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 05/20/2016

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GOLDEN LIVINGCENTER - ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

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F 000	INITIAL COMMENTS An amended Statement of Deficiencies was provided to the facility on 07/25/16 related to the results of the Informal Dispute Resolution (IDR) process. The IDR panel decision was as follows: F224 was upheld wiith a decreased scope and severity of level D. F314 was upheld with a decreased scope and severity of level D. F329 was deleted. F520 was upheld with a decreased scope and severity of level E. CMS reviewed the IDR decision. On 07/22/16 the results of the CMS review upheld the IDR decision as stated. Event ID #KBWV11.	F 000		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to provide incontinence care and failed to turn and reposition a resident who required extensive assistance and had to have a wound vacuum dressing due to facility acquired pressure sores for 1 of 1 residents reviewed for neglect (Resident #40). The findings included:	F 224	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 provisions of federal and state law.	6/24/16

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

Electronically Signed | 06/16/2016

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F 224	Continued From page 1 Resident #40 was initially admitted to the facility on 02/15/11 and was re-admitted on 03/27/15 with diagnoses which included paraplegia, seizure disorder, and diabetes mellitus. A review of a significant change Minimum Data Set (MDS) dated 04/01/16 indicated Resident #40 was cognitively intact for daily decision making. The MDS also indicated Resident #40 required extensive physical assistance of 2 persons for activities of daily living (ADL) which included bed mobility, transfers, dressing, toileting, and personal hygiene, and was totally dependent on staff for bathing. Further review of the MDS indicated under Section E titled Behavior Resident #40 was coded to have no documented behaviors or rejection of care. A review of an updated care plan with a date of 04/04/16 indicated a problem statement of at risk for further breakdown of a sacral pressure sore present and the resident was noncompliant with off-loading of the wound. The goal indicated the pressure sore would heal without complications and the interventions were listed in part to encourage and assist with turning and repositioning, provide thorough skin care after incontinent episodes, apply barrier cream, turn and position side to side, and should resident be observed not off-loading sacrum remind him to reposition off sacral area. On 05/16/16 at 11:05 AM Resident #40 was interviewed and asked if staff helped him with toileting and the resident answered, "No, before I got the colostomy I would lay in feces for hours and have even laid all night long in feces." Resident #40 stated "my wound started out as a	F 224	F 224 PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE PROPERTY Golden Living Center - Asheville (GLC-Asheville) has developed and implemented policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 1. The corrective action accomplished for Resident #40 is the resident currently has a subpubic catheter and colostomy; therefore, does not require assistance with toileting; however, he/she is checked every shift and/or as needed for catheter and/or colostomy care. This was completed as of May 20,2016. Resident #40 and with his permission his family were asked about his care as it relates to the allegation he did not receive incontinence care and when it occurred. This was so the facility could do an appropriate investigation and grievance/concern according to facility policies and procedures. Completed as of June 17, 2016. 2. Residents who have been identified by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads, their assistants, and Unit Manager/Coordinator) to have the potential to be affected are those residents who required to be turned, repositioned, who require extensive assistance, and who also use a wound vacuum dressing (a wound dressing using	

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F 224	Continued From page 2 small area and having to lay for hours in feces is what caused it to get worse. I know my wound is in a really bad area but I believe the reason I had to have the colostomy is because they did not keep me clean." The resident indicated he obtained the colostomy around 03/23/16. He further indicated the wound vacuum (a wound dressing using negative pressure to promote healing) were not changed 3 times a week as it was ordered by the wound physician. The resident also indicated he had an appointment with the physician "tomorrow" 06/17/16 and that the wound nurse (Nurse #1) had already removed the wound vacuum and had placed a wet to dry type dressing on the sacral wound until after his appointment on Tuesday, 05/17/16. Resident #40 was seen for a follow-up appointment by the wound physician on 05/17/16 and was returned to the facility around 11:30 AM. He was observed sitting up in his bed at a 45 degree angle and stated he was waiting on his lunch. The wound vacuum was observed to not be in place or turned on. Resident #40 was observed on 05/17/16 at 12:30 PM sitting up in his bed at a 45 degree angle eating his lunch. He stated his appointment had went well and the wound physician had advised him to have the staff place the wound vacuum back on as soon as he had returned to the facility. The wound vacuum was observed to not be in place or turned on. On 05/17/16 at 2:00 PM NA #6 was interviewed. NA #6 reported she was unaware of Resident #40 refusing care and that he was always pleasant and grateful for the care which was provided to him. NA #6 stated the NAs did the best they could	F 224	negative pressure to promote healing). Presently, the facility does not have any residents who required to be turned, repositioned, who require extensive assistance, and who also use a wound vacuum dressing. When the facility has a resident, the facility will monitor their bowel and bladder tracking for three days to determine when the resident is requiring incontinent care; wound vacuum physician orders will be followed; and nursing staff will monitor Nursing Assistant (NA) documentation to determine type of assistance required for turning and repositioning. 3. The measures put in place or systemic changes made are: Nursing Staff were educated on resident incontinence care, turning and repositioning by the DNS and Assistant Director of Nursing Services (ADNS) at various times from June 3, 2016 to June 9,2016. Nurses who care for residents who have wound vacuum dressings were re-inseviced on how to apply dressings and the operation of wound vacuum system by qualified staff such as Wound Care Nurse Specialist on June 9, 2016. All new nursing staff will be educated on how to apply dressings and the operation of wound vacuum system, turning and repositioning by WebEx, training seminar, or one on one in-servicing. A monitoring tool that includes turning, repositioning, and checking the wound vacuum dressing is intact and operating properly. The monitoring tool will be completed every two hours for four weeks by the Charge Nurse and Nursing Assistants; checked	

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F 224	Continued From page 3 but due to the facility being short staffed the resident care needs were not met. NA #6 further stated Resident #40 was not turned and repositioned as he was supposed to be due to the resident's minimal capability to turn and reposition himself off of his buttocks. NA #6 reported she would rarely go into Resident #40's room unless he pushed his call light for assistance. Resident #40 was observed on 05/17/16 at 3:30 PM lying on his right side with his eyes closed. The wound vacuum was observed to not be in place. On 05/17/16 at 4:47 PM NA #2 was interviewed. NA #2 reported the resident's basic needs were not always met such as keeping them clean and dry. NA #2 also reported Resident #40 was somewhat capable of turning and repositioning himself off of his buttocks and due to the facility being short staffed she would not check on the resident as she was supposed to unless he pushed his call light. Resident #40 was observed on 05/17/16 at 5:00 PM sitting up in his bed at a 45 degree angle, alert, and awake with his television playing. He stated he was waiting for his supper. When asked if the wound vacuum had been placed back on the resident stated "No, I have asked 3 times for it to be put back on and no one has come to do it yet." The wound vacuum was observed to not be in place. A review of the wound physician's order dated 05/17/16 read in part skilled nursing to perform wound care as ordered: remove old dressings, cleanse wound and surrounding areas with normal saline, pat dry with sterile 4x4 gauze,	F 224	every shift for the following four weeks and then daily the following four weeks. 4. GLC-Asheville will monitor the corrective plan to ensure the practice was corrected and will not reoccur is The Unit Manger/Coordinator and/or Manager of the Day will check to ensure the monitoring tool is complete. This will be completed daily for four weeks, five days a week for the next four weeks and three days a week for the following four weeks. The monitoring tools will be presented to the ED and/or DNS at Morning/Stand-Down Meetings. The ED will report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions as needed to ensure continued compliance. 5. The correction date for substantial compliance is June 24, 2016.	

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apply silver Granufoam, and wound vacuum to 125 mmHg (millimeters of mercury) negative pressure 3 times a week. Further instructions indicated "Please leave wound vacuum in place and transport with wound vacuum and keep resident off of back."

A review of the nurse's notes revealed Nurse #1 had documented on 05/17/16 at 5:54 PM an entry which read in part resident went to wound care appointment today. Orders to continue wound vacuum therapy received. Wet to dry dressing in place after appointment and vacuum therapy to begin tomorrow for Monday/Wednesday/Friday dressing change.

A review of the treatment administration record (TAR) dated for May 2016 indicated the following: Wound Care: One time order to use silver GranuFoam with wound vacuum therapy Mon/Wed/Fri dated 05/17/16 at 11:59 PM and a discontinue date of 05/18/16. Nurse #5 indicated by her initials that she had followed the one time order as written.

A follow-up interview was conducted with Resident #40 on 05/18/16 at 9:20 AM. Resident #40 stated the wound physician had instructed him to have the staff put the wound vacuum back on upon his arrival back to the facility. Resident #40 further stated the wound vacuum was not placed back on until late Tuesday night 05/17/16 by the 7:00 PM to 7:00 AM nurse. Resident #40 indicated he had asked Nurse #5 about the wound vacuum being put back on and at that time was when the dressing was changed and the wound vacuum was placed back on. Resident #40 stated "I do not think they would have put it back on if I had not of told them to do it and I had

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F 224	Continued From page 5	F 224		

to ask 4 or 5 times before it was actually done." The resident further stated "they never check on me unless I push my call light. I have to tell them when to change my colostomy bag and everything because they do not come into my room." Resident #40 stated he would sometimes forget to stay off of his buttocks or his right side would begin to hurt due to lying on it so much. He further stated he had not refused care or turning and repositioning should the staff bring it to his attention.

A telephone interview was conducted on 05/18/16 at 11:45 AM with Nurse #5. Nurse #5 stated Resident #40 had asked her to check the orders to have his wound vacuum put back on. Nurse #5 further stated she was unable to find the wound physician orders so she obtained a one-time order to use the GranuFoam dressing and to place the wound vacuum back on. Nurse #5 indicated she was unaware as to why the wound vacuum was not placed back on when the resident returned from the wound physician appointment. Nurse #5 further indicated it was her understanding that each time Resident #40 went out of the facility to an appointment that the wound vacuum was supposed to be started back upon his return. Nurse #5 indicated the facility was short staffed and when she placed the wound vacuum dressing on the resident that it was the first opportunity she had. Nurse #5 confirmed the wound vacuum was not in place from the beginning of her shift at 7:00 PM until 11:45 PM at which time the wound vacuum dressing was applied. Nurse #5 further confirmed Resident #40 was without the wound vacuum for approximately 5 hours for which she was able to account for.

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On 05/19/19 at 8:45 AM a telephone interview was conducted with the wound physician. He stated he would have expected the facility staff to have resumed the wound vacuum upon the resident's return to the facility. He confirmed his order dated 05/17/16 did not specifically indicate when the wound vacuum was to be re-started but was under the assumption that the re-starting of the wound vacuum would be an "automatic given since it is an important part of the wound healing process and the resident being able to advise the facility of our (physician and resident) conversation." The wound physician was unable to say should the resident have been kept clean at all times and was always complainant in staying off of his back/buttock area that the colostomy would or would not have been needed.

On 05/20/16 at 2:45 PM an interview was conducted with Nurse #1. Nurse #1 confirmed she did not change the dressing or place the wound vacuum dressing for Resident #40 on Tuesday, 05/17/16 after he had returned to the facility from the wound physician's appointment. Nurse #1 stated "I did not continue to wound vacuum because the resident stayed up too long." Nurse #1 further stated "I do not remember why the resident's wound vacuum was not put back on. I may have my days mixed up between his appointments on Tuesday and Thursday." Nurse #1 confirmed she had removed the wound vacuum dressing on Monday, 05/16/16 in order for the resident to go out of the facility on Tuesday 05/17/16 for his wound physician appointment. Nurse #1 also confirmed that Nurse #5 had placed the wound vacuum dressing on 05/17/16 late that night. Nurse #1 reported she had not observed or completed any treatments according to the physician's orders from Monday

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F 224	Continued From page 7 05/16/16 until Friday 05/20/16. She further stated she had not been into the resident's room other than on those 2 days. Nurse #1 confirmed Resident #40's wound vacuum was removed around 10:00 AM on Monday, 05/16/16 and was not placed back on the resident's sacral wound area until Nurse #5 replaced the wound vacuum dressing on 05/17/16 at 11:45 PM, Resident #40 had no wound vacuum dressing in place for approximately 38 hours.	F 224		
F 242 SS=E	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 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, record review, resident, and staff interviews the facility failed to honor a resident's choice for the number of showers in a week for 4 of 4 residents who were reviewed for choices (Residents #40, #34, #49, and #14). The findings included: 1) Resident #40 was initially admitted to the facility on 02/15/11 and was re-admitted on 03/27/15 with diagnoses which included paraplegia, diabetes mellitus, and seizure disorder.	F 242	F 242 SELF-DETERMINATION – RIGHT TO MAKE CHOICES Golden Living Center - Asheville (GLC-Asheville) honors resident's right to choose activities, schedules, and health care consistent with his/her interest, assessments, and plans of care. 1. The corrective action accomplished for Residents #40, #34, #49 was shower preferences were reviewed with these residents and Resident #14 resident's representative shower preference was discussed and new shower schedule was	6/24/16

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F 242	Continued From page 8 A review of a significant change Minimum Data Set (MDS) dated 04/01/16 indicated Resident #40 was cognitively intact for daily decision making. The MDS also indicated Resident #40 required extensive assistance of 2 person physical assist for bed mobility, transfers, dressing, toileting, and personal hygiene and was totally dependent on staff for bathing. Further review of the MDS revealed under Section E titled Behavior Resident #40 was coded to have no rejection of care type behaviors and under Section F titled Preferences for Customary Routine and Activities was coded that the choice of showers and baths was very important to Resident #40. A review of a document titled "Bathing Type Detail Report" dated 11/25/15 through 05/15/16 indicated Resident #40 was receiving a partial to full bed bath at least 2 times a week. The report also indicated Resident #40 had received a shower on 12/21/15, 04/07/16, 04/25/16, and on 05/09/16. The Director of Nursing (DON) clarified they had a lot of agency staff present in March 2016 and there was a general lack of education regarding having passwords to document showers, but she felt confident residents were given showers at least 2 times a week or anytime should they have requested one. A review of a nurse aide care guide dated 05/14/16 for Resident #40 revealed no information was indicated in regards to baths or showers. An interview was conducted on 05/18/16 at 9:20 AM with Resident #40. He stated he had not been asked about his preference for showers but had been told he would get 2 showers per week. Resident #40 stated "the nurse aides don't have	F 242	completed to allow these residents to obtain showers at their preference. This was completed on May 25, 2016. 2. Residents who have been identified by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads and their assistants, and Unit Manager/Coordinator) to have the potential to be affected are those residents who are cognitive intact for daily decision making. The residents who were identified again asked by the Unit Manager/Coordinator their shower preferences and new shower schedule was completed to allow these residents to obtain showers at their preference. Also new residents will be asked at admission their shower preferences and added to the shower schedule. This was completed on May 25, 2016. The shower schedules will be updated quarterly during the residents' assessment/care plan cycle. 3. The measures put in place or systemic changes made are: Nursing Staff and Leadership Team have been re-inserviced and new employees will be educated on the importance of residents having the opportunity right to choose activities, schedules, and health care consistent with his/her interest, assessments, and plans of care. Leadership Team will ask during Leadership Room Rounds five residents who are cognitive intact for daily decision making if they are receiving showers according to their preference. This	

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F 242	Continued From page 9 enough time to get the showers done because there is not enough staff." A follow-up interview was conducted on 05/20/16 at 8:45 AM with Resident #40. He indicated he wanted a shower 3 times a week on Monday, Wednesday, and Friday before his wound vacuum (a wound dressing using negative pressure to promote healing) and dressing changes were done to the sacral area. He stated he received a shower on Monday 05/09/16 and had not been given one since. An interview was conducted on 05/20/16 at 10:00 AM with Nurse Aide (NA) #5. NA #5 stated she was unaware of the number of showers or the specific days Resident #40 was supposed to have a shower due to his wound vacuum. NA #5 indicated she had given Resident #40 a shower but had not done so in a while. NA #5 also indicated there were times when the resident's showers were not given due to there not being enough staff. An interview was conducted on 05/20/16 at 11:10 AM with Nurse #7. She stated she expected the resident's showers to be done on their assigned days and if the showers were not done they should be done on Wednesday or Saturday because that was considered "shower free days." Nurse #7 also stated she was aware there were problems with the showers not being given 2 times a week and they were in the process of monitoring it more closely. An interview was conducted on 05/20/16 at 4:30 PM with the DON. She stated she tried to accommodate every resident regarding their personal shower preference. She further stated	F 242	monitoring will be completed five days a week for four weeks, three times a week the following four weeks and then one time a week for four weeks. 4. GLC-Asheville will monitor the corrective plan to ensure the practice was corrected and will not reoccur is the Leadership Team will bring the results of the monitoring of the showers to the ED and/or DNS at Morning/Stand-Down Meetings. The ED will report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions as needed to ensure continued compliance. 5. The correction date for substantial compliance is June 24, 2016.	

