

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345010 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 03/03/2017 |
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| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ASHEVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804 | | |
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| F 000 | <p>INITIAL COMMENTS</p> <p>1. 483.12 (F223) at J Immediate Jeopardy began on 02/22/17 when Resident #59 was verbally abused by ED #1. Immediate Jeopardy was removed on 03/03/17 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to residents rights to be free from abuse.</p> <p>2. 483.12 (F225) at J Immediate Jeopardy began on 02/22/17 when the Director of Nursing (DON) and Patient Care Assistant (PCA) #1 witnessed the ED verbally abuse Resident #59, but did not immediately report the verbal abuse to the AVP. Immediate Jeopardy was removed on 03/03/17 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to informing the ED and/or AVP of witnessed or alleged incidents of abuse.</p> <p>3. 483.12 and 483.95 (F226) at J Immediate Jeopardy began on 02/22/17 when the facility did not follow its policy to immediately report a verbal threat made by Executive Director (ED) #1 to abuse Resident #59 and did not immediately protect Resident #59. The Director of</p> | F 000 | | | |

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

TITLE

(X6) DATE

Electronically Signed

03/24/2017

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 000 | <p>Continued From page 1</p> <p>Nursing (DON) and Patient Care Assistant (PCA) #1 witnessed the incident but did not immediately report the verbal abuse to the AVP as required according to the facility's abuse policy. The DON allowed the perpetrator to remain in the building without supervision for 2 additional hours. Immediate Jeopardy was removed on 03/03/17 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to protecting residents from being abused and following the abuse policy.</p> <p>4. 483.70 (F490) at J Immediate Jeopardy began on 02/22/17 at 4:00 PM when Resident #59 was verbally abused by ED #1. The Director of Nursing (DON) and Patient Care Assistant (PCA) #1 witnessed ED #1 threatening to hit Resident #59. The DON allowed the perpetrator to remain in the building without supervision for 2 additional hours. Neither the DON or PCA #1 notified the AVP immediately of the incident. Immediate Jeopardy was removed on 03/01/17 at 5:09 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to protecting residents from being abuse, notifying the AVP and following the facility's abuse policy and procedure.</p> | F 000 | | | |

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| F 000 | Continued From page 2 | F 000 | | | |
| F 223 SS=J | <p>An extended survey was conducted as part of the facility's recertification and complaint investigation conducted from 02/26/17 through 03/03/17. Event ID# KHTF11.</p> <p>On 03/20/17 the facility was provided with an amended 2567 report. Additional information was included to tag F-000. Event ID# KHTF11.</p> <p>483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.</p> <p>483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interviews, record review and staff interviews, the facility failed to maintain 1 of 3 sampled residents' right to be free from verbal abuse (Resident #59) when Executive Director (ED) #1 threatened to hit Resident #59 causing 4 of 7 residents who witnessed the incident to be afraid, nervous and anxious (Residents #22, #59, #72 and #86).</p> <p>Immediate Jeopardy began on 02/22/17 when Resident #59 was verbally abused by ED #1.</p> | F 223 | <p>Preparation, submission and implementation of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the state of deficiencies. The plan of correction is prepared and/or executed solely because it required by provisions of federal and state law.</p> <p>Golden Living Center-Asheville has policies and procedures that prohibit</p> | 4/4/17 | |

