place, if the bed alarm was in place and/or sounding and if the call bell was in place or engaged at the time of the fall on 06/01/15. The DON reviewed the investigation and stated she did not know if the fall mats were in place or if the call bell and bed alarm were in place and/or engaged. The DON stated usually that would be looked into at the time of the investigation and did not know why that information was not included to know what approaches needed to be implemented to prevent further falls. The DON stated that, after the investigation the resident's family called asking questions about the fall and fracture. The DON stated it was at that time that she spoke with staff and the resident to determine what happened. The DON stated she did not gather any additional information from staff. The DON stated the resident reported she was trying to get out of bed though the DON noted the resident's information

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F 323	Continued From page 66 was not always reliable. During the interview the DON went to the room of Resident #5 at 5:06 PM and could not explain why the bed alarm was not in place on the bed of Resident #5. The DON reported the nursing assistant care guides were updated by the Minimum Data Set Coordinator (MDS) and could not explain why the nursing assistant care guide for Resident #5 did not indicate the need for fall mats or a bed alarm. On 06/25/15 at 5:10 PM the MDS coordinator stated she felt the 06/01/15 fall out of bed involving Resident #5 was an isolated incident because the resident usually didn't attempt to get out of bed. The MDS coordinator stated the falling star on the care guide would indicate the need for the alarm in the resident's chair and bed. The MDS coordinator could not explain why the fall mats were not identified on the care guide. On 6/26/15 at 2:55 PM Nurse Aide #3 stated she was familiar with Resident #5 and noted that a bed alarm was usually in place on the bed. NA #3 could not explain why the bed alarm was not on the bed 06/24/15 and 06/25/15. In a follow-up interview on 06/27/15 at 10:25 AM the DON was asked about the investigation of the fall out of bed for Resident #5 which occurred on 03/14/15 to determine if the fall mats and bed alarm were in place at the time of the fall. The DON stated the fall occurred before she began employment at the facility and she could not locate any additional information or investigation. The DON stated the staff member that was involved with the fall was no longer employed at the facility and she was unaware of contact information.	F 323		

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F 323	Continued From page 67 The care plan for Resident #5 was updated 06/18/15 after the fall with fracture and included the same problem area and interventions as the care plan dated 05/13/15.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to administer an anti-epileptic medication at the scheduled time ordered by the physician for 1 of 5 sampled residents. (Resident #50) The findings included: Resident #50 was admitted to the facility on 06/25/14 with diagnoses of non-Alzheimer's dementia and depression. The significant change Minimum Data Set (MDS) dated 04/10/15 revealed Resident #50 was moderately cognitively impaired but was able to understand others and others could understand her. Review of the physician orders revealed Resident #50 was to receive Keppra, (an anti-epileptic drug used to treat seizures) 500 milligrams (mg) three times a day at 8:00 AM, 12:00 PM and 4:00 PM for a head injury. Review of the medication administration record dated 06/24/15 revealed Resident #50 received Keppra 500mg at 3:29 PM and 500mg at 3:34 PM administered by Nurse #6. During an interview on 06/24/15 at 3:44 PM Nurse #6 explained she had been pulled from the sister facility to work at the Asheville facility on	F 333	F333 Resident # 50's physician was notified of medication effect. Resident suffered no ill effects from receiving 2 doses of Keppra close together. 7-25-15 All residents receiving medications have the potential to be affected. The Director of Nursing/designee will audit all medications administered to assure they are administered timely and a physician has been contacted, when medicines are required to be dispensed close together. cont.	

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F 333	Continued From page 68 06/24/15 due to short staffing. She stated she had never worked the medication cart at this facility and she was not familiar with the cart or residents and it took her longer to get medications passed. Nurse #6 stated she gave Resident #50's 8:00 AM dose of Keppra 500mg at 3:39 PM and her 12:00 PM dose of Keppra 500mg at 3:34 PM on 06/24/15. She further stated she did not call the physician to report the late medication dose or ask if the 2 doses could be given together. An interview was conducted with the Director of Nursing on 06/25/15 at 12:06 PM. She stated if medications were given late it was her expectation that the physician be notified and a medication variance report be completed. She stated it was not acceptable to give the 8:00 AM and 12:00 PM medications at the same time without consulting with the physician first.	F 333	Cont. F333 The DNS/ designee will educate license nurse, including newly hired nurses, on administering medications in a timely fashion and notifying physician for direction when need to administer 2 doses of medication close together. The DNS/designee will audit medication administration time on 6 residents weekly x 4 weeks. then 3 residents weekly x 4 weeks, then 6 residents monthly x 1 month. The results of the audits will be reported in the monthly Quality Assurance Committee meeting for 3 months to ensure quality care and compliance.	7-25-15
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.	F 353	F353 The facility has implemented daily staffing report to the Director of Nursing effective June 29, 2015, to assure that the facility operated according to Guidelines to assure adequate staffing is available to care for the resident population. Cont.	7-25-15

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F 353	Continued From page 69 Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews the facility failed to provide sufficient nursing staff to meet the needs of 63 residents present in the facility with a bed capacity of 77 residents in the areas of timely medication administration, services to meet activity of daily living needs and services to treat pressure sores. (Residents #5, #11, #23, #34, #50, #52, #53, #58, #69, #101, #103) The findings included: This tag is cross referred to: 1a. F312 Based on observation, record review, and staff interviews, the facility failed to provide personal hygiene for dependent residents in need of showering, shaving, and finger nail care for 4 of 12 residents reviewed for activities of daily living (Residents #52, #11, #5, and #50). b. F314 Based on observations, record review, resident, staff, and physician interviews, the facility failed to provide dressing changes as ordered and/or complete weekly skin assessments as ordered for 6 out of 7 residents reviewed for pressure sores and failed to change a wound vacuum assisted closure device (promote healing through negative pressure	F 353	cont. F353 The Director of Nursing Services, the Executive Director reviewed the facility's direct care staffing which is not limited to nursing personal, time and includes care provided by the Executive Director the Management Staff in the facility. These staffing levels will be reviewed to ensure adequate supervision of care and protection of the residents. on a daily basis. This process has been put in place to ensure staffing levels are adequate and consists of an analysis of the census of the facility, the acuity of the patients being cared for and a cont.	7-25-15 7-25-15