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she had identified a problem with resident's not getting their showers when she was hired and that she had been working on a process to ensure the resident's received their showers according to their preference. The DON also stated she expected showers to be given at least 2 times a week or more should the resident request more.

2) Resident #34 was admitted to the facility on 03/17/12 with diagnoses which included heart failure, diabetes mellitus, and respiratory failure.

A review of a quarterly Minimum Data Set (MDS) dated 05/04/16 indicated Resident #34 was cognitively intact for daily decision making. The MDS also indicated Resident #34 required extensive assistance for bed mobility, transfers, dressing, toileting, and personal hygiene and was totally dependent on staff for bathing. Further review of the MDS revealed under Section E titled Behavior Resident #34 was coded to have no rejection of care type behaviors and under Section F titled Preferences for Customary Routine and Activities was coded that the choice of showers and baths was very important to Resident #34.

A review of a document titled "Resident Bathing Type Weekly Report" dated 03/20/16 through 05/15/16 indicated Resident #34 had received one shower the week of 04/03/16, one shower the week of 04/10/16, one shower the week of 05/01/16, and one shower the week of 05/15/16, for a total of 4 showers in 2 months.

A review of a nurse aide care guide dated 05/14/16 indicated Resident #34 was to have "2

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showers" each week.

On 05/18/16 at 9:00 AM, Resident #34 stated "we need more help here, I don't get but one shower a week and I want 3 showers a week." Resident #34 also stated she had asked for more showers and was told that there was not enough staff to give her any additional showers.

A follow-up interview was conducted with Resident #34 on 05/20/16 at 8:45 AM. She stated she had been given a shower "yesterday" 05/19/16 and "Oh, it felt so good and I feel so much better." Resident #34 indicated she had not had a shower since the first week of 05/2016.

An interview was conducted on 05/20/16 at 10:00 AM with Nurse Aide (NA) #5. NA #5 stated Resident #34 received a shower every Thursday when she worked and was supposed to have another shower earlier in the week. NA #5 confirmed she had given Resident #34 a shower on 05/19/16. NA #5 also stated Resident #34 had not asked her about getting another shower. NA #5 further stated there were times when the resident's showers were not given due to there not being enough staff.

An interview was conducted on 05/20/16 at 11:10 AM with Nurse #7. She stated she expected the resident's showers to be done on their assigned days and if the showers were not done they should be done on Wednesday or Saturday because that was considered "shower free days." Nurse #7 also stated she was aware there were problems with the showers not being given 2 times a week and they were in the process of monitoring it more closely.

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An interview was conducted on 05/20/16 at 4:30 PM with the DON. She stated she tried to accommodate every resident regarding their personal shower preference. She further stated she had identified a problem with resident's not getting their showers when she was hired and that she had been working on a process to ensure the resident's received their showers according to their preference. The DON also stated she expected showers to be given at least 2 times a week or more should the resident request more.

3. Resident #49 was admitted to the facility on 07/22/14 with diagnoses which included diabetes, renal failure, arthritis and chronic pain. The significant change correction Minimum Data Set (MDS) dated 09/09/15 indicated Resident #49 was alert and oriented. The MDS further indicated Resident #49 required extensive assistance with dressing, toileting and hygiene, and required total assistance with bathing. The MDS also indicated Resident #49 was occasionally incontinent of urine.

During an interview on 05/16/16 at 11:34 AM with Resident #49, she stated she had not been asked about her preference for showers but had been told she would get 2 showers each week. Resident #49 also stated she would like a shower 3 times a week but "the girls (Nurse Aides) just don't have enough time to add on another shower for me because there is just not enough help."

During a 2nd interview on 05/18/16 at 4:06 PM with Resident #49, she stated she would "love to have 3 showers a week" but stated they had not given her the choice to have more than 2 a week. Resident #49 further stated her shower days

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were Tuesday and Friday, but she would rather have her showers on Tuesday, Thursday and Saturday. Resident #49 also stated at times she would get a bed bath from the nurse aides on days she did not receive her shower, but not always. Resident #49 stated she liked to wash her hair 3 times a week and she had never asked for an extra shower before because she had been told by a staff member she could only get 2 showers a week. Resident #49 was unable to recall who the staff member was, but stated she thinks it was a nurse aide.

Medical record review of the bathing type detail report for 02/19/16 to 05/17/16 indicated Resident #49 was receiving a shower, partial or full bed bath at least twice a week. There was one exception between 03/11/16 and 03/21/16 that indicated Resident #49 did not receive a shower, tub bath or bed bath. The DON clarified they had a lot of agency staff present in March 2016 and there was a general lack of education regarding having passwords to document showers, tub baths or bed baths given during that time period, but she felt confident residents were given showers, tub baths or bed baths during that time.

Review of the care guide (used by the nurse aides to guide resident care) on 05/19/16 at 3:57 PM indicated Resident #49 was to have "2 showers" each week and "inform nurse if either one does not occur."

During a staff interview with Nurse Aide (NA) #1 on 05/20/2016 at 10:11 AM, NA #1 stated that Resident #49 got a shower every Friday when she worked and had another shower earlier in the week. NA #1 also stated Resident #49 had never asked her about getting another shower.

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F 242	Continued From page 14 During an interview with the Director of Nursing (DON) on 5/20/16 at 7:43 AM, she verbalized she tried to accommodate every person regarding their personal shower preference. The DON further stated the activities department usually keeps up with this but the facility does not currently have an Activity Director. The DON also stated if she knew someone wanted a shower 3 times a week instead of 2 she would make this happen for them. 4. Resident #14 was admitted to the facility on 02/05/13 with diagnoses which included dementia, scoliosis, respiratory disorder, osteoporosis, and depression. The most recent Minimum Data Set (MDS) dated 02/19/16 indicated Resident #14 was severely cognitively impaired. The MDS further indicated Resident #14 required extensive assistance with dressing and personal hygiene and was totally dependent on staff for bathing. The MDS also revealed under Section E titled Behavior Resident #14 was coded to have no rejection of care type behaviors and under Section F titled Preferences for Customary Routine and Activities was coded that the choice of showers and baths was very important to Resident #14.	F 242		

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A review of a document titled "Bathing Type Detail Report" dated 02/19/16 through 05/14/16 indicated Resident #14 had received no shower for 15 days between 03/25/16 and 04/12/16. The document revealed Resident #14 had received 1 shower for 16 days between 04/22/16 and 05/10/16.

Review of a nurse aide care guide indicated Resident #14 was supposed to have 2 showers each week.

During an interview on 05/18/16 at 9:00 AM with Resident #14's legal representative (RP), she stated the facility was short staffed and that Resident #14 was not being given 2 showers a week. The RP further stated a Hospice Aide would come to the facility each week and give Resident #14 a bed bath. The RP also stated it was Resident #14's normal routine to get 2 showers a week and "now she only gets one a week if that many." The RP indicated there were times when she had visited the resident and had observed her hair to be dirty, greasy, and not clean.

On 05/15/16 at 3:30 PM an interview was conducted with Nurse Aide (NA) #1. She stated she was responsible for 31 residents on 05/15/16 from 7:00 AM until 3:00 PM. She further stated "No, residents do not get their showers 2 times a week and sometimes only 1 time a week." NA #1 also stated that activities of daily living (ADL) care was not provided as it was supposed to be due to the facility being short staffed. NA #1 indicated "it is all I can do check and change the residents as often as needed especially when I have 31 residents by myself."

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F 242	Continued From page 16 On 05/17/16 at 4:47 PM an interview was conducted with NA #2. She stated showers were not being provided to the residents when they wanted them due to the facility being short staffed. NA #2 also stated she was aware Resident #14 was supposed to have 2 showers a week and the resident's showers were not being provided due to being short staffed. NA #2 indicated there was not having enough time to get all of the resident's care done in an 8 hour shift. On 05/20/16 at 10:00 AM an interview was conducted with the Director of Nursing (DON). She stated she was aware of the issues the facility has had with staffing and how it has affected the resident's getting their showers according to their preference. She also stated the choices for showers was an issue that she had been working on and was trying to implement a system so she would be able to track the resident's showers to ensure that they were provided according to what the resident had requested. The DON further stated she was aware of the facility having insufficient staffing especially on 2nd and 3rd shifts and she was also working on the staffing issues.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 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.	F 246		6/24/16

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F 246	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, staff and resident interviews, the facility failed to place a call light within reach for 1 of 1 resident reviewed for accommodation of needs (Resident #48). The findings included: Resident #48 was admitted to the facility on 02/02/16 with diagnoses which included quadriplegia, anxiety, asthma, heartburn, and pain. The admission Minimum Data Set (MDS) dated 02/11/16 indicated Resident #48 required total assistance for bathing, transfers, dressing, hygiene, toileting, bathing and extensive assistance with eating. The MDS also indicated Resident #48 was alert and oriented. During an observation of Resident #48 on 05/18/16 at 9:28 AM, she was observed to be lying in bed with her call light (round and flat) in a black and pink striped sock clipped to the bed sheet. Resident #48 stated she had no use of her arms or legs and often was unable to reach her call light to request assistance. Resident #48 demonstrated by turning her head and stretching her neck toward the call light that she was unable to reach it. Resident #48 then stated if she needed help she wouldn't be able to reach her light so she would ask her roommate if she could use her call light to request assistance for her. During an observation of Resident #48 on 05/19/16 at 9:22 AM, she was observed lying in bed with her call light clipped to the bed sheet. The call light was observed to be lying halfway under her pillow and the other half is lying on top of her bed sheet. Resident #48 stated the only way she can use her call light is to have it on her pillow within reach so she can turn her head to use her call light. Resident #48 stated it had not	F 246	F 246 REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES Golden Living Center - Asheville (GLC-Asheville) honors resident's right to resident and receive services with reasonable accommodations of individual needs & preferences. 1. The corrective action accomplished for Residents #48 is immediately after notification the call light was not in reach of Resident #48 it was placed correct position according to resident's plan of care. 2. Residents who have been identified by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads and their assistants, and Unit Manager/Coordinator) to have the potential to be affected are those residents who have been assessed/care planned to need the use of a Flat pancake call light. These residents were checked by the Unit Manager/coordinator to ensure the call light was in the correct position. 3. The measures put in place or systemic changes made are: Nursing Staff and Leadership Team have been re-inserviced and new employees will be educated on the importance of residents who have been assessed/care planned to need the use of a Flat pancake call light are in correct place. The Unit Manager/Coordinator and/or Manger of	

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F 246	Continued From page 18 been on her pillow this morning. During an observation of Resident #48 on 05/19/16 at 12:07 PM, she was observed to be lying in bed with her call light completely under her pillow and not clipped to the bed sheet or her pillow. Resident #48 stated she was unable to press down hard enough through her pillow to activate her call light. During an observation of Resident #48 on 05/19/16 at 4:16 PM, the call light was observed laying on the bed sheet attached by a clip in a black and pink striped sock. Resident #48 stated she should not have to remind the staff to place her call light within reach. Resident #48 further stated the staff did not remember to do it for her and she forgets to ask them and that she was unable to use it if they did not put it beside her head on the pillow. Medical record review indicated Resident #48 had 3 different care plans all dated 02/17/16, listing an intervention to meet her goals as call bell or call light within reach. During an interview with the Director of Nursing (DON) on 05/20/16 at 7:43 AM, she stated her expectation was residents to have call lights within reach so they can use them when they need assistance. During an interview with Nurse #4 on 05/20/16 at 1:35 PM, Nurse #4 stated Resident #48 could turn her head and use her call light. Nurse #4 then stated the call light was kept on her pillow next to her face in a black and pink sock. Nurse #4 further stated she had never been in the room for Resident #48 when her call light was off her	F 246	the Day will check call light placement on residents who have been assessed/care planned to need the use of a Flat pancake call light for four weeks, the once a day for four weeks, and five times a week for four weeks. Leadership Team will check during Leadership Room Rounds for call light placement on residents who have been assessed/care planned to need the use of a Flat pancake call light. This monitoring will be completed five days a week for four weeks, three times a week the following four weeks and then one time a week for four weeks. 4. GLC-Asheville will monitor the corrective plan to ensure the practice was corrected and will not reoccur is the Leadership Team will bring the results of the monitoring of the call light placement to the ED and/or DNS at Morning/Stand-Down Meetings. The ED will report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions as needed to ensure continued compliance. 5. The correction date for substantial compliance is June 24, 2016.	

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F 246	Continued From page 19 pillow and it was always clipped to the pillow and not the bed sheet.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, staff and family interviews, the facility failed to provide an activities program to meet the physical, mental, and psychosocial well-being for 1 of 1 resident (Resident #14). The findings included: Resident #14 was admitted to the facility on 02/05/13. The quarterly Minimum Data Set (MDS) dated 02/19/16 indicated Resident #14 had diagnoses which included dementia, anxiety, depression, and high blood pressure. The MDS also indicated she required extensive assistance with bed mobility, transfers, and hygiene. The MDS further indicated that Resident #14 was significantly cognitively impaired. The MDS also indicated Resident #14 had 2 or more falls since the last assessment (significant change MDS on 12/02/15). Review of the significant change MDS dated 12/02/15 indicated Resident #14 understood verbal content, staff understood her, and that she had responded to the questions about her personal preferences. These included it was very important for her to go outside when the weather	F 248	F 248 ACTIVITIES MEET INTEREST/NEEDS OF EACH RESIDENT Golden Living Center - Asheville (GLC-Asheville) activities program ins directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional. 1. The corrective action accomplished for Residents #14 is a new Recreation Services Assessment will be completed by June 23, 2016 with input from Resident #14's family member. The assessment will include resident's leisure preferences. The residents Plan of Care will be updated to include these preferences and resident will be invited to attend activities related to his/her preferences. It will be documented which activities Resident #14 attended and quarterly according to resident's care plan schedule the care plan will be updated. This will be completed by June 24, 2016. 2. Residents who have been identified	6/24/16

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F 248	Continued From page 20 was good, somewhat important to listen to music, somewhat important to do things with groups of people, and somewhat important to do favorite activities. Medical record review indicated a care plan for activities was initiated on 03/03/16. The care plan indicated Resident #14 required assistance in participating in activities of her choice including devotions, coffee break, music and spiritual activities. The care plan also indicated she needed assistance to and from activities of her choice and that she needed to be reminded of upcoming activities. The interventions were for encouragement to participate in activities and giving compliments for her attempts to participate. During an interview with a family member on 05/16/16 at 2:20 PM, the family member indicated her mother did not attend activities as often as she would like. The family member stated, "They just don't seem to include her as often as they used to. I just don't think they have enough staff." During an interview with the Administrator on 05/17/16 at 12:13 PM, he acknowledged the Activity Director (AD) no longer worked there and stated "I know the activity program is not what it should be but they are working on that." He further stated that they are in the process of "looking for a new Activity Director." On 5/17/16 at 2:20 PM, piano playing and singing was observed in the activity area of 100 hall. Resident #14 was observed in her room, awake and lying in bed. On 5/17/16 at 3:00 PM, the music activity is continuing in the activity area of the 100 hall. Resident #14 is observed lying in bed with her eyes open and holding her call bell. During an interview with Nurse Aide (NA) #2 on 05/17/16 at 4:47 PM, NA #2 stated they didn't	F 248	by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and to have the potential to be affected are those residents who have been assessed/care planned that activities such as going outside when the weather is good, listen to music, do things with groups of people and do their favorite activities. Also those residents who need assistance to and from activities requiring them to be reminded and encouraged to attend. These residents' Plan of Care will be reviewed by June 24, 2016; an updated list will be prepared to the Activity Assistant to have available to invite them to scheduled activities. A new Recreation Services Assessment will be completed quarterly according to resident's care plan schedule. The assessment will include resident's leisure preferences. The residents' Plan of Care will be updated to include these preferences and resident will be invited to attend activities related to his/her preferences. 3. The measures put in place or systemic changes made are: Staff and Activity Assistant been re-inserviced and new employees will be educated on the importance of residents attending activities of their choice; assisting and encouraging those resident to activities. Activity attendance records will be kept for residents attending activities. These records will be reviewed weekly in the by ED and/or DNS at Morning/Stand-Down Meetings. This monitoring will be completed ever week for four weeks, every other week the following four weeks and then one time a month for four	

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F 248	Continued From page 21 have enough staff to assist in getting residents ready for activities or in taking them to activities. During a second interview with the same family member of Resident #14 on 05/18/16 at 9:00 AM, the family member stated she spent many days and evenings in the facility with her mother and that staff did not offer to take her mother to activities. The family member stated the singing on 05/17/16 was a prime example of an activity her mother would have enjoyed. The family member also stated the facility was so short staffed, no one had time to take dependent residents to activities and she never saw anyone in her mother's room providing a one on one activity of any kind. During a third interview with the same family member of Resident #14 on 05/18/16 at 4:10 PM, the family member stated her mother had not been out of bed and no one had offered her any opportunities for activities. The family member stated her mother had been more lethargic (sluggish or drowsy) today, but staff had not interacted with her to know what she would want to do or not do. During a fourth interview with the same family member of Resident #14 on 05/19/16 at 8:15 AM, the family member stated no one assisted her mother with activities on a one on one basis or in a group setting. She also stated she did not know why her mother was not involved in some type of activity program. She further stated that her mother spent her days sitting in her room or lying in bed. During an interview with the Unit Manager on 05/19/16 at 8:20 AM, she stated there was no AD in the facility and that staff take turns leading activities and making sure residents attend the activities. On 5/19/16 at 2:00 PM, bingo was observed	F 248	weeks. 4. GLC-Asheville will monitor the corrective plan to ensure the practice was corrected and will not reoccur is the ED and/or DNS at Morning/Stand-Down Meetings will monitor activity attendance records and ensure Recreation Services Assessments are completed timely according to care plan schedule. The ED will report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions as needed to ensure continued compliance. 5. The correction date for substantial compliance is June 24, 2016.	

