STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING ______ B. WING ______	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREENSBORO	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to invite a resident to partake in a scheduled care plan meeting for one of eighteen resident (Resident #152). The findings included: Resident #152 was admitted on 10/29/2015 with the following diagnoses of diabetes, paraplegia, neurogenic bladder, and a past benign brain tumor. The resident ' s Quarterly Minimum Data Set (MDS) dated 1/28/16 revealed that the resident was moderately cognitively impaired. Resident #152 required supervision with personal hygiene,	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Executive Director

(X6) DATE: 3.22.16

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 280	Continued From page 1 bed mobility, locomotion, and dressing. The resident was independent with eating. Nursing note dated 10/30/15 stated that the resident was alert and oriented time three. She was independent with meals and transfers. Nursing note dated 2/3/16 stated that the resident was alert and oriented time three. Nurse #1 was interviewed on 2/24/16 at 12:58 PM. She stated the resident had been independent and the resident does not want help with hygiene. The resident could transfer herself independently. Resident #152 was interviewed on 2/25/16 at 1:07 PM. She stated she was never invited to a care plan meeting. Resident ' s #152 family member was interviewed on 2/25/16 at 10:17 AM. She stated that she had not been to a care plan meeting before. She had read a nursing note that stated they had tried to call her about the meeting. Resident #152 had not been invited to the care plan meeting. The family member stated that she had multiple concerns with the care plan. A progress note dated 1/25/16 by the social worker stated " a care plan meeting letter was sent to the resident ' s family for a care plan meeting to be held 2/18/16 at 2:15 PM. " The care plan letter (no date) that was sent to the resident ' s family was reviewed and revealed that the Care Plan meeting was scheduled for 2/18/16 at 2:15 PM. A progress note dated 2/18/16 by the social worker stated that a care plan meeting was held with social work, nursing, and activities. Care plans, activities of daily living (ADL ' s), medications, wound care, weight, activities and discharge planning were reviewed with care plan team. The resident ' s family was called by writer but did not answer phone and a message could	F 280	Education was provided on March 8, 2016 to the Interdisciplinary Team including, the Social Worker and Resident Assessment Coordinators to verify awareness of resident invitation to attend their own care plan meeting. Beginning March 10, 2016, an audit will be performed by the Director of Nursing Services or Executive Director Weekly x 4 weeks, then monthly x 3 months of invitation of resident for the resident's care plan meeting. The results of these audits will be reviewed by the Director of Nursing Services and Executive Director and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or Executive Director. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. Audits will be reviewed monthly x 4 months at Quality Assessment Performance Improvement Committee beginning March 3, 2016. Completion Date: March 15, 2016	

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F 280	Continued From page 2 not be left due to the voicemail being full. The Social Worker was interviewed on 2/25/16 at 11:34 AM. He stated that he was responsible for sending out the letters to the resident ' s families to invite them to care plan meetings. He would also go physically go to the resident ' s room and ask the resident to attend the meeting. The Resident ' s family member was contacted the day of the care plan meeting but her voicemail was full. The care plan letter was sent on 1/25/16 and the meeting was scheduled for 2/18/16. Resident #152 was not invited to the care plan meeting. This would have been the first care plan meeting. The family member was very involved in the resident ' s care. He did not invite the resident because the resident ' s family member was very involved in the resident ' s care, which was why the letter was sent to the family and not just given to the resident. He was going to reschedule a care plan meeting sometime this week. The Director of Nursing was interviewed on 2/25/16 at 11:15 AM. She stated her expectation was for the resident to be invited to the care plan meeting and that a letter go out to the family. Resident ' s #152 family called almost daily to be updated on the resident ' s condition. The family had always been updated. The resident ' s family had requested for her not to participate in the resident care any longer.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