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| F 223 | <p>Continued From page 3</p> <p>Immediate Jeopardy was removed on 03/03/17 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to residents rights to be free from abuse.</p> <p>The findings included:</p> <p>Resident #59 was admitted to the facility on 01/03/17 with diagnoses that included chronic obstructive pulmonary disease, pneumonia, hypertension and major depressive disorder.</p> <p>The admission Minimum Data Set (MDS) dated 01/10/17 coded Resident #59 as having intact cognition, scoring a 14 out of 15 on the Brief Interview for Mental Status, which measures long and short term memory and temporal orientation. She was coded as understanding others and being understood. She was coded as having no psychosis, behavioral symptoms or rejection of care.</p> <p>A note by the Social Worker (SW) dated 02/22/17 at 9:36 AM indicated that Resident #59 was observed at 8:50 AM outside the West Wing exit squatted down between two bushes smoking. She was asked to extinguish her cigarette and return to the covered area at the front entrance to wait for transit to take her to an appointment. According to the note, Resident #59 was informed that her smoking privileges were revoked.</p> | F 223 | <p>mistreatment, neglect, exploitation and abuse of resident and misappropriation of resident property.</p> <p>1. Resident #59 has been discharged from facility on 2/22/17. Resident #59 has visited the facility since discharge with no concerns about safety of fear.</p> <p>2. Residents #29 and #72 have been discharged from the facility on 3/8/17. Before discharged were asked if they felt safe or had any fears and they did not. Residents #22, #66, #86, were interviewed on 2/24/17 to make sure they feel safe. All other residents have the potential to be affected.</p> <p>3. Staff was educated on the different types of abuse, and the Golden Living Abuse Polices and Procedures, by Social Worker, ADNS and DNS. Beginning 2/23/17, 2/24/17 and ongoing to be completed by 3/31/17 or any that have not completed will not be eligible to work. Included in this education is how to identify and how to respond if an actual or allegation of abuse is identified, regardless of who the alleged perpetrator is. Abuse training is part of the orientation process for new staff and reviewed with staff annually. In-services began 2/23/17 with all staff to be completed by 3/31/17. All staff received copy of Golden Living Center Abuse and Neglect Policies and re-educated and any staff that has not completed will not be eligible for work, training provided by DNS/BOM and BOMA. The Business Office Manager(BOM)or designee will check Monday thru Friday to make sure all</p> | | |

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| F 223 | <p>Continued From page 4</p> <p>An interview with the Director of Nursing (DON) on 02/26/17 at 2:05 PM revealed Resident #59 was observed on 02/22/17 about 9:00 AM near the West Wing emergency exit in the shrubbery smoking and was asked by the SW and Executive Director (ED) #1 to extinguish the cigarette and ED #1 informed Resident #59 that her smoking privileges were revoked. The DON stated later that morning Resident #59's physician notified ED #1 that he smelled a strong odor of cigarette smoke in Resident #66's room, the room adjacent to Resident #59's room. The DON stated both residents' rooms were searched and Resident #59 turned in 2 packs of cigarettes and a lighter. The DON stated Resident #59 was observed in the outside smoking area at 2:00 PM smoking with the other residents. The DON stated she and ED #1 met with the department managers at 3:00 PM on 02/22/17 to discuss Resident #59's violation of the smoking policy and she scheduled a meeting for 4:00 PM on 02/22/17 with all the residents who smoked and asked ED #1 to be at the meeting to reinforce the smoking rules.</p> <p>The DON stated she and ED #1 walked outside to the smoking area around 4:00 PM and observed Resident #59 was smoking a cigarette. The DON stated ED #1 asked Resident #59: "What are you doing out here? Why are you smoking?" and Resident #59 replied: "I'm just out here smoking one last time before I go." The DON stated that ED #1 then told Resident #59: "You need to leave. I want you to leave right now." The DON reported that Resident #59 continued to smoke and said: "I'm going; I'm going; I'm leaving." Then ED #1 told Resident #59: "You need to leave before I hit you." The DON stated she assured the residents that no one was going</p> | F 223 | <p>employees compliance training on abuse is completed and up to date.</p> <p>4. Department Managers are assigned residents and do daily room rounds Monday thru Friday asking residents if they know what abuse is and if they feel safe and if they have any abuse to report and discuss at Stand up and Stand Down meetings Monday thru Friday.</p> <p>5. Starting on 3/1/17 during care plans the social service or designee will ask residents and families if they feel safe have any abuse to report and know what abuse is.</p> <p>Director of Field Clinical Services for Golden Living educated the Department Managers on 3/22/17(ED,DNS,MDS Coordinator ,BOM, Admissions Coordinator, Dietitian, Dietary Manager, Housekeeping Supervisor, Rehab Director, Social Services, and Central Supply Coordinator) On identifying the signs and symptoms of stress and burnout. Coping strategies for coping with stress and burnout and we have EAP(employee assistance program) available for additional support. Education also included strategies for working with residents that can present challenging behaviors and identification of strategies work with these residents.</p> <p>6. Other staff will receive the education by 4/4/17 on identifying the signs and symptoms of stress and burnout, training by Psychologist, DNS, and FSCD. Coping strategies for coping with stress and burnout EAP(employee assistance program) available for all staff for</p> | | |