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F 353	Continued From page 70 wound therapy) for 1 of 1 resident reviewed for wound vacuum device to assist in pressure sore healing (Residents #34, #23, #101, # 103, #53, #69, and #58). c. F333 Based on medical record review and staff interview the facility failed to administer an anti-epileptic medication at the scheduled time ordered by the physician for 1 of 5 sampled residents resulting in a significant medication error. (Resident #50) 2. On 06/23/15 at 6:30 PM review of the staffing schedule noted Nurse #3 was the only nurse scheduled to work the 7:00AM-3:00 PM shift on 06/24/15 to care for 63 residents. On 06/24/15 at 7:32 AM an interview was conducted with Nurse #9 who stated he had worked the 11:00 PM to 7:00 AM shift the night before (06/23/15) on West Unit and was pulled to East Unit to continue working on the 7:00 AM to 3:00 PM shift until Nurse #6 (from a sister facility) could come and relieve him of his duties. Nurse #9 shared the facility was short staffed and he was the only nurse working on East Unit front and back hall to administer medications and obtain blood sugars at 7:30 AM prior to breakfast for residents. Nurse #9 stated there are normally 2 nurses working on East Unit during the 7:00 AM-3:00 PM shift. Nurse #9 stated Nurse #3 was caring for residents on the West Unit of the facility through the 7:00 AM-3:00 PM shift that morning. On 06/24/15 at 11:58 AM an interview was conducted with Nurse #6 who stated she arrived at the facility late to relieve Nurse #9 who had worked the night shift (11:00 PM to 7:00 AM). Nurse #6 stated she had not begun administering medications to residents on East Unit front and	F 353	cont. F353 determination of how to adjust staffing ;and resources to those patient needs. The Executive Director and/or designees will review staffing levels and allocations daily to ensure adequate staff present and allocated appropriately for continued compliance and reconcile those staffing levels to ensure adequate supervision, care and protection. Meal coverage monitoring and walking rounds will be implemented by the Director of Nursing/designee and staffing coordinator with the goal and intent to provide more interaction, observation, and communication to ensure adequate supervision, care and protection. cont.	7-25-15

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GOLDEN LIVINGCENTER - ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

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F 353	Continued From page 71 back hall until after 9:00 AM. Nurse #6 stated the Director of Nursing (DON) was aware that she had not begun her shift until after 9:00 AM. Nurse #6 stated she was not able to administer 8:00 AM medications to residents on East Unit front and back hall on time because she was running behind because of starting her shift late. Nurse #6 stated Nurse #9 was only able to obtain resident blood sugars and administer insulin for residents on East Unit front and back hall prior to Nurse #6 relieving him of his duties. In a follow-up interview on 06/24/15 at 3:47 PM Nurse #6 stated she just completed her morning medication pass and knew medications were late being administered to residents. Nurse #6 stated the late medications was due to the late start and unfamiliarity with the residents. Nurse #6 stated by the end of her shift she was only able to do one treatment and reported that to Nurse #1 that relieved her at 3:00 PM. On 06/26/15 at 3:00 PM a telephone interview was conducted with Nurse #1 who stated she relieved (7:00 AM to 3:00 PM) Nurse #6 on 06/24/15 and begun working her 3:00 PM to 11:00 PM shift. Nurse #1 stated she had to assist administering the 7:00 AM to 3:00 PM shift medications to residents prior to administering medications that were due for residents on her shift. Nurse #1 stated she was late administering medications to residents on the 3:00 PM to 11:00 PM shift on East Unit front and back hall because she had to finish the 7:00 AM to 3:00 PM medication administration. Nurse #1 stated Nurse #6 had not completed any treatments for residents on East Unit front and back hall during the 7:00 AM to 3:00 PM shift. Nurse #1 stated she had to choose which treatments she felt were	F 353	LD: The facility has determined that all residents have the potential to be affected by the alleged deficient practice. Measures to prevent recurrence of the alleged deficient practice are multifold and as follows: 1. The Director of Nursing upon notification will assure that the facility does not operate below the minimum requirements to meet the needs of the residents. 2. The facility staff has been trained on the attendance policy and a system implemented to assure that call-offs are addressed progressively so that staff who have attendance problems are ultimately removed from the facility staff roster and replaced with employees who are able to work more reliably: 3. An aggressive recruitment and orientation program will be started for new licensed	7-25-15

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F 353	Continued From page 72 the most important to complete and chose 2 residents on East Unit to do treatments, noting some treatments were not done. Nurse #1 stated for the past month there had been staffing issues and it was not uncommon for treatments to not be done or medications to be administered late to residents due to staffing issues. . 3. On 06/26/15 at 8:06 AM an interview was conducted with Nurse #2 who stated she was the only nurse working 7:00 AM to 3:00 PM on East Unit front and back hall. Nurse #2 stated usually there were two nurses present on the 7:00 AM to 3:00 PM shift on East Unit. Nurse #2 stated she was the only nurse to administer medications, provide treatments, admit residents and deal with issues during the shift for residents on front and back hall. Nurse #2 stated medication administration would be late for residents but she would assure blood sugars would be completed on time for residents. Nurse #2 stated the past month there had been staffing issues. In a follow-up interview on 06/26/15 at 3:30 PM Nurse #2 stated it had been a challenge to get medications passed to residents during her shift. Nurse #2 stated medications were late being given due to being the only nurse during her shift on the East Unit. Nurse #2 stated she was not able to do treatments during her shift but that management nursing staff assisted with doing treatments for residents on East Unit. 4. On 06/26/15 at 11:35 AM Nurse #10 stated she was formerly employed with the facility for about a month and left due to staffing issues. Nurse #10 stated she was working in a management capacity and had not been trained on the electronic medication administration	F 353	and direct care staff being added to the staff roster so that vacant positions are at a minimum. See Plan of Correction for F312 for education, correction, monitoring and QAPI reporting. See Plan of Correction for F314 for education, correction, monitoring and QAPI reporting. See Plan of Correction for F333 for education, correction, monitoring and QAPI reporting. Executive Director will report results of daily staffing, attendance, and recruitment efforts to QAPI committee for 6 months. compliance Date	7-25-15

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F 353	Continued From page 73	F 353		

system. Nurse #10 stated there had been one day she had been asked to assist with passing medication the following morning and was told she would have another nurse to assist her. Nurse #10 stated she reluctantly agreed to the plan and, when she showed up the following day, not only was there not another nurse but she was the only nurse for East Unit. Nurse #10 stated there were normally two nurses assigned to East Unit on the 7:00 AM-3:00 PM unit and she was the only nurse for the entire unit. Nurse #10 stated medications were very late being administered and that she was not able to do any treatments for residents on East Unit assigned during her shift.

Review of time cards noted there were only two nurses in the facility during the 7:00 AM-3:00 PM shift on the day referenced by Nurse #10.

5. On 06/27/15 at 10:00 AM Nurse #2 stated she was the only nurse working the 7:00 AM to 3:00 PM shift on East Unit. Nurse #2 stated there were usually two nurses present on the 7:00 AM to 3:00 PM shift on East Unit. Nurse #2 stated she was overwhelmed with the work load and that medications would be late being administered to residents on the unit.