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GOLDEN LIVINGCENTER - ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

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being played in the activity area of 100 hall. Resident #14 was observed up in her wheelchair, out of her room and playing bingo in the activity area with other residents. This was the first time Resident #14 had been observed out of her room participating in an activity since the survey started on 05/15/16.

During an interview with the Activity Assistant (AA) on 05/19/16 at 4:00 PM, she stated she only worked part-time, and there was not a full-time AD in the facility. AA also stated there was no one at the facility who was a certified AD. AA further stated with the help of staff, they tried to maintain the activities program and she depended on staff to encourage and bring residents to the activities when they were being provided. AA also stated she was not aware of any one to one activities being done with Resident #14 at that time. When AA was asked about the activities for Resident #14, she stated she had seen her playing bingo today but she had not seen her participate in activities for a while. AA reviewed the activities record for Resident #14 for the month of May 2016 and acknowledged the resident had been to no activities for the month prior to today. AA also reviewed the list for one on one activities for January, February and March of 2016, and Resident #14 was not receiving any one on one activities during that time period. AA further stated she had not found any documentation records for April 2016.

During an interview with the Director of Nursing (DON) on 05/20/16 at 10:00 AM, the DON acknowledged the activities program was an issue for the facility due to the lack of having an AD. She also stated improved activities for residents would also assist in providing more observations of the residents to keep them safe.

During an interview with Nurse #6 on 05/20/16 at

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F 248	Continued From page 23 10:30 AM, Nurse #6 stated care plans are typically updated quarterly and whenever an intervention is needed. She also stated the facility had a manager meeting every morning and care plans are updated then for any resident that needed an immediate intervention added. Nurse #6 reviewed the care plan for Resident #14 and stated her care plan had not been updated to add interventions for falls such as increased observations and activities. Nurse #6 acknowledged the care plan for Resident #14 was inadequate and did not specify any particular activities she would enjoy or include in room activities when she was unable to attend group events.	F 248		
F 249 SS=D	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family	F 249	F 249 QUALIFICATIONS OF ACTIVITY	6/24/16

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F 249	Continued From page 24 interviews, the facility failed to provide residents with an activity program directed by a qualified professional. The findings included: During an interview with a family member on 05/16/16 at 2:20 PM, the family member indicated her mother (Resident #14) did not attend activities as often as she would like. The family member stated "They just don't seem to include her as often as they used to. I just don't think they have enough staff." During an interview with the Administrator on 05/17/16 at 12:13 PM, he acknowledged the Activity Director (AD) had left employment with the facility a few weeks before and stated "I know the activity program is not what it should be." He further stated they (the corporation) was in the process of "looking for a new Activity Director." On 5/17/16 at 2:00 PM, piano playing and singing was observed in the activity area of 100 hall. During an interview with Nurse Aide (NA) #2 on 05/17/16 at 4:47 PM, NA #2 stated they didn't have enough staff to assist in getting residents ready for activities or in taking them to activities. During an interview with a family member on 05/18/16 at 9:00 AM, the family member stated she spent many days and evenings in the facility with her mother (Resident #14) and staff did not offer to take her mother to activities. The family member also stated the staff did not have time to take dependent residents to activities and she never saw anyone in her mother's room providing a one on one activity of any kind. During an interview with the 100 Unit Manager on 05/19/16 at 8:20 AM, she stated there was no AD in the facility and that staff take turns leading activities and making sure residents attend the activities. On 5/19/16 at 2:00 PM, bingo was observed in	F 249	PROFESSIONAL Golden Living Center - Asheville (GLC-Asheville) provides an ongoing program of activities to meet the interest and the physical, mental, and psychosocial well-being of each resident. 1. The corrective action accomplished for Residents #14 is a new Recreation Services Assessment will be completed by June 23, 2016 with input from Resident #14's family member. The assessment will include resident's leisure preferences. The residents Plan of Care will be updated to include these preferences and resident will be invited to attend activities related to his/her preferences. It will be documented which activities Resident #14 attended and quarterly according to resident's care plan schedule the care plan will be updated. This will be completed by June 24, 2016. The current Executive Director ((ED) Administrator) who was a former Activities Director assisted the Activities Assistant to construct a calendar for the months May & June which included special activities residents had requested during a resident group meeting and also input from the resident's calendar committee. The Leadership Team (comprised of Department Heads and their assistants, and Unit Manager/Coordinator) and/or Manager of the Day assist the Activities Assistant with all activities and ensure the activity calendar is followed. The facility is in the process of finding a qualified activities professional. 2. Residents who have been identified	

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F 249	Continued From page 25 the activity area of 100 hall. During an interview with the Activity Assistant (AA) on 05/19/16 at 10:20 AM, she stated that she was not a certified AD, was not enrolled in classes to become one, nor did she plan to enroll in classes to be an AD. During a 2nd interview with the AA on 05/19/16 at 4:00 PM, she stated she only worked part-time, the AD had left over 3 weeks ago and there was not a full-time AD in the facility. AA also stated there was no one at the facility who was a certified AD and she was not sure if the prior director was certified. AA further stated with the help of staff, they tried to maintain the activities program and she depended on staff to encourage and bring residents to the activities when they were being provided. AA also stated she was not aware of any one to one activities being done with residents at that time. During an interview with the Director of Nursing (DON) on 05/20/16 at 10:00 AM, the DON acknowledged the activities program was an issue for the facility due to the lack of having an AD.	F 249	by the ED, Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads and their assistants, and Unit Manager/Coordinator) to have the potential to be affected are those residents who have been assessed/care planned that activities such as going outside when the weather is good, listen to music, do things with groups of people and do their favorite activities. Also those residents who need assistance to and from activities requiring them to be reminded and encouraged to attend. These residents' Plan of Care will be reviewed; an updated list will be prepared to the Activity Assistant to have available to invite them to scheduled activities. A new Recreation Services Assessment will be completed quarterly according to resident's care plan schedule. The assessment will include resident's leisure preferences. The residents' Plan of Care will be updated to include these preferences and resident will be invited to attend activities related to his/her preferences. 3. The measures put in place or systemic changes made are: Staff and Activity Assistant been re-inserviced and new employees will be educated on the importance of residents attending activities of their choice; assisting and encouraging those resident to activities. Activity attendance records will be kept for residents attending activities. These records will be reviewed weekly in the by ED and/or DNS at Morning/Stand-Down Meetings. This monitoring will be completed ever week for four weeks,	

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F 249	Continued From page 26	F 249	every other week the following four weeks and then one time a month for four weeks. 4. GLC-Asheville will monitor the corrective plan to ensure the practice was corrected and will not reoccur is the ED and/or DNS at Morning/Stand-Down Meetings will monitor activity attendance records and ensure Recreation Services Assessments are completed timely according to care plan schedule. The ED will report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The ED will keep the QAPIC informed of the status of finding a qualified activities director. The QAPIC will evaluate the results and implement additional interventions as needed to ensure continued compliance. 5. The correction date for substantial compliance is June 24, 2016.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278		6/24/16

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F 278	Continued From page 27 that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, resident, and staff interviews, the facility failed to accurately assess residents' dental status on the annual Minimum Data Set (MDS) assessment for 2 of 4 residents (Resident #10 and #74). The findings included: 1. Resident #10 was admitted to the facility on 11/03/03 with diagnoses which included diabetes, anxiety, hypertension, and osteoporosis. Review of the annual MDS dated 02/29/16 revealed Resident #10 had mild cognitive impairment and required supervision with eating. There were no dental/oral concerns noted on this annual assessment. Resident #10 was observed on 05/16/16 at 9:36 AM. Resident #10 was noted to have no teeth in her upper or lower jaw. During an interview with Resident #10 on 05/18/16 at 9:13 AM, Resident #10 stated she had no teeth. Resident #10 further stated she	F 278	F 278 ASSESSMENT ACCURACY/COORDINATION/CERTIFIED Golden Living Center - Asheville (GLC-Asheville) provides resident assessment that are accurately reflect the resident's current status. 1. The corrective action accomplished for Resident #10 and #74 is their annual Minimum Data Set (MDS) assessment was modified to reflect resident's current dental status. This was completed on May 18, 2016 2. Residents who have been identified by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads and their assistants, and Unit Managers) to	

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F 278	Continued From page 28 only wears her upper dental plate on weekends and has not been able to wear her lower dental plate in years. During a staff interview with the Minimum Data Set Coordinator (MDSC) on 05/18/16 at 3:29 PM, the MDSC reviewed the annual MDS dated 02/29/16 and acknowledged she had miscoded the dental section for Resident #10. During a staff interview with the Director of Nursing (DON) on 05/20/16 at 7:43 AM, the DON acknowledged she had limited experience with the MDS and the MDSC was new to the position. The DON stated her expectation was for the MDS to be 100 percent correct. 2. Resident #74 was admitted to the facility on 04/12/16 with diagnoses which included diabetes and hypertension. Review of the admission MDS dated 04/12/16 revealed Resident #74 was alert and oriented with no cognitive impairment and required supervision with eating. There were no dental/oral concerns noted on this admission assessment. During an interview with Resident #74 on 05/18/16 at 8:41 AM, Resident #74 stated she had a full set of dentures that she used daily and she was observed to have both an upper and lower dental plate in her mouth. During a staff interview with the MDSC on 05/18/16 at 3:43 PM, the MDSC reviewed the admission MDS dated 04/12/16 and stated Resident #74 had a full set of dentures because she remembered she had previously commented to Resident #74 about how attractive her teeth were. The MDSC acknowledged she had miscoded the dental section for Resident #74. During a staff interview with the Director of Nursing (DON) on 05/20/16 at 7:43 AM, the DON acknowledged she had limited experience with	F 278	have the potential to be affected are current residents. The DNS, Assistant Director of Nursing Services (ADNS), Unit Manager/Coordinator and/or DNS designee will review current residents' dental assessment for accuracy. When necessary the MDS will be updated to reflect current dental status. 3. The measures put in place or systemic changes made are: The Minimum Data Set Coordinator (MDSC) was re-educated on how to assess and code a resident's dental status on May 18, 2018 by the Clinical Assessment Reimbursement Specialist. Licensed Nurses were re-educated on June 9, 2016 by DNS; new nursing staff during orientation will be educated on how to complete a dental assessment at admission and quarterly for accuracy. The MDSC and other Interdisciplinary Team Members will be attending an education session with the North Carolina Resident Assessment Instrument Coordinator related to MDS accuracy. Resident's Dental Assessment and MDS as completed according to the resident assessment/care plan schedule will be brought to the Morning/Stand-Down Meetings to be reviewed. These records will be reviewed weekly by ED and/or DNS at Morning/Stand-Down Meetings. This monitoring will be completed ever week for four weeks, every other week the following four weeks and then one time a month for four weeks. 4. The GLC-Asheville will monitor the corrective plan to ensure the practice was corrected and will not reoccur is the ED	

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F 278	Continued From page 29 the MDS and the MDSC was new to the position. The DON stated her expectation was for the MDS to be 100 percent correct.	F 278	will report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions and needed to ensure continued compliance. 5. The correction date for substantial compliance is June 24, 2016.	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff	F 279	F 279 DEVELOP COMPRENSIVE CARE	6/24/16

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F 279	Continued From page 30 interviews, the facility failed to develop care plans that included measurable goals and individualized interventions for 3 of 3 sampled residents (Resident #14, #34, and #40). The findings included: 1. Resident #14 was admitted to the facility on 02/05/13 with diagnoses which included dementia, osteoporosis, and respiratory disorder. The quarterly Minimum Data Set (MDS) dated 02/19/16 indicated the resident had severely impaired cognition and had trouble falling or staying asleep. Resident #14 required extensive assistance with 1 to 2 person assist for bed mobility, transfers, personal hygiene, and dressing. The MDS also indicated the resident was not steady and was only able to transfer with staff assistance. The MDS further revealed Resident #14 had 2 or more falls since her last MDS assessment. A care plan dated 03/03/16 was reviewed and was noted to be incomplete with goals and interventions of falls for Resident #14. The care plan had no interventions added after the resident's fall of 04/14/16 which caused an injury to the resident's face and head. Further review of the care plan did not indicate interventions to increase staff observations or resident involvement in activities. The falls were noted to have occurred from the resident's bed or attempting to transfer. Review of the fall reports also indicated the facility had assessed the resident post a fall, had provided the time and description of the falls, and had notified the physician and the resident's legal representative (RP). Interventions to prevent	F 279	PLANS Golden Living Center - Asheville (GLC-Asheville) uses the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 1. The corrective action accomplished for Resident #14, #34 and #40 is their care plans were including measureable goals and individualized interventions were updated to reflect their falls status and shower preferences. This was completed before June 16, 2016. 2. Residents who have been identified by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads and their assistants, and Unit Managers) to have the potential to be affected are residents who have had a fall since March 18, 2016 and those residents who are cognitive intact for daily decision making. The residents that who were identified were again asked by the Unit Manager/Coordinator their shower preferences and new shower schedule was completed to allow these residents to obtain showers at their preference. These preferences will be identified on the residents' plan of care. Also new residents will be asked at admission their shower preferences and added to the shower schedule and their plan of care. The shower schedules/plan of care will be updated quarterly during the residents' assessment/care plan cycle. This was completed on May 25, 2016. When a	

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further fall occurrences were not always indicated or documented and the summary or outcome of the fall was not always documented.

Review of a fall report dated 04/04/16 indicated an intervention to prevent a fall occurrence was identified to increase staff observation with better staff coverage. The intervention was not added to the care plan or to the nurse aide care guides.

A review of the nurse's notes dated 04/14/16 at 10:19 PM indicated Resident #14 had another fall which was not indicated on the fall report. Resident #14 was noted to be lying on the edge of the fall mat face down on her right side with bruising noted to her forehead and a bump developing, the physician and RP were notified.