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| F 223 | <p>Continued From page 5</p> <p>to hit any of them and asked Resident #59 to go inside and told ED #1 that he needed to relax and that no one was going to hit anybody. The DON stated she could tell that Resident #59 was scared and Resident #59 went inside the facility. The DON stated ED #1 remained outside in the smoking area with her and the other residents while she reviewed the facility's smoking policy and ED #1 talked about safety concerns related to residents smoking in non-designated areas. The DON stated she and ED #1 went back inside but the residents remained outside for their smoke break with other staff. The DON stated she went to look for Resident #59 to make sure she was all right then heard the residents outside in smoking area talking about being upset about what happened.</p> <p>An interview on 02/27/17 at 3:12 PM with Patient Care Assistant (PCA) #1 revealed she was outside supervising the residents on 02/22/17 at the 4:00 PM smoke break. PCA #1 stated Resident #59 came out with the other residents and she told her she wasn't allowed to smoke because her privileges had been revoked. PCA #1 stated Resident #59 told her she was just coming out to talk to the other residents. PCA #1 stated she was lighting another resident's cigarette and heard ED #1 tell Resident #59 to "get out of here before I hit you." PCA #1 stated she didn't see Resident #59 smoking. PCA #1 stated the DON moved closer to ED #1 and Resident #59 went back in the building. PCA #1 stated that Resident #29 told ED #1 that she was going to call the Ombudsman and he got mad and went back in the facility. PCA #1 stated the DON reviewed the smoking rules with the residents then she went in the building. PCA #1 stated about 5 minutes later ED #1 came back</p> | F 223 | <p>additional support. Education included for strategies for working with residents that can present with challenging behaviors effectively.</p> <p>7. Monitoring for compliance Interim ED/DNS Designee and Activity Director will conduct Resident Council meetings weekly for 4 weeks beginning 3/20/17, and then bi-weekly times 1 month then resume monthly meetings to review abuse policies and see if residents feel safe. The Interim Ed will conduct random resident interviews of residents that do not attend the Resident Council Meetings. Five random staff audits weekly for 4 weeks of the Abuse and Neglect Policies and Procedures to include what to do if an allegation or actual abuse /neglect situation is identified. The results of the audits will be reviewed at QAPI monthly meetings to review and analyze for patterns and trends. The AVP(Area Vice President) and or the DFCS(Director of Field Clinical Services) will attend the QAPI meeting either in person or via Web EX. The QAPI team will evaluate the results and implement additional interventions as indicated to ensure continued compliance. Correction date for substantial compliance is 4/4/17. The Interim ED/DNS/SW responsible for compliance.</p> | | |