In a follow-up interview on 06/27/15 at 5:00 PM Nurse #2 stated she was not able to do treatments on East Unit during her 7:00 AM-3:00 PM due to the staffing issue.

6. On 06/27/15 from 2:30 PM-3:50 PM the Director of Nursing (DON) was interviewed about staffing. The DON stated she began employment at the facility the end of April 2015 and was at the facility on an interim basis. The DON stated

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F 353	Continued From page 74 when she first started working at the facility the Assistant Director of Nursing (ADON) was responsible for the staffing schedule. The DON stated when she first started there were a total of three nurses for the day and evening shift (two on east unit, one on west unit) and two nurses on night shift. The DON stated that shortly after she started working at the facility there was a directive to decrease nurse staffing to three nurses for the days shift (two on east wing and one on west wing), two on evening shift and two on night shift. The DON stated her expectation was for nurses to be staffed accordingly and noted there had been times it was a struggle to meet the need due to the number of nurses available to cover all shifts. The DON stated there had been days when there had not been three nurses for days and two for evening and night shift. The DON stated when she first came to the facility there were 12 full time nurses to cover all shifts and now the number was down to 9 nurses. The DON stated there have been no applications by nurses in spite of running advertisements for nursing positions. The DON stated the available nurses had been working long hours and knew they were exhausted. The DON stated there was currently not an ADON, noting the position had been vacant for a couple weeks. The DON stated when there were less than three nurses for days and two for evening and nights either herself or the ADON would try to help out by processing physician orders or doing resident skin assessments. The DON stated there had been 3 instances their sister facility provided nursing staff to meet needs. The DON stated the staffing problem had become worse the past two weeks which resulted in medications being administered late to residents.	F 353		

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F 353	Continued From page 75 The DON reported that on day shift 06/24/15 she was working to the last minute on staffing and that it ended up being a disaster. The DON stated they had called the three staffing agencies contracted with the facility attempting to find coverage. The DON stated because of the staffing issues on 06/24/15 she found out medications were late and treatments did not get done. The DON stated she was not aware some residents received their 8:00 AM and 12:00 PM scheduled medications at the same time and should have been informed of such. The DON stated she was not told the nurse that came to assist from a sister facility only got one treatment done before she left. The DON reported that on day shift 06/26/15 the three agencies the facility contracts with were called to attempt to meet the staffing needs. The DON stated they did not get a response from the agencies which resulted in only one nurse during day shift on east unit. The DON acknowledged it was not acceptable and would be a challenge to the one nurse attempting to meet all resident needs during the day shift on east unit. The DON stated they attempt to get coverage by calling the 3 contract agencies, by calling the few staff they have in the as needed (PRN) pool or have staff adjust their schedule by either staying over their assigned time or coming in earlier than their assigned time. The DON stated the Social Worker and a staff member in the business office are also nursing assistants and they would help out at times. The DON stated the administrator, Medical Director and corporate consultants were all aware of the staffing challenges and had not offered any	F 353		

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F 353	Continued From page 76 solutions to the problem. The DON stated she did not have a plan to deal with the staffing issues. The DON stated she was aware medications were late and, when the physicians were notified of late medications, they were not pleased. The DON stated in addition to the need for nurses and nursing assistants there currently was not an Assistant Director of Nursing, Staff Development Coordinator, Infection Control Nurse or Admissions Coordinator. The DON stated some of the care areas identified during the survey were related to staffing challenges. 7. On 06/15 at 5:00 PM the administrator stated she began working at the facility April 2015. The administrator stated she was aware there were staffing challenges and posted ads for nursing positions. The administrator stated they had little response to the ads by nurses and was aware there were challenges with staffing at the facility. The administrator stated they began using agency staff in June and had contracts with three staffing agencies. The administrator stated in addition to nursing coverage there was a need for a Director of Nursing and Assistant Director of Nursing. The administrator stated although she was aware medications were late being administered on East Unit on 06/24/15 she was not aware treatments did not get done during both first and second shift on East Unit. The administrator stated she didn't know what else to do to address the staffing issue and that the corporate office was aware they were offering bonuses, advertising and getting contracts with agencies to attempt to meet the staffing needs.	F 353		

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F 360	Continued From page 77	F 360		
F 360 SS=D	483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interview the facility failed to serve ice cream as part of the fortified meal plan to 1 of 5 residents reviewed with nutritional needs. (Resident #29) Resident #29 was admitted to the facility 06/11/12 with diagnoses which included anxiety, depression and pernicious anemia. The current care plan for Resident #29 was last updated 04/01/15 and included the following problem areas: -Inadequate oral food/beverage intake. Approaches to this problem area included fortified foods with meals. -Chewing difficulty as related to partial or complete edentulism, oral lesions and impaired tongue movement. An approach to this problem area included fortified foods with meals. The weights for Resident #29 as documented in the medical record included the following: 09/05/14 136 12/03/14 135 01/13/15 135 02/09/15 126	F 360	F360 Resident # 29 was served ice cream as ordered and staff was instructed to read and honor what is on the tray tickets. All residents who have orders for fortified foods will be reviewed to assure residents are receiving food as ordered. The Dietary Staff will be in-serviced on reading tray cards to assure that the fortified foods are placed on the appropriate trays. A Dietary Manager/Designee will conduct audits for the tray line to assure the fortified foods are available as ordered 5 times per week for 4 weeks, then 3 times per week. The audits will be reported to the monthly QAPI committee x3 months to assure ongoing compliance. Compliance Date	7-25-15 7/25/15

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F 360	Continued From page 78 03/04/15 128 04/05/15 127 05/07/15 124 06/12/15 127 Physician orders in the medical record of Resident #29 noted a diet order for a mechanical soft diet and no dietary supplements (providing calories/protein) were ordered between meals. A nutrition progress note in the medical record of Resident #29 dated 04/21/15 noted the weight loss of Resident #29 and that the diet order was a mechanical soft diet with fortified food provided at each meal. The plan, per the progress note, was to continue supplementation of the resident's diet. Resident #29 was observed eating supper in her room on 06/22/15 at 5:40 PM. The tray card for Resident #29 noted ice cream should be served with the meal as part of the fortified meal plan. Ice cream was not included with food served at the supper meal for Resident #29. Resident #29 was observed eating supper in her room on 06/23/15 at 6:14 PM. The tray card for Resident #29 noted ice cream should be served with the meal as part of the fortified meal plan. Ice cream was not included with food served at the supper meal for Resident #29. Resident #29 was observed at the supper meal on 06/24/15 at 6:00 PM with ice cream included with the supper tray and was observed eating the ice cream. On 06/26/15 at 6:35 PM the Food Service Director stated ice cream was part of the fortified program and should have been included on the supper tray of Resident #29. The Food Service Director stated it was an oversight the ice cream was not served at the supper meal for Resident	F 360		