An interview was conducted on 05/20/16 at 10:00 AM with the Director of Nursing (DON). She stated she was aware of the issues with documentation for falls/accidents and that she was putting in place in-services for the staff to improve the paperwork and follow-up on falls/accidents. The DON stated she expected the staff to improve on their observations of residents prone to falls and she expected the care plans to be updated with the appropriate interventions after a fall investigation.

An interview was conducted on 05/20/16 at 10:30 AM with the MDS Nurse. She stated the care plans were typically updated quarterly and when an intervention was needed such as after a fall. She also stated the facility had a managers meeting every morning and care plans were updated at that time for any resident that needed an immediate intervention. The MDS nurse confirmed Resident #14's care plan was

resident has a potential for a fall and/or had a fall the resident will be reviewed at the Morning/Stand-Down Meetings and/or Weekly Risk meeting where new interventions will be added to the care plan and/or Care Area Assessment (CAA).
3. The measures put in place or systemic changes made are: The Minimum Data Set Coordinator (MDSC) was re-educated on how to assess, complete interventions and care plans to include Activities of Daily Living (ADL's) and shower preferences by Clinical Assessment Reimbursement Specialist. Licensed Nurses were re-educated by DNS on June 9, 2016; new nursing staff during orientation will be educated on how to complete shower preferences and document falls and/or potential for falls. The MDSC and other Interdisciplinary Team Members will be attending an education session with the North Carolina Resident Assessment Instrument Coordinator related to MDS accuracy, and care plans to include interventions to prevent falls and shower preferences. Resident's CAAs and MDS will be updated/completed according to the resident assessment/care plan schedule and/or as new interventions are added will be brought to the Morning/Stand-Down Meetings to be reviewed. These records will be reviewed weekly by ED and/or DNS at Morning/Stand-Down Meetings. This monitoring will be completed ever week for four weeks, every other week the following four weeks and then one time a month for four weeks.
4. The GLC-Asheville will monitor the

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F 279	Continued From page 32 inadequate and incomplete. 2) Resident #34 was admitted to the facility on 03/17/12 with diagnoses which included heart failure, Diabetes Mellitus, and respiratory failure. A review of a quarterly Minimum Data Set (MDS) dated 05/04/16 indicated Resident #34 was cognitively intact for daily decision making. The MDS also indicated Resident #34 required extensive assistance for activities of daily living (ADL) and was totally dependent on staff for bathing and had no documented behaviors or refusal of care. A review of an updated care plan for physical functioning deficit dated 05/05/16 revealed no interventions related to activities of daily living (ADL) for Resident #34. There was no care plan with measurable goals or individualized interventions initiated for Resident #34 in regards to her ADL. An interview was conducted on 05/20/16 at 10:30 AM with the MDS Nurse. She stated she was responsible for developing care plans based on the information she obtained from the record review, other documentation and interviews with direct care staff. She stated the care plans were incorporated into the computer system and she checked the intervention she wanted to use. She further stated the resident's care plans were individualized as much as possible. The MDS nurse stated she should have developed an ADL care plan for Resident #34. An interview was conducted on 05/20/16 at 4:30	F 279	corrective plan to ensure the practice was corrected and will not reoccur is the ED will report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions and needed to ensure continued compliance. 5. The correction date for substantial compliance is June 24, 2016.	

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PM with the Director of Nursing. She stated she was aware of the issues with documentation and preferences of showers and ADL care and that she was putting in place systems to ensure preferences of showers and ADL care was followed and maintained. The DON also stated she expected the care plans to be initiated and updated as appropriate with interventions in regards to ADL.

3) Resident #40 was initially admitted to the facility on 02/15/11 and was re-admitted on 03/27/15 with diagnoses which included paraplegia, seizure disorder, and Diabetes Mellitus. A review of a significant change Minimum Data Set (MDS) dated 04/01/16 indicated Resident #40 was cognitively intact for daily decision making. The MDS also indicated Resident #40 required extensive physical assistance of 2 persons for activities of daily living (ADL) which included bed mobility, transfers, dressing, toileting, and personal hygiene, and was totally dependent on staff for bathing. Further review of the MDS indicated under Section E titled Behavior Resident #40 was coded to have no documented behaviors or rejection of care.

A review of an updated care plan for physical functioning deficit dated 04/04/16 revealed no interventions related to activities of daily living (ADL) for Resident #40. There was no care plan with measurable goals or individualized interventions initiated for Resident #40 in regards to his ADL care.

An interview was conducted on 05/20/16 at 10:30 AM with the MDS Nurse. She stated she was responsible for developing care plans based on

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F 279	Continued From page 34 the information she obtained from the record review, other documentation and interviews with direct care staff. She stated the care plans were incorporated into the computer system and she checked the intervention she wanted to use. She further stated the resident's care plans were individualized as much as possible. The MDS nurse stated she should have developed an ADL care plan for Resident #40. An interview was conducted on 05/20/16 at 4:30 PM with the Director of Nursing. She stated she was aware of the issues with documentation and preferences of showers and ADL care and that she was putting in place systems to ensure preferences of showers and ADL care was followed and maintained. The DON also stated she expected the care plans to be initiated and updated as appropriate with interventions in regards to ADL.	F 279		
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 observations, medical record review, staff, and resident interview, the facility failed to provide services that met professional standards for 2 of 2 residents reviewed (Resident #10 and #49). The findings included: 1. Resident #10 was initially admitted to the facility on 11/03/03 with diagnoses which included high blood pressure, peripheral vascular disease	F 281	F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided and arranged by Golden Living Center - Asheville (GLC-Asheville) meet professional standards of quality. 1. The corrective action accomplished for Residents #10 was the contents of the	6/24/16

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F 281	Continued From page 35 (a narrowing of blood vessels that restricts blood flow to the legs), and diabetes. The annual Minimum Data Set (MDS) dated for 02/29/16 indicated Resident #10 had mild cognitive impairment. During an observation on 05/16/16 at 9:41AM, a clear 30 cc medicine cup with a white cream inside it was noted sitting on the bed of Resident #10. When asked about the contents of the medicine cup, Resident #10 stated a nurse gave it to her yesterday to put on her legs because of her poor circulation, although she was unsure which nurse it was. Resident #10 stated she had not used all of it and was keeping it to use again. During an interview with Nurse #2 on 05/16/16 at 9:49 AM, Nurse #2 visualized the contents of the medicine cup and stated she was unsure what the medication was. Nurse #2 went to the treatment cart and was looking to see if she could figure out what it was. Nurse #2 stated that the medication was a medicated cream, Triamcinolone, Resident #10 was to receive twice a day for the skin on her lower legs. Nurse #2 verified she had not given Resident #10 the medication this morning. During an interview with the wound care treatment nurse (Nurse #1) on 05/16/16 at 10:02 AM, Nurse #1 stated she had not yet seen Resident #10 today and did not give her the medicated cream to put on her legs. Nurse #1 stated she offered Resident #10 the medicated cream and if Resident #10 accepted it she would apply it and not allow Resident #10 to apply it herself. Nurse #1 stated she didn't know whether Resident #10 had an assessment to determine if she could self-administer medications. Nurse #1 also indicated the physician's order was still active and had not been discontinued. The medical record review indicated a physician's	F 281	medicine cup was discarded on May 16, 2016. Resident # 49 was provided three cups of ice water and her preferences was updated to include three cups of ice water each shift. This was completed on May 20, 2016. 2. Residents who have been identified by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads and their assistants, and Unit Manager/Coordinator) to have the potential to be affected are current residents. Unit Manager/Coordinators checked resident rooms for medicine cups with contents in them and/or any medications at residents' bedside and for ice water. This was completed on May 20,2016 no medications were noted at bedside. 3. The measures put in place or systemic changes made are: Nursing Staff and Leadership Team have been re-inserviced on June 3rd and June 16th and new employees will be educated on the importance of not leaving medicine cups at bed side and ensure residents have ice water. Leadership Team during Room Rounds will be checking for medications and ice water. This monitoring will be completed five days a week for four weeks, three times a week the following four weeks and then one time a week for four weeks. 4. GLC-Asheville will monitor the corrective plan to ensure the practice was corrected and will not reoccur is the Leadership Team will bring the results of	

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F 281	Continued From page 36 order initially started on 12/18/12 with no stop date for Triamcinolone cream topically (on the skin) to both lower legs and was scheduled to be administered routinely, twice a day. The physician's order further stated the medicated cream was to be applied every day and evening shift. Review of the Medication Administration Record (MAR) for May 2016 indicated the most recent signatures for administration of the medication was by Nurse #3 on 05/15/16 and 05/16/16. A phone interview was conducted with Nurse #3 on 05/20/16 at 3:50 PM. Nurse #3 verified that she had worked from 4PM to 10PM on 05/15/16 and 7AM - 4PM on 05/16/16. Nurse #3 stated she clearly remembered putting cream on both legs for Resident #10 on both days. Nurse #3 stated Resident #10 did not have her own labeled container of medicated cream and she had to transfer the cream into a medicine cup to take it into her room. Nurse #3 stated that she washed her hands, put on gloves, applied the cream to Resident #10's legs and then removed her gloves, washed her hands and took the medicine cup back out of the room with her when she left. Nurse #3 stated she would never leave medicine, even a medicated cream, with a resident to put on without an order verified the resident could do so. During a staff interview with the Director of Nursing (DON) on 05/20/16 at 7:43 AM, the DON stated that she expected nursing staff not to leave medications at the bedside. 2. Resident #49 was admitted to the facility on	F 281	the audits and Leadership Room Rounds to the ED and/or DNS at Morning/Stand-Down Meetings. The ED will report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions as needed to ensure continued compliance. 5. The correction date for substantial compliance is June 24, 2016.	

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07/22/14 with diagnoses which included diabetes, high cholesterol, chronic lung disease, arthritis and chronic pain. The significant change correction Minimum Data Set (MDS) dated 09/09/15 indicated Resident #49 required extensive assistance with bed mobility and transfers. The MDS further indicated Resident #49 had pain that limited her day to day activities.

During an interview with Resident #49 on 05/16/16 at 11:44AM, Resident #49 stated she did not get the fluids she wanted between meals. Resident #49 also stated she did not get water or ice in the morning very often and when she asked for water or ice she still often did not get any.
Review of a grievance filed by Resident #49 on 03/15/16 indicated she was receiving "no water.: The resolution to the grievance was "Treatment Administration Record (TAR) - extra water per shift."
Review of the TAR for May 2016 indicated under "Unscheduled Other Orders" was listed "3 styrofoam cups of ice/water at each shift." There was not an area on the TAR specifically designated to document when or if this was being done.
An order summary report (all orders currently active for the resident) was reviewed for May 2016. The report noted an order listed as "3 styrofoam cups of ice water each shift" and was signed by the physician on 05/03/16.
During an interview with Resident #49 on 05/18/16 at 4:06 PM, Resident #49 stated she had received ice and water in her styrofoam cup twice today.
During an interview with Resident #49 on 05/19/16 at 3:26 PM, Resident #49 stated she knew she was supposed to be getting 3 styrofoam cups of ice water each shift. Resident

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F 281	Continued From page 38 #49 stated that she drinks what they give her with her pills and then sips out of her cups during the day. Resident #49 also stated her mouth gets very dry and she likes to have her water with her. She stated that she had only been given 2 styrofoam cups of ice water today. During an interview with Nurse Aide (NA) #4 on 05/19/16 at 3:40 PM, NA #4 stated she had given Resident #49 only 2 styrofoam cups of ice water on first shift because she didn't know she was supposed to have 3 cups each shift. NA #4 also stated she had a care guide for what needed to be done for her and this was not listed. Review of the care guide for 05/19/16 indicated no directions for 3 cups of ice water to be given per shift. During an interview with the Director of Nursing (DON) on 05/20/16 at 7:43 AM, the DON stated she had recently had an in-service with the NA's about ice water. The DON also stated her expectation was for the nurses and aides to make sure the resident has ice water in her styrofoam cups each time they come in to the room and make sure the orders are followed. During an interview with the 100 hall Unit Manager (UM) on 05/20/16 at 10:05 AM, UM stated Resident #49 received 3 cups of water each shift. UM further indicated this was a preference of Resident #49 and not an order. During an interview with NA #1 on 05/20/16 at 10:11 AM, NA #1 stated Resident #49 got 2 cups of ice water during the day.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		6/24/16

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F 282	Continued From page 39 care. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, resident, and staff interviews, the facility failed to follow the care plan for using a mechanical lift for 2 of 2 residents who were dependent on staff for transfers (Resident #26 and #40). The findings included: A document titled "Mechanical Lift, Hydraulic" with a creation date of 01/08/15, a last review date of 01/22/16, and an effective date of 01/26/15 read "Place the Manufacturer's Instructions for the Facility Mechanical Lift Here" the page was 1 of 1 and had no other writing on the paper. Another facility provided document titled "General Information: Policy on Number of Staff Members Required for Patient Transfer" read in part lifts are designed for safe usage with one caregiver. There are circumstances, such as combativeness, obesity, contractures, etc. of the individual that may dictate the need for a two-person transfer. It is the responsibility of each facility to determine if a one or two person transfer is more appropriate. 1) Resident #26 was admitted to the facility on 03/30/12 with diagnoses which included cerebral palsy, Alzheimer's disease, psychotic disorder, and chronic pain. Review of an annual Minimum Data Set (MDS) dated 03/28/16 indicated Resident #26 was cognitively intact and capable of making his needs known. The MDS specified Resident #26	F 282	F 282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Golden Living Center - Asheville (GLC-Asheville) provides or arranges services by a qualified person in accordance with each resident's written plan of care. 1. The corrective action accomplished for Resident #26 & #40 is reviewed and updated their lift assessments and plan of care on May 31, 2016. 2. Residents who have been identified by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads and their assistants, and Unit Managers) to have the potential to be affected are those residents who use a mechanical lift. These residents lift assessments and plan of care were reviewed and updated on June 1, 2016. Residents lift assessments and plan of care will be updated quarterly during the residents' assessment/care plan cycle. 3. The measures put in place or systemic changes made are: Nursing staff will be re-inserviced on how complete a lift assessment and carry out care when using a mechanical lift on June 15 & 16, 2016 by representative from the mechanical lift manufacturer. New employees will be trained during	

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F 282	Continued From page 40 required extensive assistance of 2 persons for bed mobility, transfers, dressing, toileting, and personal hygiene, and was totally dependent on staff with 2 persons assist for bathing. The MDS indicated Resident #26 was always incontinent of bowel and bladder. Review of an updated care plan dated 03/29/16 revealed Resident #26 was at risk for falls related to not steady during transfers with a goal that the resident would have no fall related injury. The care plan indicated interventions which read in part to assist resident back to bed as requested, call light and personal items in easy reach, and for transfers to use a mechanical lift and assist of staff times 2 persons. Review of a nurse aide (NA) care guide (card/sheet with resident information used by nurse aides) dated 05/14/16 for Resident #26 read in part lift with assist of 2 for transfer, assist back to bed per request. On 05/16/16 at 2:25 PM Nurse Aide (NA) #5 was observed to transfer Resident #26 using a Hoyer (mechanical) lift from his wheelchair to his bed. There was no other staff observed in the room with NA #5 and the resident. An interview was conducted with NA #5 on 05/16/16 at 3:05 PM. NA #5 stated she was responsible for the care of Resident #26 and was hired through an agency as a nurse aide and was not an employee of the facility. NA #5 confirmed she had transferred Resident #26 by herself using the mechanical lift. She stated she had been trained when using a mechanical lift that there were supposed to be 2 people. NA #5 reviewed and confirmed that according to the	F 282	orientation. Weekly during the Morning/Stand-down Meetings and RISK Meetings (meets weekly) lift assessments will review for completeness and accuracy weekly for one month, every other week a month and then monthly for three months. 4. GLC-Asheville will monitor the corrective plan to ensure the practice was corrected and will not reoccur is the ED will report the findings from the review of lift assessments to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions and needed to ensure continued compliance. 5. The correction date for substantial compliance is June 24, 2016.	