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| F 223 | <p>Continued From page 6</p> <p>outside for a split second and told the residents he was going to call the Ombudsman about the incident because what he said was wrong.</p> <p>A second interview with the DON on 02/28/17 at 9:12 AM revealed 11 residents were outside in the smoking area on 02/22/17 at 4:00 PM. The DON stated the residents told her that ED #1 had come back outside but she didn't observe ED #1 outside. The DON stated she met Resident #59 in the hall and went to her office with Resident #59 to get her cigarettes and lighter then walked with her to the front entrance. The DON stated Resident #59 wanted to say good-bye to a friend on the West Wing and as they passed ED #1's office, he came out in the hall and apologized to Resident #59. The DON stated Resident #59 left.</p> <p>An interview with ED #1 on 02/28/17 at 5:00 PM revealed he went outside to the smoke area on 02/22/17 at 4:00 PM after a staff member reported seeing Resident #59 smoking in the outside smoking area with other residents. ED #1 stated he asked Resident #59: "What are you doing?" and she didn't respond. ED #1 stated he then asked Resident #59: "Where did you get that cigarette?" and she still didn't respond. ED #1 stated he then said to Resident #59: "I can't believe you're out here smoking" and Resident #59 replied: "I wanted one last cigarette. ED #1 stated he then told Resident #59: "You need to put that cigarette out and you need to leave the smoking area" but Resident #59 didn't say anything or get up to leave. ED #1 stated he was standing about 10 - 12 feet away from Resident #59. ED #1 stated he then told Resident #59: "You need to get up and leave now before I hit you." ED #1 stated he couldn't believe what he had just said and immediately told Resident #59:</p> | F 223 | | | |

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| F 223 | <p>Continued From page 7</p> <p>"I just violated your rights. I'm so sorry. I didn't mean that." ED #1 stated Resident #59 left the smoking area and went in the facility. ED #1 stated he remained outside with the DON while she reviewed the smoking rules but he didn't say anything further. ED #1 stated he and the DON came back in the building around 4:30 PM and he told her they needed to report the incident. ED #1 stated someone told him they heard the residents in the smoking area talking about calling the Ombudsman so he stepped back outside in the smoking area briefly to tell the residents he was going to notify the Ombudsman of the incident himself. He was unable to recall the exact time that he went back outside but stated it was between 4:30 PM and 5:00 PM. The ED stated about 5:00 PM he saw Resident #59 in the hall near the West Wing nurses station and he went out to apologize.</p> <p>During a telephone call on 02/28/17 at 7:59 PM with Resident #59 when she was asked if she was abused while she was a resident at the facility, she stated no she wasn't. When asked if anything happened outside on 02/22/17 at the 4:00 PM smoke break and if she was threatened, Resident #59 stated she wasn't threatened but was asked to go back inside which she did. Resident # 59 stated she knew she wasn't supposed to be out in the smoking area and she knew they were just setting an example for the other residents. When asked if ED #1 threatened to hit her- Resident #59 stated he didn't threaten to hit her. She stated he just told her to go back inside. When asked if she ever felt afraid that ED #1 was going to hit her, she stated she didn't feel afraid that he was going to hit her.</p> <p>On 03/01/17 at 2:14 PM Resident #59 came to</p> | F 223 | | | |

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| F 223 | <p>Continued From page 8</p> <p>facility to speak to surveyor and stated she didn't really tell the truth about ED #1 during the phone interview on 02/28/17 because she was afraid of getting in trouble for smoking and also afraid of getting the DON in trouble. Resident #59 stated ED #1 came out in the smoking area and asked her: "What are you doing?" Resident #59 stated she told him she was having one last smoke break. Resident #59 stated ED #1 asked her: "Where did you get that cigarette?" She said she told him it fell out in her purse. She said ED #1 then told her: "You get in there before I hit you." Resident #59 stated ED #1 had his fists clenched at his side and it really scared her. Resident #59 stated the DON was in the smoking area with them and told her that ED #1 wouldn't hit her. Resident #59 stated she was still shaking when her family arrived to pick her up. Resident #59 stated she was getting ready to leave when ED #1 apologized to her at the West Wing nurse's station.</p> <p>Resident # 72 was admitted to the facility on 01/20/17 with diagnoses including: osteomyelitis, hypertension, generalized anxiety disorder and depression. A significant change MDS dated 01/31/17 coded Resident #72 as having intact cognition with a BIMS score of 15 out of 15. She was coded as understanding others and being understood. She was coded as having no delirium, psychosis, behavioral symptoms or rejection of care.</p> <p>An interview on 02/27/17 at 10:53 AM with Resident #72 revealed she was in the outside smoking area on 02/22/17 at 4:00 PM when ED#1 came raging through the door and around to the table where another resident was sitting and told her to get out of his building before he hit</p> | F 223 | | | |