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F 360	Continued From page 79 #29 on 06/22/15 and 06/23/15.	F 360		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interview the facility failed to provide palatable food for 4 of 5 residents reviewed for food palatability (Resident #72, #41,#100, #69). The findings included: 1. Resident # 72 was admitted to the facility on 05/06/14 with diagnoses of diabetes and chronic kidney disease. Review of the quarterly Minimum Data Set dated 05/20/15 revealed Resident #72 was cognitively intact, able to make herself understood and able to understand others. Resident #72 was interviewed on 06/24/15 at 11:00 AM. During the interview the resident voiced a concern that food served at the facility did not always taste good, look good or cooked properly. He stated the meat is very tough, the scrambled eggs look like a sponge and have a green tint to them and the bacon is burned 90% of the time. He further stated the food is cold when it is served. An observation was made on 06/25/15 at 9:30 AM of Resident #72's breakfast tray. The scrambled eggs were in a mound form and Resident #72 placed his fork in the center of the	F 364	The Dietary Cooks and Dietary Aides were in-serviced on food preparation methods to conserve nutritive value, flavor, appearance and that the food is palatable and at the proper temperature. Residents #72, #41, #100, and #69 are receiving palatable. Each residents will receive palatable food Test trays will be audited to assure taste, temperature and appearance are acceptable. Menus and recipes will be followed to assure palatable, nutritious food that will be served at appropriate temperatures. The Dietary Manager/Designee will conduct audits 10 times per week, to assure that the meals are appealing and that the food is palatable tasting food 5 times per week, for 3 weeks. A QAPI will be performed by the Dietary Manager/Designee and will be reviewed by the QAPI committee monthly for 3 months to assure ongoing compliance. Compliance DATE	7-25-15 7-25-15

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F 364	Continued From page 80 eggs and picked them up all at once. Resident #72 placed 2 pats of butter on his cream of wheat and it did not melt during the breakfast observation. The resident stated the eggs, cream of wheat and toast were cold. On 06/27/15 observations were made of food trays delivered to 100 hall at 8:58 AM. The trays were passed and staff assisted residents with their meal by 9:15 AM. The test tray was delivered for tasting at 9:15. The scrambled eggs were spongy with green hue and did not have a good flavor. The biscuit was covered with a greasy sausage gravy and the gravy did not have a good flavor, and there was a film on the gravy. The bacon strip was cold with a greasy film. There was butter on top of the bowl of oatmeal and the butter did not melt. The corporate facility staff member witnessed the testing since the Dietary Manager was not available. She stated "No I won't taste it, I can see what you are talking about. I would not serve this to my loved one." 2. Resident #100 was admitted to the facility on 06/07/15 with diagnoses which included coronary artery disease, kidney disease, depressive disorder, abdominal aneurysm, and hypertension. The admission Minimum Data Set (MDS) dated 06/12/15 coded resident as having no cognitive deficits, was capable of making his needs known. On 06/23/15 at 10:29 AM Resident #100 was observed in his room with his unfinished breakfast tray in front of him. Resident #100 revealed the food was not appetizing and was served cold and the meats were not cooked properly.	F 364		

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F 364	Continued From page 81 On 06/25/15 at 9:00 AM Resident #100 was observed in his room eating his breakfast, he complained the breakfast food was always cold. He was served scrambled eggs and cream of wheat. The scrambled eggs were cold and he had a spoon stuck in the center of the cream of wheat and the spoon stayed upright. On 06/25/15 at 6:00 PM Resident #100 was observed in his room with his supper tray in front of him. He stated the tea tasted like dish water and the food was not appetizing and the soup was always served cold. On 06/26/15 at 8:30 AM Resident #100 was observed in his room eating his breakfast and he stated his breakfast was cold. On 06/22/15 at 6:00 PM observations were made of the 100 hall supper trays being passed. The tray cart arrived on the hall at 6:00 PM. Resident #100 received his tray at 6:25 PM. The last tray was passed at 6:36 PM. On 06/26/15 observations were made of food trays being delivered to the 100 hall at 1:07 PM with the last tray passed by 1:12 PM. The test tray was delivered at 1:13 PM. The ice cream was soft on top and around the sides. The middle of the ice cream was hard. The butter was cold and did not melt on the mashed potatoes. The chili was warm and the cole slaw was cold. The tea and water were cold. On 06/27/15 observation of food trays delivered to 100 hall at 8:58 AM. The trays were passed and staff assisted residents with their meal by 9:15 AM. The test tray was delivered for tasting	F 364		

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F 364	Continued From page 82 at 9:15. The scrambled eggs were spongy with green hue and did not have a good flavor. The biscuit was covered with a greasy sausage gravy and the gravy did not have a good flavor, and there was a film on the gravy. The bacon strip was cold with a greasy film. There was butter on top of the bowl of oatmeal and the butter did not melt. The corporate facility staff member witnessed the testing since the Dietary Manager was not available. She stated "No I won't taste it, I can see what you are talking about. I would not serve this to my loved one." Interview on 6/27/15 at 2:30 PM with Nurse Aide #1 revealed there were usually only 1 to 2 staff members who passed trays. She further revealed there were residents who required assistance with tray setup. Nurse Aide #1 stated it could take up to 1 hour to pass the trays to the residents. 3. A record review revealed Resident #69 was admitted to the facility on 01/22/15 with diagnoses of bilateral ankle fractures, bilateral heel wounds, depressive disorder, diabetes, end stage renal failure, and peripheral vascular disease. A record review of a quarterly MDS dated 04/20/15 revealed Resident #69 as having no cognitive deficits, no behaviors and was capable of making her needs known. On 06/22/15 at 6:10 PM observed Resident #69 supper tray. There was a rectangle piece of cheese pizza, with a piece of garlic bread on top of the pizza, salad with dressing, mandarin oranges and ice tea. Resident #69 states the pizza was cold and hard, and the garlic bread was soggy. Resident #68 stated her meals were served cold. On 06/23/15 at 9:05 AM observed Resident #69	F 364		