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F 315 Continued From page 3
who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on record review, observation, staff, family and resident interviews, the facility failed to ensure that a resident who was intermittently catheterized prior to admission to the nursing home was assessed and had care plans to restore intermittent catheterization after admission. Physician orders were not in place for the continued use of an indwelling Foley catheter for 1 of 1 resident reviewed for catheter use (Resident #152).
The findings included:
The facility policy dated 9/21/15 for preventing associated Urinary Tract Infections (UTI) stated to " document (per facility protocol or as ordered) the following information: the continued need for the resident ' s indwelling catheter and any signs or symptoms of UTI. "
The Resident ' s Care Transfer form dated 10/21/15 indicated Resident #152 would be transferred to Golden Living of Greensboro from another care facility. Resident #152 had an order summary sheet from the previous facility dated 10/20/15 revealed the resident had an order to " place a 18 French Foley Catheter 12 hours prior to flight to North Carolina. " The care transfer packet also stated under bowel and bladder that the resident " straight catheterizes at night and only has a Foley catheter for the flight " .
Resident #152 was admitted on 10/29/2015 with diagnoses including Diabetes, Paraplegia, Neurogenic bladder, and a past benign brain

F 315

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F315

Resident # 152 care plan was updated on February 25th, 2016. On March 4th, 2016 resident received education and teaching on catheter care by Director of Clinical Education and Charge Nurse. An order for the foley catheter had previously been obtained on December 11, 2015 by RN Supervisor.

On March 3rd, 2016 an audit, by the Director of Nursing Services, of all residents in the facility occurred on to verify if orders were present for catheters, catheters present if ordered, correct supporting diagnosis documented, accurate care plan of catheter care, and who was supposed to perform care, resident or staff.

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F 315	Continued From page 4 tumor. The Admission Clinical Health Status dated 10/29/15 stated the resident was admitted to the facility from a care facility in another state on 10/29/15 at 6:00 PM. It revealed that the resident had a colostomy and performed self-care. Under Urinary Incontinence, it stated that the resident used liners/briefs and the last void date was 10/29/15. The indwelling catheter evaluation assessment portion was not completed. Order summary dated 10/29/15 revealed that resident had no orders for a urinary catheter or for catheter care to be completed. A General Note dated 10/30/15 by nursing staff stated that resident was independent with meals, transfers, colostomy care, and Foley care. Set up was required for hygiene and grooming. General note dated 10/31/15 stated that resident was alert and oriented times three. She continued to function on an independent basis for colostomy and Foley catheter care. " The resident connects and disconnects the Foley catheter at her discretion. She also drains her bladder at bedside per self-care. " The Medication Administration Record (MAR) for 10/2015 revealed that there were no orders for catheter care or for a Foley catheter to be in place. Order summary dated 11/2/15 revealed the resident had no orders for a urinary catheter or for catheter care to be completed. A Physician note dated 11/3/15 stated that the resident had a neurogenic bladder and straight catheterized in the daytime and catheter was indwelling overnight. The resident was at high risk with indwelling catheter overnight. Physician #1 who oversaw the resident ' s care from her admission date through December, was interviewed on 2/25/16 at 12:10 PM. She stated that the resident was being in and out catheterized when she was first admitted to the	F 315	Beginning March 3, 2016, education was given by the Director of Nursing Services with full time and part time Nurses regarding orders for catheters, correct supporting diagnosis documented, and documentation on catheters. Any PRN nurse that is scheduled will have education completed prior to the next worked shift. On March 8, 2016, education was provided by the Director of Nursing Services to the Social Worker, Registered Nurse Assessment Coordinator, Activities Director, and Dietary Manager . Beginning March 4, 2016, the Director of Nursing Services or RN Supervisor will review orders 5 x weekly x 4 months to review for any new catheter orders, appropriate diagnosis, and accuracy of care plan. Beginning March 4, 2016, any new residents will be assessed within 72 hours of admission by a Registered Nurse to verify if a catheter is in place. In addition, interdisciplinary progress notes will be reviewed 5 x weekly x 4 months to monitor for catheter documentation by Director of Nursing Services or RN Supervisor.	