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| F 223 | <p>Continued From page 9</p> <p>her. Resident #72 stated ED #1's fist was clenched but then he unclenched his fist and didn't do anything. Resident #72 stated she was frightened because ED #1 was in such a rage and raised his voice and she wasn't sure what he was going to do. Resident #72 stated she didn't feel threatened now but would feel scared if ED #1 came back to the facility.</p> <p>An interview with Resident #29 on 02/27/17 at 10:55 AM revealed she was in the outside smoking area on 02/22/17 at the 4:00 PM smoke break with other residents for a meeting with the DON and ED #1. Resident #29 stated she saw one resident smoking when she went outside and none of the other residents had their cigarettes. Resident #29 stated when ED #1 came out and saw Resident #59 smoking he asked her what she was doing and where she got her cigarettes. Resident #29 stated ED #1 then told Resident #59 to get out of his building right now before he hit her and his fists were balled up. Resident #29 stated the DON very quickly said: "No one is going to hit anybody." Then, ED #1 told Resident #59 that he wasn't going to hit her. Resident #29 stated the DON and ED #1 went ahead with the meeting to discuss the smoking rules then went back in the facility. Resident #29 stated she and the other residents were discussing calling the Ombudsman and ED #1 came back outside and told them that he was going to call the Ombudsman about the incident. Resident #29 stated when she came in from the smoking area and past the front entrance ED #1 was at the front door with the men who were working on the door. Resident #29 stated she didn't see ED #1 after that time. Resident #29 stated she was angry about what ED #1 said to Resident #59 because it was very inappropriate for someone in</p> | F 223 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345010 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 03/03/2017 |
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| F 223 | <p>Continued From page 10</p> <p>his position to threaten to hit a resident.</p> <p>Resident #86 was admitted to the facility on 12/11/16 with diagnoses including Diabetes Mellitus type II, Anemia and Depression. An admission MDS dated 12/22/16 coded Resident #86 as having intact cognition with a BIMS score of 15 out of 15. She was coded as understanding others and being understood. She was coded as having no delirium, psychosis, behavioral symptoms or rejection of care.</p> <p>An interview on 02/27/17 at 11:06 AM with Resident #86 revealed she was in the outside smoking area on 02/22/17 at the 4:00 PM smoke break with the other residents. Resident #86 stated ED #1 came out the door shouting at another resident and asked her why she was out there and where she got the cigarettes. Resident #86 stated ED #1 was sort of wild-looking and told the other resident to get out of the smoking area before he hit her. Resident #86 stated ED #1's face was red and his fist was clenched at his side. Resident #86 stated she was nervous and anxious because she didn't know what he was going to do.</p> <p>An interview with Resident #66 on 02/27/17 at 11:38 AM revealed she was in the outside smoking area with other residents on 02/22/17 at the 4:00 PM smoke break and heard ED #1 tell Resident #59 to get off the premises before he hit her but he then apologized as soon as he said it. Resident #66 stated it didn't scare her and she didn't feel like ED #1 was going to hit Resident #59.</p> <p>Resident #22 was admitted to the facility on 09/27/16 with diagnoses including congestive</p> | F 223 | | | |

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| F 223 | <p>Continued From page 11</p> <p>heart failure, hypertension, diabetes mellitus type II, anxiety disorder and depression. A quarterly MDS dated 12/23/16 coded Resident #22 as having intact cognition with a BIMS score of 15 out of 15. She was coded as understanding others and being understood. She was coded as having no delirium, psychosis, behavioral symptoms or rejection of care.</p> <p>An interview on 02/27/17 at 3:05 PM with Resident #22 revealed she was in the outside smoking area on 02/22/17 at the 4:00 PM smoke break and was sitting beside Resident #59. Resident #22 stated that ED #1 saw Resident #59 smoking and yelled at her that he was so mad he could hit her. Resident #22 said the residents in the smoking area after the incident were discussing calling the Ombudsman when ED #1 came back outside and screamed out at them that he was calling the Ombudsman himself. Resident #22 stated she was upset for 2 days.</p> <p>On 03/01/17 at 9:14 AM, ED #2 was informed of Immediate Jeopardy. The Administration provided an acceptable allegation of compliance on 03/03/17 at 2:45 PM.</p> <p>Allegation of Compliance GLC Asheville March 3rd, 2017 F 223 Abuse The Immediate Plan below was implemented beginning on 2/22/17 to ensure all residents will be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Residents have the right to exercise his or her rights. 02/22/17 at or around 4 PM, the facility's Executive Director (ED) entered the facility's</p> | F 223 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/29/2017
FORM APPROVED
OMB NO. 0938-0391