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F 364	Continued From page 83 in her bed with her breakfast on her bedside table over the resident. Resident #69 states the juice was watered down and the scrambled eggs were cold. On 06/24/15 at 6:25 PM observed Resident #69 eating her supper. She states there was a little meat on the sub sandwich and the bread for the sandwich was a hot dog bun not a sub roll. She further stated the stew tomatoes and the vegetable soup were cold. On 06/26/15 at 6:18 PM observed Resident #69 eating her supper. On Resident #69 tray there was chicken with Alfredo sauce and pasta, roll, salad with dressing and ice tea. Resident #69 stated the pasta was cold and hard. On 06/27/15 at 9:10 AM observed Resident #69 eating her breakfast. On Resident #69 tray was one whole biscuit in the center of her plate with gravy that covered the top and all around the biscuit. Resident #69 stated she could not eat the biscuit because it was too hard. On 06/22/15 at 6:00 PM observation of the west wing hall supper tray being passed. The tray cart arrived on the hall at 6:00 PM. There were 14 trays in the cart. Resident #69 received her at tray at 6:07 PM. The last tray was passed at 6:36 PM. On 06/26/15 observation of food trays delivered to 100 hall at 1:07 PM, last tray were passed by 1:12 PM. The test tray was delivered at 1:13 PM. The ice cream was soft on top and around the sides. The middle of the ice cream was hard. The butter was cold and did not melt on the mashed potatoes. The chili was warm and the cole slaw was cold. The tea and water were cold. On 06/27/15 observation of food trays delivered to 100 hall at 8:58 AM. The trays were passed	F 364		

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F 364	Continued From page 84 and staff assisted residents with their meal by 9:15 AM. The test tray was delivered for tasting at 9:15. The scrambled eggs were spongy with green hue and did not have a good flavor. The biscuit was covered with a greasy sausage gravy and the gravy did not have a good flavor, there was a film on the gravy and it had a poor appearance. The bacon strip was cold with a greasy film. There was butter on top of the bowl of oatmeal and the butter did not melt. The corporate facility staff member witnessed the testing since the Dietary Manager was not available. She stated " No I won't taste it, I can see what you are talking about. I would not serve this to my loved one." Interview on 6/27/15 at 2:30 PM with Nurse Aide #1 revealed there were usually only 1 to 2 staff members who passed trays. She further revealed there were residents who required assist with tray setup. Nurse Aide #1 stated it could take up to 1 hour to pass the trays to the residents. 4. Resident #41 was admitted to the facility on 05/18/15 with a diagnosis of Diabetes Mellitus. Review of Resident #41's Minimum Data Set (MDS) of 05/25/15 revealed she was cognitively intact, able to make herself understood and able to understand others. Resident #41 was interviewed on 06/26/15 at 10:15 AM. During the interview the resident	F 364		

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F 364	Continued From page 85 voiced a concern that foods served at the facility did not always taste good. The resident specified that she often received foods on her meal trays that were either overcooked or undercooked and lacked seasoning. Observations on 06/26/15 at 1:00 PM of Resident #41's lunch meal tray revealed she was served two potato wedges with this meal. The resident stated that the potato wedges were too hard to eat and when she turned one of the potato wedges over it was burned. The resident stated she could not eat the potato wedges and this was another example of the facility serving her food that she could not eat due to it being overcooked. An interview was conducted with the Dietary Manager (DM) on 06/26/15 at 4:35 PM. The DM confirmed the potato wedges served during the lunch meal of 06/26/15 were not seasoned properly and were overcooked. The DM stated she would work with the facility's cooks to ensure foods were cooked properly.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	F371 All affected food items were discarded and the ice scoop holder was cleaned. cont.	7-25-15

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F 371	Continued From page 86 by: Based on observation and staff interview the facility failed to 1) discard outdated foods, 2) store frozen foods in a manner to prevent ice crystallization and dry appearance, 3) ensure foods were dated and labeled, and 4) clean an ice scoop holder in the west wing pantry. Findings included: 1. An initial tour of the kitchen was conducted on 06/22/15 at 3:15 PM with the Dietary Manager. Observation of the dry storage area revealed 10 packets of Carnation Breakfast Essentials with an expiration date of 03/03/15 and 1 unlabeled and undated plastic bag containing 2 hamburger buns. Observation of the walk-in freezer on 06/22/15 at 3:25 PM revealed 1 freezer bag of meat with ice crystallization that was dry in appearance and not labeled with the type of meat it contained, 1 freezer bag containing pepperoni with no label with 2 dates on the outside of the bag that read 3/8/15 and 5/11/15, and 1 opened bag of diced chicken that was folded over and had ice crystallizations and appeared dry with a date of 5/17/15. On 06/22/15 at 3:20 PM an interview was conducted with the dietary manager who stated food supplies were to be checked daily for outdated and unlabeled food. The dietary manager verified the 10 packets of Carnation Breakfast Essentials should have been discarded and the hamburger buns in the plastic bag should have been labeled and dated. On 06/22/15 at 3:30 PM an interview was conducted with the dietary manager who stated any food in the freezer unlabeled, undated, or with the appearance of freezer burn should be discarded.	F 371	Cont F371 All ice scoop holders in the health care center were reviewed for cleanliness and were cleaned. An audit of stored products was performed by the Dietary Manager and any expired products were discarded. All dining staff were in-serviced on procedures for maintaining sanitary conditions in the kitchen, including food storage, disposing of out of date products, and cleaning the ice scoop holder properly, labeling and dating food. The Dietary Manager/Designee will audit Food storage for out of date items 5 times per week times 4 weeks, then 3 times per week for 4 weeks. The cleaning of the ice scoops and holders in both pantries will be audited daily times 3 weeks and them 5 times per week for 4 weeks. Audit of labeling and dating food will be done 5 times per week times 4 weeks, then 3 times per week for 4 weeks. cont	7-25-15

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F 371	Continued From page 87 2. Observations were made of a clear plastic ice scoop holder attached to the side of the ice machine in the west wing nourishment pantry on 06/26/15 at 9:40 AM. These observations were made in the presence of the Food Service Director (FSD) and corporate Registered Dietitian (RD). The ice scoop holder had a clear plastic removable insert with a lipped bottom and the ice scoop was stored in the insert. The base of the ice scoop was immersed in approximately 3/4" of water in the lipped area, at the bottom of the insert. When held up to light, there was clear, gelatinous appearing debris in the water. The water was discarded and the bottom of the ice scoop holder had a slimy looking appearance. The area at the bottom of the insert was felt and it was slimy across the entire bottom area of the insert and the slimly matter was easily removed with light pressure. The RD and FSD agreed the ice scoop holder needed to be cleaned and the FSD stated she had just started working at the facility and was not aware the dietary department was responsible for removing and cleaning the ice scoop holder in the nourishment pantry. The RD verified it was the responsibility of the dietary department to remove and clean the ice scoop holders in the nourishment pantry every day. The FSD and RD stated they could not determine the last time the ice scoop holder had been cleaned.	F 371	Cont. F371 The Dietary Manager/Designee will perform a QAPI and it will be reviewed by the QAPI committee monthly for 3 months to assure ongoing compliance. Compliance date 7-25-15	7-25-15
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	F431 No resident received the expired medication. cont	7-25-15