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F 315	Continued From page 5 facility. She stated standing protocol should have carried over and does not recall writing or not writing orders for catheter care. It was in the nursing care notes before she was admitted that she intermittently catheterized. The resident did not have a Foley when she saw her. They could have possibly put a Foley catheter in. She recalled that the resident was alert and oriented, conversational and was able to do the in and out catheterization. However, she cannot remember what she had ordered or what was done. The resident ' s Admission Minimum Data Set dated 11/5/15 stated that the resident was moderately cognitively impaired. Resident was independent with hygiene, eating and dressing. The Resident required supervision with locomotion, transfers and bed mobility. The resident had an indwelling catheter and ostomy. The resident ' s Care Area Assessment revealed care areas that triggered included Urinary Incontinence and indwelling catheter. The Resident had a care plan in place initiated 11/12/15 for alteration in elimination of bowel and bladder with indwelling urinary catheter/neurogenic bladder. The goal included to be free of Urinary Tract Infections. Interventions included " change Foley catheter and bag per protocol, indwelling catheter care every shift and as needed, check catheter tubing for proper drainage and positioning, irrigate catheter as ordered, keeping drainage bag of catheter below the level of the bladder and off floor, monitor and report signs and symptoms of urinary tract infections, and labs as ordered. " Another care plan problem was for Urinary Tract Infections, actual or potential associated with the use of an indwelling catheter and intermittent (self in and out) catheterization for neurogenic bladder. Interventions included to " observe and report	F 315	The results of these audits will be reviewed by the Director of Nursing Services and Executive Director and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or Executive Director. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. Audits will be reviewed monthly x 4 months at Quality Assessment Performance Improvement Committee beginning March 3, 2016. Completion Date: March 15, 2016	

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F 315	Continued From page 6 signs of UTI, encourage fluids, provide indwelling catheter care every shift and as needed, provide medications as ordered and urology consult as needed. The Medication Administration Record (MAR) for 11/2015 revealed that there were no orders for catheter care or for a Foley catheter to be in place. Order summary dated 12/2/15 revealed the resident had no orders for a urinary catheter or for catheter care to be completed. The Nurse Practitioner ' s note dated 12/2/15 stated that the resident " self in and out catheterizes during the day and leaves in at night. No recent Urinary Tract infections. " The Nurse Practitioner was interviewed on 2/25/16 at 11:02 AM. She stated that she started caring for this resident in December 2015. She stated that she charted what the resident had said. It may had been mis-documentation and the documentation was her error. She stated she would amend her notes to correct. The Nurse Practitioner amended her note on 2/25/16 to reflect that the resident had a Foley catheter. It stated that she had been aware since December 1st, 2015 that the resident had a Foley catheter and that she does not in and out catheterize herself despite what she will tell others at times. Order summary dated 1/4/16 revealed that resident #152 had orders dated 12/11/15 for a " Foley catheter to straight drain. Change catheter monthly on the 27th every day shift starting on the 27th and ending on the 27th every month. " The resident also had orders dated 12/11/15 for " Foley catheter care every shift. " Nursing note dated 1/27/16 stated that the resident ' s catheter was changed on 1/13/16 per need. The catheter had already been changed this month. The catheter would be changed next	F 315		

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F 315	Continued From page 7 month on new monthly date. The care plan interventions were updated on 2/9/16 to include that the " resident does in and out catheterization during the day and leaves in at night. " The care plan was last updated on 2/19/16 and 2/20/16, which stated " antibiotics for urinary Tract Infections ". The MDS nurse was interviewed on 2/25/16 at 11:40 AM about the care plan intervention on 2/9/16 that stated that resident does an " in and out catheter in the day and leave in at night. " She stated that even on the quarterly MDS assessments that interviews are conducted as well as visual assessments. The information was either from the resident or the nurse. She might have assumed that the resident meant that she performed in and out catheterization here when she really meant before admission. On the resident ' s first MDS assessment on 11/12/15, catheter interventions were assessed. The resident ' s family was interviewed on 2/23/16 at 1:12 PM. She stated that the resident had a Foley catheter since she was first admitted and they were fine with her having the catheter for convenience on admission. The resident still has a catheter. She stated that she thought the resident could self-catheterize now. Nursing Assistant #1 was interviewed 2/24/16 at 9:05 AM. She stated resident #152 ' s Foley catheter had always been in place and the resident was independent with care. The resident was interviewed on 2/24/16 at 9:47 AM. She stated that she performs her own catheter care and has had an indwelling catheter since she was admitted. An observation was made on 2/24/16 at 9:47 AM of resident performing self-care in a wheelchair in the bathroom. The resident changed her ostomy bag first. The resident did not wear gloves while	F 315		