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care guide Resident #26 was a total lift and was supposed to be transferred using a mechanical lift with 2 persons assist. NA #5 stated this was her normal routine and that she would occasionally have a second person to assist her when using a mechanical lift when there were additional staff. She further stated she was unable to find another NA or nurse to assist in the transfer of Resident #26 transfer that was why she transferred the resident by herself.

An interview was conducted with Resident #26 on 05/16/16 at 3:30 PM. Resident #26 stated there were lots of times when only 1 NA would transfer him. He also stated the facility was short staffed and the NAs worked hard but was unable to provide the residents the care sometimes that was needed.

An interview was conducted with NA #2 on 05/17/16 at 4:47 PM. NA #2 stated it was not unusual to be responsible for 30 or more residents on 2nd or 3rd shifts. NA #2 further stated "there are a lot of times we have to transfer a resident using a mechanical lift by ourselves because there is not enough staff for anyone to help assist us." NA #2 indicated she had transferred residents using a mechanical lift by herself.

An interview was conducted with Nurse #8 on 05/19/16 at 10:37 AM. Nurse #8 stated he expected 2 NAs to transfer Resident #26 using a mechanical lift. Nurse #8 indicated there was a shortage of staff and there were times when residents were not provided the care they needed in a timely manner.

An interview was conducted with NA #7 on

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05/19/16 at 11:00 AM. NA #7 stated she was trained to have 2 person assist when using a mechanical lift and there were times when she would transfer a resident by herself due to the facility being short staffed.

An interview was conducted with Nurse #7 on 05/19/16 at 11:10AM. She stated she expected there to be 2 staff members every time a resident had to be transferred by the use of a mechanical lift. Nurse #7 further stated she would have expected Resident #26 to have been transferred with 2 person assist.

An interview was conducted with the Director of Nursing (DON) on 05/19/16 at 2:30 PM. The DON stated the manufacturer of the lift indicated that one or two persons assist with transfers using a mechanical lift. The DON further stated that she would have expected the NAs to transfer a resident according to that resident's plan of care to ensure the safety of the resident.

2) Resident #40 was re-admitted to the facility on 03/27/15 with diagnoses which included paraplegia, seizure disorder, and psychotic disorder.

Review of a significant change Minimum Data Set (MDS) dated 04/01/16 indicated Resident #40 was cognitively intact and was capable of making his needs known. The MDS specified Resident #40 required extensive assistance of 2 persons assist for bed mobility, transfers, dressing, toileting, and personal hygiene, and required 2 persons assist for bathing.

Review of an updated care plan dated 04/04/16

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revealed Resident #40 was at risk for falls related to the need for assistance with mobility and activities of daily living (ADL) with a goal that the resident would have no fall related injuries. The care plan indicated interventions which read in part to use the maxi-lift for transfers, mechanical lift and assist of staff times 2 persons for transfers.

Review of a nurse aide (NA) care guide dated 05/14/16 for Resident #40 read in part mechanical lift with assist of 2 for transfers.

An interview was conducted on 05/20/16 at 8:45 AM with Resident #40. He stated there were times when there would only be one NA to transfer him from his bed to his wheelchair or from his wheelchair to the bed because the facility was short staffed and there was not another NA or nurse to assist without having to wait a long time. Resident #40 also stated when he returned from his doctor's appointment "yesterday" due to being short staffed he was not transferred from his wheelchair back to his bed between 9:30 PM and 9:45 PM. He indicated he had asked the staff 2 to 3 times to be transferred to bed and was told that they would get to him as soon as they could. He further indicated when he was transferred to bed that only 1 NA was in his room at the time using the mechanical lift.

An interview was conducted with NA #2 on 05/17/16 at 4:47 PM. NA #2 stated it was not unusual to be responsible for 30 or more residents on 2nd or 3rd shifts. NA #2 further stated "there are a lot of times we have to transfer a resident using a mechanical lift by ourselves because there is not enough staff for anyone to help assist us." NA #2 indicated she

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GOLDEN LIVINGCENTER - ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 282	Continued From page 44 had transferred residents using a mechanical lift by herself. An interview was conducted with Nurse #8 on 05/19/16 at 10:37 AM. Nurse #8 stated he expected 2 NAs to transfer Resident #40 using a mechanical lift. Nurse #8 indicated there was a shortage of staff and there were times when residents were not provided the care they needed in a timely manner. An interview was conducted with NA #7 on 05/19/16 at 11:00 AM. NA #7 stated she was trained to have 2 person assist when using a mechanical lift and there were times when she would transfer a resident by herself due to the facility being short staffed. An interview was conducted with Nurse #7 on 05/19/16 at 11:10AM. She stated she expected there to be 2 staff members every time a resident had to be transferred by the use of a mechanical lift. Nurse #7 further stated she would have expected Resident #40 to have been transferred with 2 person assist. An interview was conducted with the Director of Nursing (DON) on 05/19/16 at 2:30 PM. The DON stated the manufacturer of the lift indicated that one or two persons assist with transfers using a mechanical lift. The DON further stated that she would have expected the NAs to transfer a resident according to that resident's plan of care to ensure the safety of the resident.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312		6/24/16

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F 312	Continued From page 45 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 observations, record review, resident, and staff interviews the facility failed to assist residents with a shower who were totally dependent on staff for bathing for 2 of 2 residents sampled for activities of daily living (Resident #40 and #34). The findings included: 1) Resident #40 was initially admitted to the facility on 02/15/11 and was re-admitted on 03/27/15 with diagnoses which included paraplegia, Diabetes Mellitus, and seizure disorder. A review of a significant change Minimum Data Set (MDS) dated 04/01/16 indicated Resident #40 was cognitively intact for daily decision making. The MDS also indicated Resident #40 required extensive assistance of 2 person physical assist for activities of daily living (ADL) and was totally dependent on staff for bathing and had no documented behaviors or refusal of care. A review of a document titled "Bathing Type Detail Report" dated 11/25/15 through 05/15/16 indicated Resident #40 was receiving a partial to full bed bath at least 2 times a week. The report also indicated Resident #40 had received a shower on 12/21/15, 04/07/16, 04/25/16, and on 05/09/16.	F 312	F 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Golden Living Center - Asheville (GLC-Asheville) ensures a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene. 1. The corrective action accomplished for Residents #40, and #34, is shower preferences were reviewed with these residents to obtain showers at their preference. This was completed on May 25, 2016. 2. Residents who have been identified by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads and their assistants, and Unit Manager/Coordinator) to have the potential to be affected are those residents who are total dependent on staff for bathing and are cognitively intact for daily decision making. The residents that who were identified again asked by the Unit Manager/Coordinator their shower preferences and new shower schedule was completed to allow these residents to obtain showers at their preference. Also	

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F 312	Continued From page 46 A review of nurse's notes dated from 05/01/16 through 05/18/16 revealed there was no documentation that Resident #40 had refused baths or showers. A review of an updated care plan for physical functioning deficit dated 04/04/16 indicated interventions per resident request of 3 showers a week, anticipate needs, and assist as needed. Resident #40 was observed on 05/15/16 at 3:30 PM to be lying in his bed, eyes closed, and sleeping. He was observed to have short hair and his scalp was noted to be greasy and shiny looking. Further observation revealed a sweaty underarm type body odor. Resident #40 was observed on 05/16/16 at 9:00 AM setting up in his bed eating his breakfast with his face unshaven, scalp greasy and shiny looking, and a sweaty type body odor. An interview was conducted on 05/17/16 at 11:30 AM with Nurse Aide (NA) #6. She stated she had given Resident #40 a bed bath earlier in the morning at his request before leaving for his doctor's appointment. NA #6 indicated she had not given the resident a shower because she was too busy and there was not enough time or staff to complete all the care needs of the residents. An interview was conducted on 05/18/16 at 9:20 AM with Resident #40. He stated he had requested to have a shower at least 3 times per week and due to facility being short staffed he had not received a shower since Monday 05/09/16. Resident #40 further stated "the nurse aides don't have enough time to get the showers done because there is not enough staff."	F 312	new residents will be asked at admission their shower preferences and added to the shower schedule. The shower schedules will be updated quarterly during the residents' assessment/care plan cycle. This was completed on May 25, 2016. 3. The measures put in place or systemic changes made are: Nursing Staff and Leadership Team have been re-inserviced and new employees will be educated on the importance of residents having the opportunity right to choose activities, schedules, and health care consistent with his/her interest, assessments, and plans of care. Leadership Team will ask during Room Rounds five residents who are cognitive intact for daily decision making if they are receiving showers according to their preference. This monitoring will be completed five days a week for four weeks, three times a week the following four weeks and then one time a week for four weeks. 4. GLC-Asheville will monitor the corrective plan to ensure the practice was corrected and will not reoccur is the Leadership Team will bring the results of the monitoring of the showers to the ED and/or DNS at Morning/Stand-Down Meetings. The ED will report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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F 312	Continued From page 47 An interview was conducted on 05/19/16 at 11:00 AM with NA #7. She stated she had not given Resident #40 a shower and that she was unsure of his shower days. NA #7 indicated there were times when showers were not given 2 times a week due to being so busy. She stated "we do the best we can to give the residents their showers but there is no way with as short staff as we are." A follow-up interview was conducted on 05/20/16 at 8:45 AM with Resident #40. He indicated he wanted a shower 3 times a week on Monday, Wednesday, and Friday before his wound vacuum and dressing changes were done to the sacral area. He re-stated he had received a shower on Monday 05/09/16 and had not been given one since. An interview was conducted on 05/20/16 at 10:00 AM with Nurse Aide (NA) #5. NA #5 stated she had been assigned to care for Resident #40 and confirmed the resident was totally dependent on staff for bathing. NA #5 indicated she had not given Resident #40 a shower due to being so busy. She also indicated there were times when the resident's showers and care was not provided due to there not being enough staff. An interview was conducted on 05/20/16 at 11:10 AM with Nurse #7. She stated she expected the resident's showers to be done on their assigned days and if the showers were not done they should be done on Wednesday or Saturday because that was considered "shower free days." Nurse #7 also stated she was aware there were problems with the showers not being given 2 times a week and they were in the process of monitoring it more closely.	F 312	5. The correction date for substantial compliance is June 24, 2016.	

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An interview was conducted on 05/20/16 at 4:30 PM with the Director of Nursing. She stated she was aware of the issues the facility has had with staffing and how it has affected the resident's not getting their showers. She also stated she was trying to implement a system so she would be able to track the resident's showers to ensure that they were provided. The DON further stated she was aware of the facility having insufficient staffing especially on 2nd and 3rd shifts and that she was working on the staffing issues.

2) Resident #34 was admitted to the facility on 03/17/12 with diagnoses which included heart failure, Diabetes Mellitus, and respiratory failure. A review of a quarterly Minimum Data Set (MDS) dated 05/04/16 indicated Resident #34 was cognitively intact for daily decision making. The MDS also indicated Resident #34 required extensive assistance for activities of daily living (ADL) and was totally dependent on staff for bathing and had no documented behaviors or refusal of care.

A review of a document titled "Resident Bathing Type Weekly Report" dated 03/20/16 through 05/15/16 indicated Resident #34 had received one shower the week of 04/03/16, one shower the week of 04/10/16, one shower the week of 05/01/16, and one shower the week of 05/15/16, for a total of 4 showers in 2 months.

A review of nurse's notes dated 05/01/16 through 05/18/16 revealed there was no documentation that Resident #34 had refused baths or showers.

A review of an updated care plan for physical

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functioning deficit dated 05/05/16 indicated interventions to anticipate resident needs and staff to assist as needed.

On 05/15/16 at 3:20 PM Resident #34 was observed in her wheelchair setting in the hallway with her hair messy, her clothes disheveled, and un-clean in appearance.

05/16/16 at 9:30 AM Resident #34 was observed in her wheelchair self-propelling in the hallway with her hair partially braided, messy, un-clean, and disheveled.

On 05/18/16 at 9:00 AM, Resident #34 stated "we need more help here, I don't get but one shower a week and I want 3 showers a week." Resident #34 also stated she had asked for more showers and was told that there was not enough staff to give her any additional showers.

An interview was conducted on 05/19/16 at 11:00 AM with NA #7. She stated she had not given Resident #34 a shower and that her shower days were on Monday and Thursday. NA #7 indicated there were times when showers were not given 2 times a week due to being so busy. She stated "we do the best we can to give the residents their showers but there is no way with as short staff as we are."

A follow-up interview was conducted with Resident #34 on 05/20/16 at 8:45 AM. She stated she had been given a shower "yesterday" 05/19/16 and "Oh, it felt so good and I feel so much better." Resident #34 indicated she had not had a shower since the first week of 05/2016.

An interview was conducted on 05/20/16 at 10:00

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F 312	Continued From page 50 AM with Nurse Aide (NA) #5. NA #5 stated Resident #34 received a shower every Thursday when she worked and was supposed to have another shower earlier in the week. NA #5 confirmed she had given Resident #34 a shower on 05/19/16. NA #5 also stated Resident #34 had not asked her about getting another shower. NA #5 further stated there were times when the resident's showers were not given due to there not being enough staff. An interview was conducted on 05/20/16 at 11:10 AM with Nurse #7. She stated she expected the resident's showers to be done on their assigned days and if the showers were not done they should be done on Wednesday or Saturday because that was considered "shower free days." Nurse #7 also stated she was aware there were problems with the showers not being given 2 times a week and they were in the process of monitoring it more closely. An interview was conducted on 05/20/16 at 4:30 PM with the Director of Nursing. She stated she was aware of the issues the facility has had with staffing and how it has affected the resident's not getting their showers. She also stated she was trying to implement a system so she would be able to track the resident's showers to ensure that they were provided. The DON further stated she was aware of the facility having insufficient staffing especially on 2nd and 3rd shifts and that she was working on the staffing issues.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		6/24/16

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F 314	Continued From page 51 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, and staff interviews the facility failed to provide ordered weekly wound assessments and failed to provide incontinence care to a resident with facility acquired pressure sores for 1 of 1 residents reviewed for pressure sores (Resident #40). The findings included: Resident #40 was initially admitted to the facility on 02/15/11 and was re-admitted on 03/27/15 with diagnoses which included paraplegia, osteomyelitis (infection of the bone), diabetes mellitus, seizure disorder, depressive disorder, and kidney disorder. A review of a significant change Minimum Data Set (MDS) dated 04/01/16 indicated Resident #40 was cognitively intact for daily decision making. The MDS also indicated Resident #40 required extensive assistance of 2 person physical assist for activities of daily living (ADL) and Section E of the MDS titled Behavior Resident #40 was coded to have no rejection of care type behaviors. Further review of the MDS indicated under Section M titled Skin Conditions that Resident #40 was at risk for developing pressure sores	F 314	F 314 TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE SORES Golden Living Center - Asheville (GLC-Asheville) ensures that a resident who resides at Golden Living Center without pressure sores does not develop pressure sores unless the individual□s clinical condition demonstrates that they were unavoidable; and a resident receives treatment and services to promote healing, prevent infection and prevent new sores from developing. 1. The corrective action accomplished for Resident #40 is that according to the Wound Evaluation Flow Sheet dated February 17, 2011 (time of admission) a Stage IV Length 8.7cm by width 6.5cm by depth 1.4cm. and another Stage III area Length 2.3 cm by width 6.6cm by depth 0.3cm both areas were located on the resident□s sacrum. Resident #40 did not acquire a pressure sore while in the facility to his/her sacrum. Resident #40 currently has a subpubic catheter and colostomy; therefore, does not require assistance with toileting; however, he/she is checked every shift	