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F 431	Continued From page 88 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to remove 12 of 12 single dose vials of expired Lorazepam for injection from 1 of 2 medication storage refrigerators. The findings included:	F 431	F431 cont. F431 7-25-15 No resident received the expired medication. Medication storage areas including medication carts, closets will be audited for any expired medications by Director of Nursing/Designee. The Director of Nursing/Designee will re-educate license nursing staff on checking dates of medications. New hires, permanent and temporary will be educated on checking medications for expiration dates during orientation. Medication storage areas will be checked weekly by licensed nurses for any expired medications. The DNS/designee will audit medication storage areas weekly for	

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F 431	Continued From page 89 On 06/26/15 at 04:28 PM 8 vials of Lorazepam injectable with an expiration date of 09/01/14 and 4 vials of Lorazepam injectable with an expiration date of 04/01/15 were observed in the East Unit medication storage refrigerator in a locked controlled substance box. On 06/26/15 at 4:30 PM an interview was conducted with Nurse #8 who confirmed 12 of 12 single dose vials of Lorazepam injectable were expired. Nurse #8 immediately removed the expired Lorazepam injectable from the locked controlled substance box. Nurse #8 was observed providing the expired Lorazepam to the DON for disposal. On 06/26/15 at 4:40 AM an interview was conducted with Nurse #4 who stated nurses on the 11:00 PM to 7:00 AM shift were responsible to check for expired medications in the locked control substance box in the East Unit medication storage refrigerator. On 06/26/15 at 4:55 PM an interview was conducted with the DON who verified that 12 of 12 single dose vials of Lorazepam injectable were expired and stated Lorazepam injectable was available for resident use. The DON stated the nurses working on third shift were assigned to check for outdated medication in the medication storage refrigerator. The DON stated no specific nurse was assigned the task of checking for expired medication but it was the responsibility of the nurse who worked Thursdays on third shift. The DON stated there was no process in place to validate if the nurse who worked on Thursday third shift checked for expiration dates of medications. The DON stated her expectations were that nurses would have checked the control	F 431	any expired medications x 4 weeks, then bimonthly x 4 then monthly x 1 month. The results of the audits will be reported in the monthly Quality Assurance Committee meeting for 3 months to ensure quality care and compliance. Compliance DATE 7-25-15	

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F 431	Continued From page 90 substance box in the medication storage refrigerator on East Unit for expired medication. The DON stated it was the facility policy for nursing to check for expired medication and not the pharmacy. On 06/26/15 at 5:55 PM an interview was conducted with the Executive Director who stated it was nursing's responsibility to check for expired medications in the facility and not the responsibility of the pharmacy. The Executive Director stated it was her expectation that nursing would have checked for expired medication prior to administering medication. The Executive Director stated it was her expectation that control substance box, medication storage refrigerators, and medication storage areas were monitored by nursing staff for expiration dates and expired medication removed and the appropriate people notified to replace the expired medication. The Executive Director revealed the facility policy indicated nursing staff were responsible to check for expired medications in the facility.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	Resident #103 infection was cleared The facility implemented an Infection Control program on 6/27/15. Adhoc QAPI completed on 6/27/15. The facility has registered a nurse to attend Spice training in September, 2015. cont.	7-25-15

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F 441	Continued From page 91 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement an infection control program; failed to have a designated infection control preventionist that would track, trend and analyze facility infections for 63 residents present in the facility with a bed capacity of 77 residents and failed to implement contact isolation precautions for 1 of 1 resident diagnosed with infections requiring contact isolation (Resident #103). The findings included: 1. During an interview conducted on 06/27/15 at	F 441	Cont. F441 All residents in facility on antibiotics were audited by Field Service Coordinator, RN and Executive Director for tracking and trending of infections in facility on 6/27/15. The Director of Nursing/Designee will educate all staff on the Infection Control program including information on Klebsiella. The Director of Nursing/Designee will maintain Golden Living Infection Control Procedures and Protocols at the daily Clinical "Start Up" meeting on a daily basis to track and trend infections.. Director of Nursing/designee will verify that any resident identified during "start up" meeting requiring isolation has the appropriate precautions in place per Golden living infection control guidelines. Tracking and trending results will be reported to QAPI committee monthly. The Director of Nursing/Designee will audit up to 6 residents on	7-25-15

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F 441	Continued From page 92 11:00 AM with the DON she explained the Assistant Director of Nursing (ADON) was in charge of the infection control program. She stated the facility did not currently have an ADON. She stated there had been two ADON's since she began work at the facility April 2015 and when she looked for the infection control logs earlier in the week she was unable to find any infection control logs, tracking, trending or the infection control policies. She stated they did not discuss new infections in the daily morning meetings. She stated the ADON/Infection Control Nurse should have been documenting daily labs and antibiotics to track and trend infections in the facility. During an interview conducted on 06/27/15 at 11:05 AM with the former ADON #2 she stated she had not been provided any time to work on infection control while she was the ADON at the facility. She stated she worked at the facility for a month and during that time she was pulled to work on the floor every day due to short staffing. She further stated she had no training in infection control. An interview was conducted on 06/27/15 at 12:22 PM with the former ADON #1. He stated he did not do any infection control monitoring, tracking or trending while he worked at the facility from 02/2015 through 05/2015. He stated he was not aware that was part of his job responsibilities. An interview was conducted on 06/27/15 at 2:48 PM with the Administrator. She stated when she began working at the facility in 04/2015 the former DON was in charge of the Infection Control Program and she assumed when she left in 05/2015 the current DON took over the program. She stated she was unaware infection control logs, tracking and trending of infections and placing residents on isolation precautions had not been being followed and carried out. She	F 441	antibiotics for type/ trend of infections weekly x 4 weeks, then monthly thereafter until no longer deemed necessary by the QAPI committee. The results of the audits will be reported in the monthly Quality Assurance Committee meeting for 3 months to ensure quality care and compliance. Compliance Date	7-25-15

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F 441	Continued From page 93 further stated she looked back at the minutes of the last quality assurance committee meeting in 05/2015 and infection control had not been discussed. 2. Resident #103 was admitted to the facility on 06/17/15 with diagnoses of neurogenic bladder and a urinary tract infection (UTI). The admission Minimum Data Set (MDS) dated 06/24/15 revealed Resident #103 was severely cognitively impaired but could sometimes make herself understood and sometimes could understand others. The MDS further revealed Resident #103 was totally dependent for transfers and toileting and had an indwelling urinary catheter. Review of the hospital discharge summary dated 06/17/15 revealed Resident #103 had a urinary tract infection caused by klebsiella (bacteria that can cause different types of health care associated infections) upon discharge from the hospital. Review of the Center for Disease Control (CDC) guidelines for preventing the spread of klebsiella infections between patients, health care personnel must follow specific infection control precautions that may include strict adherence to hand hygiene and wearing gowns and gloves when they enter rooms where patients with klebsiella related illnesses are housed. Healthcare facilities also must follow strict cleaning procedures to prevent the spread of klebsiella. Review of the Infectious Disease in the Workplace facility policy dated 04/06/15 read in part: direct caregivers, such as nurses and nursing assistants, shall be informed if they are providing care to a patient with an infectious disease. The facility contact isolation policy for residents was unable to be located by the Director of Nursing (DON).	F 441		