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F 315	Continued From page 8 performing care. The resident rinsed her hands off with water but did not use soap between changing the ostomy bag and providing perineal care for herself. The resident took a wet wash rag without soap and washed perineal area/Foley catheter. The resident had an indwelling Foley catheter in place. The wash rag appeared not to have soap on it. The perineal area was not red or have an odor present. The resident ' s Foley catheter did not appear to be leaking. The tubing of the Foley catheter was not kinked or looped. After resident performed self-perineal/Foley catheter care she rinsed hands with only water. The Director of Nursing (DON) was interviewed on 2/25/16 at 8:40 AM. She stated the resident has had a Foley catheter in the entire time she had been at the facility. The DON was interviewed on 2/25/16 at 12:29 PM. She stated that when a resident comes in with a catheter that the resident had a diagnosis for the catheter and catheter care is performed at least once a shift or more frequent. This information should be included in the care plan. The physicians write their own notes and send the notes to the nursing home. There are no standing orders for Foley catheter care. If there ' s any changes in routine care or changes with the resident ' s condition then the resident's physician would be contacted.	F 315		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514		

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F 514	Continued From page 9 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff, family and resident interviews, the facility inaccurately documented intermittent catheterizations for one of eighteen residents (Resident #152). The findings included: Resident #152 was admitted on 10/29/2015 with diagnoses including Diabetes, Paraplegia, Neurogenic bladder, and a past benign brain tumor. A Physician note dated 11/3/15 stated that the resident had a neurogenic bladder and straight catheterized in the daytime and catheter was indwelling overnight. The Physician #1 who oversaw the resident ' s care from her admission date through December, was interviewed on 2/25/16 at 12:10 PM. She stated that the resident was being in and out catheterized when she was first admitted to the facility. It was in the nursing care notes before she was admitted that she intermittently catheterized. The resident did not have a Foley when she saw her. They could have possibly put a Foley catheter in. She recalled that the resident was alert and oriented, conversational and was able to do the in and out catheterization. The resident ' s Admission Minimum Data Set (MDS) dated 11/5/15 stated that the resident was moderately cognitively impaired. The resident had	F 514	***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** F514 Resident #152 had an indwelling foley catheter since admission. Foley catheter order was obtained on December 11, 2015 by RN Supervisor. No inaccurate documentation occurred after this date. A Summary of Stay note reflecting an accurate clinical assessment review of resident's stay was placed in the medical record on March 8, 2016 by Director of Nursing. A review of documentation of the last 6 months for every resident with a foley catheter present has occurred as of March 10, 2016 by Director of Nursing Services.	

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F 514	Continued From page 11 Foley catheter since she was first admitted. The resident still had a catheter. Nursing Assistant #1 was interviewed 2/24/16 at 9:05 AM. She stated resident #152 Foley catheter had always been in place and the resident was independent with care. The resident was interviewed on 2/24/16 at 9:47 AM. She stated that she performs her own catheter care and has had an indwelling catheter since she was admitted. An observation was made on 2/24/16 at 9:47 AM and the resident had an indwelling Foley catheter in place. The Director of Nursing was interviewed on 2/25/16 at 8:40 AM. She stated the resident has had a Foley catheter in the entire time she had been at the facility. The Director of Nursing was interviewed on 2/25/16 at 12:29 PM. She stated that the physicians are responsible for doing their notes and sending them in.	F 514		