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| F 223 | Continued From page 12 outside smoking area and approached resident #59 for smoking after her privileges had been revoked. Where he proceed to verbally abuse #59 by stating to her if she did not leave the facility he would hit her. The Director of Nurses was witness to the event and had resident # 59 come to her side and addressed all the smoking residents: #29, #72, #86, #10, #23, #79, #67, #66, #22, #28 and #75. The Director of Nurses explained that no one was going to be abused, asked if they felt safe and reviewed smoking policy with them. They all replied yes to feeling safe. Then the Executive Director and Director of Nurses reentered the building and the Executive Director went to his office. Then the Director of Nurses heard the outside smoking group talking loudly and she went outside and they stated the Executive Director had come back to the smoking outside door and stated I will be calling the ombudsman to report myself. She asked if they were ok and they all replied yes and she explained to the residents not to worry she would be reporting to all appropriate agencies. Resident #59 was discharging as previously planned and needed her belongings that were locked in Director of Nursing office and the Director of Nursing proceeded to assist with her discharge and had the MDS Coordinator stay with the Executive Director till she finished assisting resident #59. The Director of Nurses then called the North Carolina Ombudsman and then the Executive Director's superior, Regional Vice President of Operations, to let him know of the incident and he suspended the Executive Director immediately. Executive Director was suspended and left the facility on 02/22/17 at or around 6:20 PM pending investigation and was terminated on 02/27/17 at 7:45 AM. | F 223 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| F 223 | <p>Continued From page 13</p> <p>The Director of Nurses failed to follow facility abuse policy to immediately remove the Executive Director from facility. She was reeducated on abuse, neglect policy and chain of command by Field Service Clinical Director on 03/01/17 and with any abuse she has the authority to remove her superior in the event of alleged abuse while investigation pending. Maintaining resident's safety at all times. This incident was reported by Director of Nurses Services to ombudsman on 02/22/17 via voice mail at or around 6 PM.</p> <p>The 24 hour reportable was started and completed 02/23/17 and sent to North Carolina Department of Health and Human Services All other residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. On 03/01/17 the managers interviewed all other interviewable residents for any signs of abuse, understanding of abuse, if they know how to report abuse, and if they have any abuse they would like to report. Beginning on 03/01/17 Department Managers or designee will monitor with daily room rounds by asking the residents if they feel safe, if they want to report any abuse and if they know what abuse is. Beginning 03/01/17 during the residents care plans Social Worker will ask the residents if they feel safe, if they know what abuse is, who do you report abuse to and do you have any abuse to report. Abuse and Neglect training initiated to all staff on 02/23/17 including: nursing, environmental services, dietary personnel, therapy, and department managers. This in-service was conducted by Social Worker and Assistant Director of Nurses. Training continues to be ongoing for current employees who were not present on 02/23/17 including the types of abuse,</p> | F 223 | | | |