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F 441	Continued From page 94 During an interview conducted on 06/27/15 at 11:00 AM with the DON she stated she was not aware Resident #103 was readmitted to the facility with klebsiella in her urine. She stated the nurse can place the resident on contact isolation precautions without a physician's order but they do need to let the physician know. She stated the nurse that admitted Resident #103 should have initiated contact precautions for Resident #103 and informed the physician. The DON further revealed Resident #103 had not been placed on isolation precautions due to staff not knowing she had klebsiella in her urine and there had been no residents on isolation precautions since she began working at the facility in May 2015.	F 441		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and interviews with residents and staff the facility administration failed to effectively manage and provide oversight in the areas of treatment to pressure sores and infection control. (Residents #23, #34, #53, #58, #69, #101, #103) The findings included: This tag is cross referred to;	F 490	F 490 Refer to F 314 for compliance, monitoring, auditing and QAPI process for residents #23, #34, #53, #58, #69, #101, #103. Refer to F 441 for compliance, monitoring, auditing, and QAPI process for resident #103. Education will be provided by Field Services Clinical Director to Executive Director and Director of Nursing on effectively managing and providing oversight in the areas of treatment of pressure sores and of infection control. cont.	

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F 490	Continued From page 95 1a. F314: Services to prevent and treat pressure sores: Based on observations, record review, resident, staff, and physician interviews, the facility failed to provide dressing changes as ordered and/or complete weekly skin assessments as ordered for 6 out of 7 residents reviewed for pressure sores and failed to change a wound vacuum assisted closure device (promote healing through negative pressure wound therapy) for 1 of 1 resident reviewed for wound vacuum device to assist in pressure sore healing (Residents #34, #23, #101, # 103, #53, #69, and #58). b. F441: Infection Control: Based on observations, record review and staff interviews, the facility failed to implement an infection control program; failed to have a designated infection control preventionist that would track, trend and analyze facility infections for 63 residents present in the facility with a bed capacity of 77 residents and failed to implement contact isolation precautions for 1 of 1 resident diagnosed with infections requiring contact isolation (Resident #103).	F 490	Cont F490 The Field Services Clinical Director will monitor the auditing of F314 and F 441. Her audits will be presented to the monthly QAPI meeting x 3 months Compliance date 7-25-15	7-25-15
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify	F 520	F520 Refer to F157 for compliance, monitoring, auditing and QAPI process for Resident #40. Refer to F241 for compliance, monitoring, auditing and QAPI process for resident's #11, #44, and #52 cont.	7-25-15

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	345010	A. BUILDING _____ B. WING _____	C 06/27/2015

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F 520	Continued From page 96 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 staff and resident interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place June 2014 and September 2014. This was for eight recited deficiencies which were originally cited in June 2014 on the recertification investigation and one recited deficiency from a complaint investigation September 2014. The deficiencies were in the areas of notification of change, dignity, choices, response to resident council grievances, significant medication error, sufficient staffing, kitchen sanitation and infection control. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. (Residents #11, #23, #34, #40, #41, #44, #50, #52, #53, #58, #68, #69, #101 and #103)	F 520	Cont. F520 Refer to F242 for compliance, monitoring, auditing and QAPI process for resident's #41, #68 Refer to F244 for compliance, monitoring, auditing and QAPI process for resident's Refer to F333 for compliance, monitoring, auditing and QAPI process for resident #50. Refer to 353 for compliance, monitoring, auditing and QAPI process for resident's #23, #34,#50, #53, #58, #69, #101, #103 Refer to 371 for compliance, monitoring, auditing and QAPI process. Refer to F441 for compliance, monitoring, auditing and QAPI process for resident #103 The regional nurse consultant will re-educate the QAPI committee by reviewing Golden Living QAPI policies on identifying issues and systems of care, root cause analysis, and the implementation of the plan of correction. Cont.	7-25-15

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F 520	Continued From page 97 The findings included: This tag is cross referred to: 1a. F157: Notification of significant change: Based on record review and staff interview the facility failed to notify a family representative of a change in physician's orders for a medication that had been discontinued for 1 of 3 residents reviewed (Resident # 40). During the recertification survey of June 20, 2014 the facility was cited for F157 for failure to notify a resident's Responsible Party of refusal of medications and a change in dosage of psychotropic medication. On the current recertification survey the facility failed to notify a family representative of a change in medication. b. F241: Dignity: Based on observation, record review, and resident interview, and staff interviews, the facility failed to: dress a resident in personal clothing, interact with a resident during a meal, keep nails clean, provide incontinence care, and maintain cleanliness to prevent odors for 3 of 11 residents (Residents #44, #52, #11). During a complaint investigation on September 12, 2014 the facility was cited for F241 for an issue with staff treatment of a resident. On the current recertification survey the facility failed to dress a resident in personal clothing, interact with a resident during a meal and ensure resident were clean and free of odors. c. F242: Choices: Based on observations, medical record review, staff and resident interviews, the facility failed to honor a resident's choice of the time for getting up in the mornings (Resident #68) and failed to honor resident's food preferences (Resident #41) for 2 of 12 sampled residents who were reviewed for	F 520	Cont. F520 The regional nurse consultant will audit all QAPI meetings for one year to ensure ongoing compliance. compliance date 7-25-15	7-25-15

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F 520	Continued From page 98 choices. During the recertification survey of June 20, 2014 the facility was cited for F242 for failure to honor resident choices with bed transfers and bathing. On the current recertification survey the facility failed to honor resident choices with bed transfers and food preferences. d. F244: Response to Resident Council grievances: Based on resident and staff interviews and review of the resident council meeting minutes the facility failed to respond to resident council concerns of staffing and slow response to requests for assistance. During the recertification survey of June 20, 2014 the facility was cited for F244 for failure to respond to resident council grievances related to sufficient staffing to meet resident needs. On the current recertification survey the facility failed to respond to resident council grievances related to sufficient staffing. e. F333: Significant Medication Error: Based on medical record review and staff interview the facility failed to administer an anti-epileptic medication at the scheduled time ordered by the physician for 1 of 5 sampled residents. (Resident # 50) During the recertification survey of June 20, 2014 the facility was cited for F333 for failure to adjust a medication for a resident on dialysis. On the current recertification survey the facility failed to administer an anti-epileptic at the scheduled time ordered by the physician. f. F353: Sufficient Staffing: Based on observations, medical record review and staff interviews the facility failed to provide	F 520		