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F 314	Continued From page 52 and having 1 stage 4 pressure sore and 2 unstageable pressure sores. A review of an updated care plan with a date of 04/04/16 indicated a problem statement of at risk for altered skin integrity related to incontinence, current pressure ulcers, and non-compliance with care. The goals indicated resident would not have further skin breakdown and the interventions were listed in part to provide thorough skin care after incontinent episodes, apply barrier cream, provide treatments as ordered, conduct weekly skin inspections, and conduct weekly wound assessments. Further review of an updated care plan dated 04/04/16 indicated a problem statement of a sacral pressure sore, at risk for further breakdown, and "resident is noncompliant with off-loading wound." The goal indicated was the pressure sore would heal without complication with interventions listed which read in part encourage and assist resident with turning and repositioning, resident to roll side to side, turn and position side to side, wound consults as ordered, and to remind resident to reposition off sacral area. A wound physician progress note dated 01/12/16 indicated a recommendation for the use of a wound vacuum and to follow-up with infectious disease for recommendations in regards to antibiotic coverage. A review of a document titled "Wound Evaluation Flow Sheet Multiple Weeks" dated 12/18/15 indicated a pressure sore (facility acquired) identified on 09/01/15 of the coccyx (a small bone at the base of the spinal column) with a	F 314	and/or as needed for catheter and/or colostomy care. This was completed as of May 20,2016. Resident #40 and with his permission his family were asked about his care as it relates to the allegation he did not receive incontinence care and when it occurred. This was so the facility could do an appropriate investigation and grievance/concern according to facility policies and procedures. Completed as of June 17, 2016. 2. Residents who have been identified by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads, their assistants, and Unit Manager/Coordinator) to have the potential to be affected are those residents who have a pressure ulcer. These residents have been assessed for pressure sores and will be continued weekly. 3. The measures put in place or systemic changes made are: Nursing Staff were educated on resident continence care, turning and repositioning by the DNS and Assistant Director of Nursing Services (ADNS) at various times from June 3, 2016 to June 9,2016. Nurses who care for residents who have pressure ulcers were re-inseviced on how to assess wounds, pressure ulcer treatment protocol, and preventive interventions by ADNS on June 16, 2016. All new nursing staff will be educated during orientation. Wound assessments will be brought to the	

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F 314	Continued From page 53 measurement in centimeters (cm) as length 6.5 by width 2.0 by depth 5.7 and unstageable. A facility physician's order dated 02/11/16 at 2:43 PM was verbally obtained by the wound nurse (Nurse #1) for Wound Care: 1) Remove old dressing. 2) Clean with cleanser or normal saline. 3) Rinse with normal saline. 4) Pat dry with sterile 4x4 gauzes. 5) Apply one-quarter (1/4) strength Dakins solution moistened gauze to wound bed of sacrum. Cover with abdominal pad (ABD). Change twice daily and as needed if soiled or dislodged dressing and every day and night shift. The order was signed by the facility physician and dated 02/12/16. Another physician's order dated 02/11/16 at 2:43 PM was verbally obtained by Nurse #1 for Wound Care: 1) Cleanse with mild cleanser or normal saline. 2) Pat dry with sterile 4x4 gauze 3) Apply wound vacuum to wound bed. Use 125 milliliters mercury (mmHg), use GranuFoam (foam used for open wounds and wound vacuums) as needed for wound care. Replace for soiling and dislodgement every day shift every Monday, Wednesday, and Friday for wound care. The order was signed by the facility physician and dated 02/12/16. Another physician's order dated 02/11/16 at 2:54 PM was verbally obtained by Nurse #1 to discontinue Dakin's solution to sacrum wound site, gauze, ABD pads, cloth surgical tape to cover two times a day related to Unspecified Open Wound of Unspecified Buttock, Initial encounter. The order was signed by the facility physician and dated 02/12/16. A review of the weekly wound evaluation revealed	F 314	Morning/Stand-Down Meetings to be reviewed for accuracy and completeness. These records will be reviewed weekly by ED and/or DNS at Morning/Stand-Down Meetings. This monitoring will be completed ever week for four weeks, every other week the following four weeks and then one time a month for four weeks. The facility is also reaching out to our Quality Improvement Organization (QIO) for assistance on prevention of pressure sores. 4. GLC-Asheville will monitor the corrective plan to ensure the practice was corrected and will not reoccur is the ED will report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions as needed to ensure continued compliance. 5. The correction date for substantial compliance is June 24, 2016.	

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the next assessment of the coccyx wound was dated 02/16/16. The coccyx wound measurement in (cm) was length 6.5 by width 0.5 by depth 0.1 and a treatment of Dakin's solution wet to dry dressing.

The facility was unable to provide wound evaluation documents from 12/18/16 to 02/16/16.

Further review of the weekly wound evaluations revealed an assessment of the coccyx wound was dated 03/16/16. The coccyx wound measurement on 03/16/16 indicated a measurement in (cm) was length 5.5 by width 3.5 by depth 4.5 and a treatment of Dakins solution wet to dry dressing twice a day (BID).

The facility was unable to provide weekly wound evaluation documents from 02/16/16 to 03/16/16.

Continued review of the weekly wound evaluations revealed 2 additional assessments for subsequent weeks also dated 03/16/16 with no changes in the coccyx wound measurements.

A weekly wound evaluation which was dated 03/25/16 indicated the coccyx wound measurement in (cm) was length 5.0 by width 3.5 by depth 4.0 and continued treatment of Dakins solution wet to dry dressing BID.

Further review of the weekly wound evaluations revealed 2 additional assessments for subsequent weeks also dated 03/25/16 with no measurements documented.

A weekly wound evaluation dated 04/15/16 indicated a pressure sore (facility acquired) identified on 04/13/16 of the sacrum (a bone at

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the base of the vertebral column) with a measurement in (cm) as length 4.3 by width 3.5 by depth 4.7 and unstageable with a continued treatment of Dakins solution wet to dry dressing BID.

A review of the wound physician's follow-up progress note dated 04/20/16 indicated Resident #40 had undergone a sacral wound debridement in an operating room due to the diagnosis of osteomyelitis (infection in the bone) of the sacral area (tail-bone) and intravenous antibiotic treatment. The progress note further indicated Resident #40 had
"underwent a colostomy procedure approximately 3-4 weeks ago (between 03/22/16 and 03/25/16) and that the procedure was done due to extreme soiling of the wound on a constant basis from stool and the inability to use the wound vacuum appropriately." The wound physician's measurements of the sacral wound in (cm) was length 5.5 by width 9.0 by depth 1.0. The progress note include the wound physician ' s orders which read in part to keep the wound clean and resume the wound vacuum with a follow-up in one month.

Further review of the weekly wound evaluations indicated an assessment dated 05/06/16 with the sacrum wound measurement in (cm) was length 3.0 by width 2.5 by depth 2.6 an treatment of Dakins solution wet to dry dressing.

The next weekly wound evaluation was also dated 05/06/16 with a measurement as length 3.0 by width 2.0 by depth 3.0 and a treatment of a wound vacuum therapy.

The following weeks wound evaluation was dated

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05/13/16 with a measurement as length 3.0 by width 2.4 by depth 2.7 and a treatment indicated as wound vacuum in place.

An interview was conducted with Resident #40 on 05/16/16 at 11:05 AM. Resident #40 stated "I have laid in feces for hours and have even laid all night long in feces before I got the colostomy." Resident #40 further stated "my wound started out as a small area and having to lay for hours in feces is what caused it to get worse. I know my wound is in a really bad area but I believe the reason I had to have the colostomy is because they did not keep me clean." Resident #40 indicated the staff had not changed the dressing and the wound vacuum 3 times a week as the wound physician had ordered. The resident further indicated he had an appointment with the wound physician "tomorrow" 05/17/16 and that the wound nurse (Nurse #1) had already removed the wound vacuum and dressing and had placed a wet to dry type dressing until after his appointment on Tuesday, 05/17/16. Resident #40 confirmed there were times when he was not compliant with staying off of his back and that he would forget. He stated the wound vacuum was placed on his left side and he tried to position himself on his right side as much as possible but there were times when he would forget and roll back onto his back side. Resident #40 was observed to position his upper body, from his hips up onto his right side but was unable to move or re-position his legs.

Resident #40 was seen for a follow-up appointment by the wound physician on 05/17/16 and returned to the facility the same day. A review of the wound physician orders read in part to remove the old dressings, cleanse the wound

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and surrounding areas with normal saline, pat dry with sterile 4x4 inch gauze, apply silver GranuFoam, and use wound vacuum to 125 millimeters of mercury (mmHg) negative pressure, and change 3 times per week. Additional orders indicated to leave the wound vacuum in place and transport with the wound vacuum and return for follow-up in 2 months, and keep the resident off of his back.

Resident #40 was observed on 05/17/16 at 12:30 PM sitting up in his bed and eating his lunch. He stated his appointment had went well and the wound physician had advised him to have the staff place the wound vacuum back on as soon as he returned to the facility.

Resident #40 was observed on 05/17/16 at 3:30 PM lying on his right side with his eyes closed. The wound vacuum was observed to not be in place.

Resident #40 was observed on 05/17/16 at 5:00 PM sitting up in his bed at a 45 degree angle, alert, and awake with his television playing. He stated he was waiting for his supper. When asked if the wound vacuum had been placed back on the resident stated
"No, I have asked 3 times for it to be put back on and no one has come to do it yet." The wound vacuum was observed to not be in place.

A review of the nurse's notes on 05/18/16 at 9:00 AM revealed Nurse #1 had documented on 05/17/16 at 5:54 PM a note which read in part resident went to wound care appointment today. Orders to continue wound vacuum therapy received. Wet to dry dressing in place after appointment and vacuum therapy to begin

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tomorrow for Monday/Wednesday/Friday dressing change.

A review of the treatment administration record (TAR) dated for May 2016 indicated the following: Wound Care: One time order to use silver GranuFoam with wound vacuum therapy Mon/Wed/Fri dated 05/17/16 at 11:59 PM and a discontinue date of 05/18/16. Nurse #5 indicated by her initials that she had followed the one time order as written.

A follow-up interview was conducted with Resident #40 on 05/18/16 at 9:20 AM. Resident #40 stated the wound physician had instructed him to have the staff put the wound vacuum back on upon his arrival back to the facility. Resident #40 further stated the wound vacuum was not placed back on until late Tuesday night 05/17/16 by the 7:00 PM to 7:00 AM nurse. Resident #40 indicated he had asked Nurse #5 about the wound vacuum being put back on and at that time was when the dressing was changed and the wound vacuum was placed back on. Resident #40 stated "I do not think they would have put it back on if I had not of told them to do it." The resident further stated "they never check on me unless I push my call light. I have to tell them when to change my colostomy bag and everything because they do not come into my room."

A telephone interview was conducted on 05/18/16 at 11:45 AM with Nurse #5. Nurse #5 stated Resident #40 had asked her to check the orders to have his wound vacuum put back on. Nurse #5 further stated she was unable to find the original wound physician orders so she obtained a one-time order to use the GranuFoam dressing

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and to place the wound vacuum back on. Nurse #5 indicated she was unaware as to why the wound vacuum was not placed back on when the resident returned from the wound physician appointment. Nurse #5 further indicated it was her understanding that each time Resident #40 went out of the facility to an appointment that the wound vacuum was supposed to be started back upon his return.

On 05/19/19 at 8:45 AM a telephone interview was conducted with the wound physician. He stated he would have expected the facility staff to have resumed the wound vacuum upon the resident ' s return to the facility. He confirmed his order dated 05/17/16 did not specifically indicate when the wound vacuum was to be re-started but was under the assumption that the re-starting of the wound vacuum would be an "automatic given since it is an important part of the wound healing process and the resident being able to advise the facility of our (physician and resident) conversation." The wound physician was unable to say should the resident have been kept clean at all times and was always complainant in staying off of his back that the colostomy would or would not have been needed. The wound physician indicated due to the location of the wound and normal functioning of bowel movements that the colostomy was the best option for healing of the sacral wound.

On 05/20/16 from 9:30 AM until 10:30 AM Resident #40's wounds were observed during dressing change and treatment which was conducted by the wound nurse (Nurse #1). Nurse #1 indicated the measurements of the sacral wound was length 3.1 by width 2.2 by depth 4.5.

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On 05/20/16 at 2:45 PM an interview was conducted with Nurse #1. Nurse #1 stated she assessed the resident's pressure sores and continued the treatments as ordered or she would verbally discuss a different treatment with the facility physician, write up the physician's order, and asked him to sign that particular order. Nurse #1 stated the Dakins solution wet to dry dressing was supposed to be used only when the resident was sent out to an appointment or should the wound vacuum malfunction. Nurse #1 confirmed she did not change the dressing or place the wound vacuum back on Tuesday 05/17/16 after Resident #40's wound physician appointment. Nurse #1 stated "I did not continue the wound vacuum because the resident stayed up too long." Nurse #1 further stated "I may have my days mixed up between Tuesday and Thursday. I do not remember why the resident's wound vacuum was not put back on." Nurse #1 stated she had been filling in as the wound nurse until approximately 2 weeks ago at which time she became the full-time wound nurse. Nurse #1 had no explanation as to why the measurements and dates on the weekly wound documents had discrepancies. Nurse #1 confirmed she had changed the sacral wound dressing, replaced, and re-started the wound vacuum on Friday 05/13/16. She further confirmed she had removed the wound vacuum on Monday 05/16/16, placed a Dakin's wet to dry dressing in order for the resident to go out of the facility on Tuesday 05/17/16 to the wound physician appointment. Nurse #1 indicated Nurse #5 had changed the sacral wound dressing and replaced the wound vacuum on 05/17/16. Nurse #1 also confirmed she had not observed or completed any treatments for Resident #40 from Monday 05/16/16 until Friday 05/20/16. She indicated she

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F 314	Continued From page 61 would not have been expected to change the dressing on Wednesday since Nurse #5 did it on Tuesday night. An interview was conducted on 05/20/16 at 3:18 PM with the facility physician. He stated Resident #40 was followed by a wound physician. He further stated he had not observed and had no involvement in the treatment of Resident #40's pressure sores. The physician indicated the orders were obtained by Nurse #1 and the wound physician's recommendations and he signed the orders accordingly. On 05/20/16 at 4:30 PM an interview was conducted with the Director of Nursing (DON). The DON stated when she was hired in February 2016 she had identified a consistent problem with the assessments and treatments of pressure sores. The DON stated she expected every nurse to be capable of assessing a residents wound and to do dressing changes. She further stated she expected the skin assessments and wound assessments to be done weekly which meant every 7 days. The DON indicated she was aware of the assessment and treatment discrepancies. The DON stated she had recently started a weekly meeting with Nurse #1 to discuss resident's wounds, the measurements, and to ensure the treatments were working for that individual resident. She further stated she was unaware Resident #40 had not been provided proper care and dressing changes to his wounds.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		6/24/16

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F 323	Continued From page 62 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, interviews and record reviews the facility failed to implement interventions for a resident with a history of falls for 1 of 1 resident reviewed for falls (Resident #14). The findings included: Resident #14 was admitted to the facility on 02/05/13 with diagnoses which included dementia, osteoporosis, and respiratory disorder. The quarterly Minimum Data Set (MDS) dated 02/19/16 indicated the resident had severely impaired cognition and had trouble falling or staying asleep. Resident #14 required extensive assistance with 1 to 2 person assist for bed mobility, transfers, personal hygiene, and dressing. The MDS also indicated the resident was not steady and was only able to transfer with staff assistance. The MDS further revealed Resident #14 had 2 or more falls since her last MDS assessment. The Care Area Assessment (CAA) dated 12/02/15 triggered falls due to poor balance during transfers, a history of falls, and poor safety awareness. A care plan dated 03/03/16 was reviewed and was noted to be incomplete with goals and	F 323	F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Golden Living Center - Asheville (GLC-Asheville) ensures that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. The corrective action accomplished for Resident #14 is his/her interventions were reviewed and updated to prevent future falls on June 15, 2016. A new Recreation Services Assessment will be completed by June 23, 2016 with input from Resident #14's family member and included in his/her plan of care to attend activities of choice to prevent falls. 2. Residents who have been identified by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads and their assistants, and Unit Managers) to have the potential to be affected are those residents who have had a fall or potential for falls since March 18, 2016. When a resident has a potential for a fall based on Care Area Assessment (CAA) and/or had a fall the resident will be reviewed at the	