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F 520	Continued From page 99 sufficient nursing staff to meet the needs of 63 residents present in the facility with a bed capacity of 77 residents in the areas of timely medication administration, services to meet activity of daily living needs and services to treat pressure sores. (Residents #23, #34, #50, #53, #58, #69, #101, #103) During the recertification survey of June 20, 2014 the facility was cited for F353 for failure to provide sufficient staff to assist dependent residents with dining. On the current recertification survey the facility failed to provide sufficient staff to meet resident needs in the areas of timely medication administration, services to meet activity of daily living needs and services to treat pressure sores. g. F371: Kitchen Sanitation: Based on observation and staff interview the facility failed to 1) discard outdated foods, 2) store frozen foods in a manner to prevent ice crystallization and dry appearance, 3) ensure foods were dated and labeled, and 4) clean an ice scoop holder in the west wing pantry. During the recertification survey of June 20, 2014 the facility was cited for F371 for failure to properly store and label dry foods and failure to clean and maintain kitchen equipment. On the current recertification survey the facility failed to properly store and label food and clean an ice scoop holder. h. F441: Infection Control: Based on observations, record review and staff interviews, the facility failed to implement an infection control program; failed to have a designated infection control preventionist that would track, trend and analyze facility infections for 63 residents present in the	F 520		

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F 520	Continued From page 100 facility with a bed capacity of 77 residents and failed to implement contact isolation precautions for 1 of 1 resident diagnosed with infections requiring contact isolation (Resident #103). During the recertification survey of June 20, 2014 the facility was cited for F441 for failure to disinfect a blood glucose meter. On the current recertification survey the facility failed to have a designated infection control preventionist to track, trend and analyze facility infections and failed to implement contact isolation precautions for a resident. 2. On 06/27/15 at 5:00 PM the Administrator stated she began working at the facility April 2015. The Administrator stated she had not fully read the investigation results from the June 2014 recertification survey or the September 2014 complaint investigation. The administrator stated there had been two Quality Assurance meetings since she began working at the facility; one in May 2015 and another in June 2015. The Administrator stated she attended the May 2015 Quality Assurance meeting but was unable to attend the June 2015 meeting and was not aware what was discussed at the June 2015 meeting. The Administrator stated there had not been ongoing monitoring of areas cited during the April 2014 recertification investigation and September 2014 complaint investigation in the areas of notification of change, dignity, choices, resident council grievances, significant medication errors, staffing, kitchen sanitation and infection control.	F 520		

Division of Health Service Regulation

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	NH0321	A. BUILDING: _____ B. WING _____	06/27/2015

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L 040	.2209(A) INFECTION CONTROL 10A-13D.2209 (a) (a) A facility shall establish and maintain an infection control program for the purpose of providing a safe, clean and comfortable environment and preventing the transmission of diseases and infection. This Rule is not met as evidenced by: Based on staff interviews the facility failed to have designated staff who were responsible for infection control, complete the Statewide Program for Infection Control and Epidemiology (SPICE) a state approved program for infection control. The findings included: During an interview conducted on 06/26/15 at 4:39 PM with the Director of Nursing (DON) she explained that she had been the Interim DON for a month and a half and during that time no one had worked in the position of the Infection Control Nurse. She stated she had never attended SPICE training and no other staff member in the facility had been to SPICE training. During an interview conducted on 06/27/15 at 2:48 PM with the Administrator she stated she was not aware a nurse had not been assigned to the infection control program nor was she aware a staff member was required to attend the SPICE program. She confirmed there was no staff currently in the facility that had attended SPICE training.	L 040	A Staff Nurse has been registered for the Spice Training scheduled for 09/09/15 through 09/11/15. Compliance date 07/25/2015 L040 See F tag 441.	7-25-15
L 043	.2209(D) INFECTION CONTROL 10A-13D.2209 (d) The facility shall ensure communicable disease testing as required by 10A NCAC 41A, "Communicable Disease Control" which is incorporated by reference, including subsequent amendments. Copies of these Rules may be obtained at no charge by contacting the	L 043	LO43 All Golden Living-Asheville staff team members have updated TB tests and results. cont.	7-25-15

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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L 043	Continued From page 1 N.C. Department of Health and Human Services, Division of Public Health, Tuberculosis Control Branch, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. Screening shall be done upon admission of all patients being admitted from settings other than hospitals, nursing facilities or combination facilities. Staff shall be screened within seven days of the hire date. The facility shall ensure tuberculosis screening annually thereafter for patients and staff. This Rule is not met as evidenced by: Based on a review of facility policy and staff interviews the facility failed to screen new employees for tuberculosis for 7 of 28 new employees hired after 01/01/15. The findings included: The facility's policy for Infectious Disease in the Workplace read in Part: · Baseline tuberculosis (TB) screening test - All employees who have direct contact with nursing home residents will complete a baseline TB screening test, after they have accepted an offer of employment and prior to beginning work. Employees will also be screened for TB annually, semi-annually, or periodically, based on the level of exposure. Review of a list of employees hired after 01/01/15 and their TB screening forms revealed 7 out of 28 employees had not been screened for TB. During an interview conducted on 06/27/15 at 11:00 AM with the Director of Nursing (DON) she explained the Infection Control Nurse was in charge of making sure new employees received their TB screening before beginning work. She stated the last Assistant Director of Nursing (ADON) was in charge of Infection Control but when she looked for the new employee records	L 043	cont. F043 The Human Resources Specialist will be re-educated on the TB testing regulations by the Golden Living Regional Nurse. The Human Resource Specialist will assure employee TB testing and results will be performed prior to resident contact. The Business Office Manager will audit all newly hired employees' TB tests and results for 1 month then 5 per month for 2 months. The Business Office Manager will perform a QAPI and present the results at the monthly QAPI meeting to the QAPI Committee to assure ongoing compliance for 3 months.	7-25-15

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L 043	Continued From page 2 she discovered the ADON had not screened all of the new employees. She stated it was her expectation that all new employees were screened for TB before beginning work in the facility. During an interview conducted on 06/27/15 at 12:22 PM with the former ADON he stated it was not in his job description to be the Infection Control Nurse and he had never given TB screenings to new employees. During an interview conducted on 06/27/15 at 2:48 PM with the Administrator she explained it was her understanding the ADON assumed the duties of the Infection Control Nurse and provided all TB screenings to new employees. She stated she could not find any record of a TB screening for 7 out of the 28 new employees hired after 01/01/15. The Administrator further stated it was not acceptable employees were working with residents without being screened for TB.	L 043		