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F 323	Continued From page 63 interventions of falls for Resident #14. The care plan had no interventions added after the resident's fall of 04/14/16 which caused an injury to the resident's face and head. Further review of the care plan did not indicate interventions to increase staff observations or resident involvement in activities. A review of the fall accident reports indicated Resident #14 had falls on the following dates and times: · 01/02/16 at 10:00 AM · 01/11/16 at 3:06 PM · 03/04/16 at 5:10 AM · 03/23/16 at 9:00 AM · 04/04/16 at 5:20 PM · 04/16/16 at 6:32 PM · 05/06/16 at 7:09 PM The falls were noted to have occurred from the resident's bed or attempting to transfer. Review of the fall reports also indicated the facility had assessed the resident post a fall, had provided the time and description of the falls, and had notified the physician and the resident's legal representative (RP). Interventions to prevent further fall occurrences were not always indicated or documented and the summary or outcome of the fall was not always documented. Review of a fall report dated 04/04/16 indicated an intervention to prevent a fall occurrence was identified to increase staff observation with better staff coverage. The intervention was not added to the care plan or to the nurse aide care guides. Review of the staffing on the dates of Resident #14's falls indicated the following: · 01/02/16 at 10:00 AM, 6 nurse aides (NAs)	F 323	Morning/Stand-Down Meetings and/or Weekly Risk meeting where new interventions will be added to the care plan. 3. The measures put in place or systemic changes made are: The Minimum Data Set Coordinator (MDSC) was re-educated by Clinical Assessment Reimbursement Specialist on May 18, 2016 on how to assess, complete interventions and care plans to include a potential for falls and/or a fall occurs. Licensed Nurses were re-educated on June 9, 2016, new nursing staff during orientation will be educated on how to complete fall assessment and document falls and/or potential for falls. The MDSC and other Interdisciplinary Team Members will be attending an education session with the North Carolina Resident Assessment Instrument Coordinator related to MDS accuracy, and care plans to include interventions to prevent falls. Resident's CAAs and MDS will be updated/completed according to the resident assessment/care plan schedule and/or as new interventions are added will be brought to the Morning/Stand-Down Meetings to be reviewed. These records will be reviewed weekly by ED and/or DNS at Morning/Stand-Down Meetings. This monitoring will be completed ever week for four weeks, every other week the following four weeks and then one time a month for four weeks. 4. GLC-Asheville will monitor the corrective plan to ensure the practice was corrected and will not reoccur is the ED will report the findings of the	

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F 323	Continued From page 64 scheduled for 1st shift (7:00 AM until 3:00 PM) for 55 residents, Resident #14 was found on the floor next to her bed with an intervention implemented to remind the resident to use the call bell, no other interventions to the care plan were identified. · 01/11/16 at 3:06 PM, 4 NAs scheduled for 2nd shift (3:00 PM until 11:00 PM) for 54 residents, Resident #14 was observed to un-do her lap belt and rolled from her wheelchair to the floor, with interventions implemented to monitor the resident for anxiety and restlessness. · 03/04/16 at 5:10 AM, 3 NAs scheduled for 3rd shift (11:00 PM until 7:00 AM) for 55 residents · 03/23/16 at 9:00 AM, 6 NAs scheduled for 1st shift for 55 residents, during medication administration Resident #14's alarm was heard sounding and the resident was found lying in the floor bedside her bed. No additional interventions were added to the care plan. · 04/04/16 at 5:20 PM, 3 NAs scheduled for 2nd shift for 57 residents, Resident #14 had rolled out of her bed and was found in the floor, interventions was the recommendation to include better staff coverage and the interventions added to the care plan included bed in low position and a concave mattress. These interventions were already on the care plan and were updated with no new interventions added. An increase in staff coverage or observation was not added. · 04/14/16 at 10:19 PM, 5 NAs scheduled for 2nd shift for 59 residents and one NA had called in and another NA had left at 7:00 PM with 3 NAs in the building when Resident #14 fell. The fall investigation for this occurrence was incomplete and indicated Resident #14 had suffered from facial bruising and a hematoma, there were no new interventions added to the care plan. · 04/16/16 at 6:32 PM, 3 NAs scheduled 2nd	F 323	reviews/monitoring to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions and needed to ensure continued compliance. 5. The correction date for substantial compliance is June 24, 2016.	

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F 323	Continued From page 65 shift for 58 residents, Resident #14 was found on the floor scooting on her bottom. There were no care plan revisions or interventions added. · 05/06/16 at 7:09 PM, 3 NAs scheduled for 2nd shift for 61 residents, Resident #14 was found at the foot of the bed face down in a crawling type position. The accident report indicated care plan revisions were made but no additional interventions to the care plan were noted. A review of the nurse's notes dated 04/14/16 at 10:19 PM indicated Resident #14 had another fall which was not indicated on the fall report. Resident #14 was noted to be lying on the edge of the fall mat face down on her right side with bruising noted to her forehead and a bump developing, the physician and RP were notified. A review of a care guide indicated Resident #14 had fall precautions which included bed alarms, an alarming seatbelt, fall mats to both sides of her bed, a body pillow, low bed position, concave mattress, and non-skid footwear. An interview was conducted on 05/15/16 at 3:40 PM with NA #1. She stated she was assigned and responsible for 31 residents on 1st shift. NA #1 stated the facility was "very short staffed" and there were times when showers were not given, residents were not changed as frequently as they needed to be, and that ADL care and personal hygiene care was not provided. She further indicated with the number of residents for which 1 NA was responsible for she was unable to keep an eye on residents to help avoid falls or other accidents. NA #1 also indicated when a resident has to be transferred with a mechanical lift they	F 323		

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do it by themselves due to the facility being short staffed.

An interview was conducted on 05/16/16 at 2:20 PM with Resident #14's RP. The RP stated "there is not enough staff here to take care of her and watch her like they should to keep her from falling." The RP further stated she had stayed all night with Resident #14 with 1 NA on the hall and no one had checked on the resident all night.

Resident #14 was observed on 05/17/16 at 11:30 AM in her room setting in her wheelchair with the seatbelt in place and the chair alarm functional.

Resident #14 was observed on 05/17/16 at 2:30 PM lying in bed on a concave mattress, bed in low position, fall mats on both sides of the bed, bed alarm in place and on.

An interview was conducted on 05/17/16 at 4:47 PM with NA #2. She stated she has been assigned and responsible for 34 residents in an 8 hour shift. NA #2 indicated resident care which included incontinent care, personal hygiene care, and showers was not getting done due to being short staffed and not having the time to get all of the care completed for each resident. NA #2 also indicated "Yes, we have to transfer a resident by our-self using the mechanical lift because there is no one else to assist us." NA #2 stated she was unable to keep an eye on a residents to help avoid falls or other accidents with being responsible for the care of 30 or more residents on a shift.

On 05/18/16 at 4:00 PM Resident #14 was observed in her bed with the bed in low position, call bell within reach, fall mats in the floor on both

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sides of the bed, and the RP in the room with the resident. The RP stated "I believe the falls in the past 3 months could be attributed to the lack of staff which causes no one to be able to check on the residents frequently enough."

An interview was conducted on 05/19/16 at 8:20 AM with the 100 hall Unit Manager (UM). She stated she expected the staff to check on residents prone to accidents more often. She further stated when the NAs were busy the nurses and nurse managers were responsible for going around to the rooms of residents on fall precautions to make sure the interventions for that particular resident was in place.

On 05/19/16 at 2:05 PM Resident #14 was observed to be out of her room, in her wheelchair, and in an activity playing bingo. This was the first time Resident #14 was observed out of her room since 05/15/16.

An interview was conducted on 05/19/16 at 3:15 PM with NA #3. She stated Resident #14 was prone to falls and that interventions were in place but should an NA be in another resident's room providing care there would not always be someone available to watch the other residents. NA #3 also stated she tries to ensure all of the care is provided to the residents but that was not always possible when there was no one else to help.

An interview was conducted on 05/20/16 at 10:00 AM with the Director of Nursing (DON). She stated she was aware of the issues with documentation for falls/accidents and that she was putting in place in-services for the staff to improve the paperwork and follow-up on

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F 323	Continued From page 68 falls/accidents. The DON further stated she was aware of the issues the facility has had with staffing and that it was an important part of many of the issues the facility was dealing with. The DON stated she expected the staff to improve on their observations of residents prone to falls and she expected the care plans to be updated with the appropriate interventions after a fall investigation. She further stated she was aware that insufficient staffing especially on 2nd and 3rd shifts were part of the issue and that she was working to improve the staffing. An interview was conducted on 05/20/16 at 10:30 AM with the MDS Nurse. She stated the care plans were typically updated quarterly and when an intervention was needed such as after a fall. She also stated the facility had a managers meeting every morning and care plans were updated at that time for any resident that needed an immediate intervention. The MDS nurse confirmed Resident #14's care plan was inadequate and incomplete.	F 323		
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:	F 353		6/24/16

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F 353	Continued From page 69 Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. 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, record review, family, staff, and resident interviews, the facility failed to provide sufficient nursing staff to meet the needs for 5 of 5 residents on 2 of 2 halls in the areas of staff not meeting the needs of the residents such as showers, incontinent care, and/or services to meet the residents activities of daily living needs (Residents #40, #34, #14, #49, and #26). The findings included: This tag is cross referred to: 1) F 242 Based on observations, record review, resident, and staff interviews the facility failed to honor a resident's choice for the number of showers in a week for 4 of 4 residents who were reviewed for choices (Residents #40, #34, #14, and #49). 2) F 282 Based on observations, medical record review, resident, and staff interviews, the facility failed to follow the care plan for using a mechanical lift for 2 of 2 residents who were dependent on staff for transfers (Resident #26 and #40).	F 353	F353 SUFFICIENT 24-HR NURSING STAFF PER CARE PLAN Golden Living Center - Asheville (GLC-Asheville) has 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. 1. The corrective action accomplished for Resident #40, #34, #19, #49, and #26 is as follows: F242:The corrective action accomplished for Residents #40, #34, #49 was shower preferences were reviewed with these residents and Resident #14 resident's representative shower preference was discussed and new shower schedule was completed to allow these residents to obtain showers at their preference. This was completed on May 25, 2016. F282: The corrective action accomplished for Resident #26 & #40 is reviewed and updated their lift assessments and plan of care on May 31,	

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F 353	Continued From page 70 3) F 312 Based on observations, record review, resident, and staff interviews the facility failed to assist residents with a shower who were totally dependent on staff for bathing for 2 of 2 residents sampled for activities of daily living (Resident #40 and #34). 4) F 314 Based on observations, record review, resident, and staff interviews the facility failed to provide ordered weekly wound assessments and failed to provide incontinence care to a resident with facility acquired pressure sores for 1 of 1 residents reviewed for pressure sores (Resident #40). 5) F 323 Based on observations, interviews and record reviews the facility failed to implement interventions for a resident with a history of falls for 1 of 1 resident reviewed for falls (Resident #14). A review of the employee list provided by the facility revealed a total of 12 full-time nurses 2 shifts/7days a week; day shift (7:00 AM to 7:00 PM) and night shift (7:00 PM to 7:00 AM). A total of 13 full-time nurse aides (NAs) for 3 shifts/7 days a week; 1st shift (7:00 AM to 3:00 PM), 2nd shift (3:00 PM to 11:00 PM), and 3rd shift (11:00 PM to 7:00 AM). There were a total of approximately 3 Nurses and 10 Nurse Aides (NAs) which were not listed on the employee list and were contracted to work at the facility through a staffing agency. A review of the facility's grievance/concern tracking log dated 07/14/15 through 05/20/16 revealed there were concerns filed in regards to staffing and resident care as follows:	F 353	2016. F312: The corrective action accomplished for Residents #40, #34, #34 was shower preferences were reviewed with these residents and Resident #14 resident's representative shower preference was discussed and new shower schedule was completed to allow these residents to obtain showers at their preference. This was completed on May 25, 2016. F314: The corrective action accomplished for Resident #40 is that according to the Wound Evaluation Flow Sheet dated February 17, 2011 (time of admission) a Stage IV Length 8.7cm by width 6.5cm by depth 1.4cm. and another Stage III area Length 2.3 cm by width 6.6cm by depth 0.3cm both areas were located on the resident's sacrum. Resident #40 did not acquire a pressure sore while in the facility to his/her sacrum. Resident #40 currently has a subpubic catheter and colostomy; therefore, does not require assistance with toileting; however, he/she is checked every shift and/or as needed for catheter and/or colostomy care. This was completed as of May 20,2016. Resident #40 and with his permission his family were asked about his care as it relates to the allegation he did not receive incontinence care and when it occurred. This was so the facility could do an appropriate investigation and grievance/concern according to facility policies and procedures. Completed as of June 17,	

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F 353	Continued From page 71 · 07/14/15 NA care · 08/04/15 Nurse care · 09/23/15 NA care · 10/05/15 Staff concerns · 10/19/15 Resident showers · 11/03/15 Staffing concerns · 01/07/16 Call lights · 01/12/16 Staffing and call lights not being answered · 02/04/16 NA care · 02/06/16 2 concerns filed; 1 related to resident not getting a shower and the other related to call lights not being answered · 03/01/16 Call lights not being answered timely · 04/04/16 Resident not getting a shower · 04/14/16 Call light not being answered and lack of Staff Coverage · 05/10/16 Residents not getting ice water and call lights not being answered · 05/16/16 Short staffed and care not being provided Review of the Resident Council Minutes dated 07/29/15 through 05/10/16 revealed the following concerns which were voiced by alert and oriented residents who attended the meetings: · 07/29/15 Call lights not being answered timely · 10/27/15 Call lights not being answered timely and staffing concerns · 11/05/15 Call lights not being answered timely, activities, and staffing concerns · 01/20/16 Snacks not being provided in the evenings · 02/25/16 Staffing concerns · 04/14/16 Call lights not being answered timely · 05/10/16 Staffing concerns and call lights not	F 353	2016. F323: The corrective action accomplished for Resident #14 is his/her interventions were reviewed and updated to prevent future falls on June 15, 2016. A new Recreation Services Assessment will be completed by June 23, 2016 with input from Resident #14's family member and included in his/her plan of care to attend activities of choice to prevent falls. 2. Residents who have been identified by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads, their assistants, and Unit Manager/Coordinator) to have the potential to be affected are current residents. Please see the measures put in place under section #3. 3. The measures put in place or systemic changes made are: Nursing management and Executive Director evaluated the staffing patterns to establish patient acuity and staffing ratio required. DNS evaluated the nursing staff schedule to accommodate the needs of residents i.e. 12 hour shifts, 3 positions for personal care assistant (PCA) was open to meet non-nursing direct care duties. Review daily staffing schedule to ensure adequate nursing staff is available to accommodate the acuity level and provide quality care. Facility is networking with area Nursing Homes, Community Colleges, and Agency pools for staffing, recruitment and	

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F 353	Continued From page 72 being answered timely On 05/15/16 at 2:45 PM during an initial tour of the facility revealed the following staff: · 100 Hall had 31 residents with 1 NA and 1 Nurse · 200 Hall had 34 residents with 2 NAs and 2 Nurses On 05/15/16 at 3:40 PM NA #1 was interviewed. NA #1 stated she was responsible for 31 residents on 1st shift from 7:00 AM to 3:00 PM. NA #1 indicated most residents were supposed to have 2 showers a week and that sometimes they only get 1 shower a week. She stated the residents were not checked on or changed as they needed to be and due to the facility being short staffed and working with no other NA for assistance she would often transfer a resident by herself using the mechanical lift. NA #1 further indicated the resident's personal hygiene care and ADL care was not provided as it should be because she was unable to get around to all 31 residents in an 8 hour shift and provide care to the residents adequately. On 05/15/16 at 4:10 PM NA #6 was interviewed. NA #6 indicated she had worked an 8 hour shift and due to a staff call out she was working until another staff member could relieve her. NA #6 stated the NAs did the best they could but due to the facility being short staffed the resident care needs were not met. On 05/16/16 at 2:08 PM NA #4 was interviewed. NA #4 reported the facility was short staffed and the care of the residents was not being provided and that the NAs worked short staffed most days.	F 353	retention. Also partnering with our QIO on implementing new retention & recruitment tools. Executive director will review staffing pattern with the DNS weekly for the next 3 months. 4. GLC-Asheville will monitor the corrective plan to ensure the practice was corrected and will not reoccur is The monitoring tools will be presented to the ED and/or DNS at Morning/Stand-Down Meetings. The ED will report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions as needed to ensure continued compliance. 5. The correction date for substantial compliance is June 24, 2016.	

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On 05/17/16 at 4:47 PM NA #2 was interviewed. NA #2 stated she was responsible for 28 residents on 2nd shift from 3:00 PM to 11:00 PM. NA #2 reported due to working short staffed the NAs had not had time to provide oral care, showers, nail care, and that the resident's basic needs were not always met such as keeping them clean and dry. NA #2 also reported there were many times that she had transferred a resident using a mechanical lift by herself because there was no one to help assist.

On 05/18/16 at 2:10 PM NA #7 was interviewed. NA #7 reported she had transferred a resident using a mechanical lift by herself. NA #7 also reported the facility was short staffed and the care of the residents was not being provided and the NAs worked short staffed most days.

On 05/18/16 at 4:32 PM an interview was conducted with a resident's legal representative (RP). The RP stated that her loved ones basic care needs were not being met due to the facility being short staffed most days. The RP reported she had visited her loved one when they were wet and soiled, with dried food on their clothing, and a strong odor in the resident room. The RP indicated the resident was supposed to receive a shower 2 times a week and they had not received a shower but 1 time a week for a long time. The RP further indicated on the days she visited the resident she would give him a complete bed bath in order for him to feel better and not smell. The RP stated she had spoken with the Director of Nursing (DON) and the Administrator in regards to the facility being short staffed and that all she had ever been told was that they were working on getting more staff hired.

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On 05/19/16 at 10:37 AM Nurse #8 was interviewed. Nurse #8 stated the expectation was for a resident to have at least 2 showers a week or more should the resident request more, residents who were incontinent should be checked and changed at least every 2 hours, and there should always be 2 staff when a resident was transferred using a mechanical lift. Nurse #8 reported that the nurses had had to work as NAs due to the facility being short staffed.

On 05/19/16 at 11:10 AM Nurse #7 was interviewed. She stated she had been assigned to assist on the halls in the capacity of a Nurse Aide due to the halls being short staffed and that she was responsible for taking call also. Nurse #7 further stated the NAs could not keep the residents clean, dry, complete showers, and the ADL were not getting done due to the lack of staffing. Nurse #7 reported that the nurses have had to work as NAs at least 1 to 2 days a week in the past several months due to the facility being short staffed.

On 05/19/16 at 2:00 PM NA #8 was interviewed. NA #8 stated the NAs worked short staffed most days. NA #8 further stated the NAs do the best they can and that it was impossible to complete the resident's care such as showers, oral care, and shaving due to the facility being short staffed.

On 05/19/16 at 2:30 PM the Director of Nursing (DON) was interviewed. She stated it was her expectation that all care should be provided to the resident and if certain care areas were missed they should be reported for the next shift to do. The DON stated she was aware and had identified a problem of the staffing shortage and the administrative staff was working to hire

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F 353	Continued From page 75 additional employees. The DON further stated she did not know what needs were not being met for the residents except for showers due to staffing. The DON confirmed there had been many instances when staff from the staffing agency worked in an attempt to meet the resident's needs.	F 353		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to follow a physician's order for lab work for 1 of 5 sampled resident (Resident #49). The findings included: 1. Resident #49 was admitted to the facility on 07/22/14 with diagnoses which included diabetes, high cholesterol, hyperthyroidism, renal failure, anemia, arthritis and chronic pain. Review of medical records indicated Resident #49 had physician's orders originating on 07/22/14 with no stop date for the following: a. "BMP, A1c and CBC every 3 months (Sept, Dec. March, June)" b. "TSH, Lipid panel, LFT every 6 months (Sept, March)" A review of the lab reports in the medical record indicated the Basic Metabolic Panel (BMP - a series of 7 or 8 blood chemistry tests), A1c (blood test showing how well diabetes is controlled), Complete Blood Count (CBC - a blood test used	F 502	F 502 ADMINISTRATION – LABORATORY SERVICES Golden Living Center - Asheville (GLC-Asheville) provides laboratory services to meet the needs of our residents. 1. The corrective action accomplished for Resident #49 is the attending physician was contacted and ordered Basic Metabolic Panel (BMP), Complete Blood Count (CBC), Thyroid Stimulating Hormone (THS) and A1C (blood test showing how well diabetes is controlled) on May 20, 2016. The same day the results were called to the attending physician; no changes were ordered. 2. Residents who have been identified by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team	6/24/16

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F 502	Continued From page 76 to evaluate overall health and detect a wide range of disorders including anemia), Thyroid Stimulating Hormone (TSH - a blood test used to detect problems with the thyroid gland), Lipid Panel (helps determine risk of developing heart disease) and Liver Function Tests (LFT - groups of blood tests that provide information about the condition of the liver) had not been completed in March 2016. The most recent labs for BMP, CBC and A1c were in December of 2015. The TSH was collected in September 2015 and the LFT and Lipid Panel were collected in August 2015. During an interview with the Medical Records Director on 05/19/2016 at 10:31 AM, she indicated she had reviewed the medical records and could find no lab results so she contacted the lab services they used and they verified these six labs had not been completed this year and the most recent labs were in December of 2015. During an interview with the Director of Nursing (DON) on 05/20/16 at 7:43 AM, she stated she had identified poor lab follow through as a problem when she first started working at the facility and she had been working toward a resolution. The DON stated the changes included 3rd shift licensed nurses now check to see if there was any dictation on that day from a physician with lab orders, then they transfer the information into the lab book and monitor to ensure there is follow through with the lab orders. The lab book was started in April 2016 and identified when each resident had labs due. She acknowledged all labs were done through an outside laboratory and her expectation was for all lab orders to be followed with 100 percent accuracy.	F 502	(comprised of Department Heads and their assistants, and Unit Managers) to have the potential to be affected are current residents. An audit of the facility was completed for Laboratory Services (LABs) to ensure all ordered LABs were completed timely. 3. The measures put in place or systemic changes made are: Licensed Nurses were re-educated by DNS on June 9, 2016 and June 15, 2016; new nursing staff during orientation will be educated on LAB protocol, how to write LAB orders, LAB requisitions, ensure LAB was obtained and sent; notify the attending physician of results and carry out new orders. LAB book will be checked daily by Charge Nurse. Audits and monitoring will be completed five times a week for one month, three times a week, and then once a week. These audits will be brought to the Morning/Stand-Down Meetings to be reviewed. These records will be reviewed by ED and/or DNS at Morning/Stand-Down Meetings. 4. The GLC-Asheville will monitor the corrective plan to ensure the practice was corrected and will not reoccur is the ED will report the audits from LAB services to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions and needed to ensure continued compliance. 5. The correction date for substantial compliance is June 24, 2016.	

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F 520	Continued From page 77	F 520		
F 520 SS=E	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 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 facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place August 2015 and October 2015. This was for eight recited deficiencies which were originally cited June 2015 on the recertification survey and	F 520	F520 QAA COMMITTEE □ MEMBERS/MEET QUARTERLY/PLANS Golden Living Center - Asheville (GLC-Asheville) has maintains a quality assessment and assurance committee consisting of the director of nursing services, a physician, and at least three	6/24/16

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F 520	Continued From page 78 on the current recertification survey. The deficiencies were in the areas of choices, accommodation of needs, services to meet professional standards, activities of daily living, pressure sores, accidents, sufficient staffing, and quality assessment and assurance. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 1a. F242: Choices: Based on observations, record review, resident, and staff interviews the facility failed to honor a resident's choice for the number of showers in a week for 4 of 4 residents who were reviewed for choices (Resident #40, #34, #14, and #49). During the recertification survey of June 27, 2015 the facility was cited for F242 for failure to honor a resident's choice of the time for getting up in the mornings and failed to honor a resident's food preferences. On the current recertification survey the facility failed to honor a resident's choice for the number of shower in a week. b. F246: Accommodation of Needs: Based on observations, medical record review, staff, and resident interviews the facility failed to place a call light within reach for 1 of 1 resident reviewed for accommodation of needs (Resident #48). During the recertification survey of June 27, 2015 the facility was cited for F246 for failure to keep a call bell in reach. On the current recertification	F 520	other members of the facility□s staff. The committee identifies issues with respect to which quality assessment and assurance activities are necessary; and develops and maintains appropriate plans of action to correct identified quality deficiencies. 1. The corrective action accomplished for F242 Choices; F246 Accommodations of Needs; F281 Services to meet Professional Standards; F312 Activities of Daily Living; F314 Pressure Sores; F323 Accidents; F353 Sufficient Staffing; is as follows: F242: The corrective action accomplished for Residents #40, #34, #49 was shower preferences were reviewed with these residents and Resident #14 resident□s representative shower preference was discussed and new shower schedule was completed to allow these residents to obtain showers at their preference. This was completed on May 25, 2016. F246: The corrective action accomplished for Residents #48 is immediately after notification the call light was not in reach of Resident #48 it was placed correct position according to resident□s plan of care. F281: The corrective action accomplished for Residents #10 was the contents of the medicine cup was discarded on May 16, 2016. Resident # 49 was provided three cups of ice water and her preferences was updated to include three cups of ice water each shift. This was completed on May 20, 2016. F312: The corrective action accomplished for Residents #40, #34, #34 was shower preferences were reviewed	

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	345010	A. BUILDING _____ B. WING _____	C 05/20/2016

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F 520	Continued From page 79 survey the facility failed to place a call light within reach of a resident. c. F281: Services to Meet Professional Standards: Based on observations, medical record review, staff, and resident interviews, the facility failed to provide services that met professional standards for 2 of 2 residents reviewed (Resident #10 and #49). During the recertification survey of June 27, 2015 the facility was cited for F281 for failure to clarify the correct method of administration of medication and the correct dose of medication. On the current recertification survey the facility failed to provide services that met professional standards. d. F312: Activities of Daily Living: Based on observations, record review, resident, and staff interviews the facility failed to assist residents with a shower who were totally dependent on staff for bathing for 2 of 2 residents sampled for activities of daily living (Resident #40 and #34). During the recertification survey of June 27, 2015 the facility was cited for F312 for failure to provide personal hygiene for dependent residents in need of showering, shaving, and fingernail care. On the current recertification survey the facility failed to assist residents with a shower who were totally dependent on staff for bathing. e. F314: Pressure Sores: Based on observations, record review, resident, and staff interviews the facility failed to provide ordered weekly wound assessments and failed to provide incontinence care to a resident with facility acquired pressure sores for 1 of 1 residents	F 520	with these residents and Resident #14 resident□s representative shower preference was discussed and new shower schedule was completed to allow these residents to obtain showers at their preference. This was completed on May 25, 2016. F314: The corrective action accomplished for Resident #40 is that according to the Wound Evaluation Flow Sheet dated February 17, 2011 (time of admission) a Stage IV Length 8.7cm by width 6.5cm by depth 1.4cm. and another Stage III area Length 2.3 cm by width 6.6cm by depth 0.3cm both areas were located on the resident□s sacrum. Resident #40 did not acquire a pressure sore while in the facility to his/her sacrum. Resident #40 currently has a subpubic catheter and colostomy; therefore, does not require assistance with toileting; however, he/she is checked every shift and/or as needed for catheter and/or colostomy care. This was completed as of May 20,2016. Resident #40 and with his permission his family were asked about his care as it relates to the allegation he did not receive incontinence care and when it occurred. This was so the facility could do an appropriate investigation and grievance/concern according to facility policies and procedures. Completed as of June 17, 2016. F323: The corrective action accomplished for Resident #14 is his/her interventions were reviewed and updated to prevent future falls on June 15, 2016. A new Recreation Services Assessment will be	

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F 520	Continued From page 80 reviewed for pressure sores (Resident #40). During the recertification survey of June 27, 2015 the facility was cited for F314 for failure to provide dressing changes as ordered and/or complete weekly skin assessments as ordered and failed to change a wound vacuum assisted closure device. On the current recertification survey the facility failed provide weekly wound assessments and provide incontinence care to a resident with facility acquired pressure sores. f. F323: Accidents: Based on observations, interviews and record reviews the facility failed to implement interventions for a resident with a history of falls for 1 of 1 resident reviewed for falls (Resident #14). During the recertification survey of June 27, 2015 the facility was cited for F323 for failure to analyze the circumstances of 2 falls and place an alarm on the bed. On the current recertification survey the facility failed to implement interventions for a resident with a history of falls. g. F353: Sufficient Staffing: Based on observations, record review, family, staff, and resident interviews the facility failed to provide sufficient nursing staff to meet the needs of 5 of 5 residents on 2 of 2 halls in the areas of staff not meeting the needs of the residents such as showers, incontinent care, and/or services to meet the residents activities of daily living needs (Residents #40, #34, #14, #49, and #26). During the recertification survey of June 27, 2015 the facility was cited for F353 for failure to provide sufficient nursing staff to meet the needs of 63 residents present in the facility with a bed	F 520	completed by June 23, 2016 with input from Resident #14□s family member and included in his/her plan of care to attend activities of choice to prevent falls. F353: The measures put in place or systemic changes made are: Nursing management and Executive Director evaluated the staffing patterns to establish patient acuity and staffing ratio required. DNS evaluated the nursing staff schedule to accommodate the needs of residents i.e. 12 hour shifts, 3 positions for personal care assistant (PCA) was open to meet non-nursing direct care. duties. Review daily staffing schedule to ensure adequate nursing staff is available to accommodate the acuity level and provide quality care. Facility is networking with area Nursing Homes, Community Colleges, and Agency pools for staffing, recruitment and retention. Also partnering with our Quality Improvement Organization (QIO) on implementing new tools related to retention & recruitment. Executive Director ((ED) Administrator) will review staffing pattern with the DNS weekly for the next 3 months. A special called meeting of the (Quality Assessment Performance Committee (QAPIC) was held on June 15, 2016 to discuss their role in the corrections process for the areas of concern. Reporting and monitoring as outlined in those plans of corrections respectively will be addressed. 2. Residents who have been identified by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads, their	

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F 520	Continued From page 81 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. On the current recertification survey the facility failed to provide sufficient nursing staff to meet the needs of the residents such as showers, incontinent care, and/or services to meet the resident's activities of daily living needs. During the current recertification survey the facility failed to maintain implemented procedures and monitor these interventions that the committee put into place August 2015 and October 2015. This was for eight recited deficiencies which were originally cited June 2015 on the recertification survey and on the current recertification survey. The deficiencies were in the areas of choices, accommodation of needs, services to meet professional standards, activities of daily living, pressure sores, accidents, sufficient staffing, and quality assessment and assurance. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. On 05/20/16 at 4:00 PM the Administrator stated he began working for the facility March 2016. The Administrator stated he had reviewed the 2567 from last year's recertification survey in June 2015. The Administrator stated he realized there were a number of issues at that time and there were still a number of issues since he became the Administrator in March. He stated the Quality Assurance meetings were being held every 2 weeks with ongoing monitoring of areas cited during the June 2015 recertification survey in the areas of choices, accommodation of needs,	F 520	assistants, and Unit Manager/Coordinator) to have the potential to be affected are current residents. Please see the measures put in place under section #3. 3. The measures put in place or systemic changes made are: All results from the monitoring and action plan steps will be discussed in detail at each QAPI meeting for 3 months, and existing action steps will be revised or added to ensure correction. The new ED has been trained in the Malcolm Baldrige National Quality Award Program and is a current Senior Examiner for the Quality Award Program with the American Health Care Association. He will be incorporating Best Practices in the QAPI program at GLC-Asheville. Also GLC-Asheville will be partnering with our QIO to help staff understand Best Practices and ways to prepare the facility for the future needs of our residents. 4. GLC-Asheville will monitor the corrective plan to ensure the practice was corrected and will not reoccur is The monitoring tools will be presented to the ED and/or DNS at Morning/Stand-Down Meetings. The ED will report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions as needed to ensure continued compliance. The QAPIC will determine the scope and span as well as continued necessity of any continuing or expanded monitoring,	

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F 520	Continued From page 82 services to meet professional standards, activities of daily living, pressure sores, accidents, sufficient staffing, and quality assessment and assurance.	F 520	as well as any further interventions and corrective actions. These activities will be recorded within the minutes maintained by the facility for QAPIC. By monitoring the other plans of correction for effectiveness, the committee will continually insure that its goal of quality and performance improvement is accomplished. 5. The correction date for substantial compliance is June 24, 2016.	