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| F 223 | <p>Continued From page 14</p> <p>mandated reporting requirements, and immediate steps to ensure the residents safety. Staff will not be allowed to work until training on abuse and neglect is completed.</p> <p>Staff will receive education on the Abuse and Neglect Policy upon hire, and will be reviewed quarterly. This will be conducted by Director of Nursing services, Assistant Director of Nursing Services and Business Office Specialist</p> <p>A Resident Council Meeting was held on 03/01/17 to review resident rights, reporting of abuse and neglect. Resident Council meeting was conducted by Activity Director and Executive Director. Approximately 12 residents were in attendance. No concerns or complaints were voiced and all felt safe since the Executive Director was gone. The results of the Resident Council Meeting Minutes will be reviewed at Quality Assurance Performance Improvement.</p> <p>On 03/01/17 an audit of current nursing home employees was conducted by department managers and asked if they felt stressed, burnt out, if they felt unsafe, knew of any abuse or desire to abuse residents. Did they know how to report abuse and who to report it to?</p> <p>This incident was reported by the new Interim Executive Director to Adult Protective Service on 03/01/17 at 7:30 PM.</p> <p>The incident was reported by the new Interim Executive Director to North Carolina Board of Administrators via voice mail on 03/01/17.</p> <p>Immediate Jeopardy was removed on 03/03/17 at 5:09 PM when interviews with nursing staff, administrative staff and non-nursing staff confirmed they had received in-service training and knew the different types of abuse and the right of every resident to be free from abuse.</p> | F 223 | | | |

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| F 225 F 225 SS=J | Continued From page 15 483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that | F 225 F 225 | | 4/4/17 | |

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| F 225 | <p>Continued From page 16</p> <p>cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident interviews, record review and staff interviews, the facility failed to immediately report verbal abuse of a resident by Executive Director (ED) #1 to the Area Vice President (AVP) and also failed to notify the North Carolina Health Care Personnel Investigations (NCHCPI) within 2 hours of the incident. This affected 1 of 3 residents sampled for abuse (Resident #59).</p> <p>Immediate Jeopardy began on 02/22/17 when the Director of Nursing (DON) and Patient Care Assistant (PCA) #1 witnessed the ED verbally</p> | F 225 | <p>1. Resident #59 was discharged from facility on 2/22/17. Resident #59 has visited the facility since discharge with no concerns about safety of fear.</p> <p>2. All other residents have the potential to be affected. All actual or potential to be affected. All actual or potential allegations of Abuse or Neglect are reported to the ED, and to the North Carolina Department of Health and Human Services, APS, and the Ombudsman and investigation to be completed.</p> | | |

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| F 225 | <p>Continued From page 17</p> <p>abuse Resident #59, but did not immediately report the verbal abuse to the AVP. Immediate Jeopardy was removed on 03/03/17 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to informing the ED and/or AVP of witnessed or alleged incidents of abuse.</p> <p>The findings included:</p> <p>Resident #59 was admitted to the facility on 01/03/17 with diagnoses that included chronic obstructive pulmonary disease, pneumonia, hypertension, tobacco use and major depressive disorder.</p> <p>The admission Minimum Data Set (MDS) dated 01/10/17 coded Resident #59 as having intact cognition, as understanding others and being understood. She was coded as having no psychosis, behavioral symptoms or rejection of care and required supervision of one person for all activities of daily living except eating for which she was independent.</p> <p>A note by the Social Worker (SW) dated 02/22/17 at 9:36 AM indicated that Resident #59 was observed at 8:50 AM outside the West Wing exit squatted down between two bushes smoking. She was asked to extinguish her cigarette and return to the covered area at the front entrance to wait for transit to take her to an appointment. According to the note, Resident #59 was informed that her smoking privileges were</p> | F 225 | <p>3. Staff were educated beginning on 2/23/17 and 2/24/17 by the Social Worker, DNS and ADNS and ongoing till all staff have completed in-services on the different types of abuse, and the Golden Living Abuse Policies and Procedures by 3/31/17 or they will not be eligible to work. Included in this education is how to identify and how to respond if an actual or allegation of abuse is identified, regardless of who the alleged perpetrator is. Abuse training is part of the orientation process for new staff and reviewed with staff annually.</p> <p>4. Director of Field Clinical Services for Golden Living educated the Department Managers on 3/22/17 (ED, DNS, MDS Coordinator, BOM, Admissions Coordinator, Dietitian, Dietary Manager, Housekeeping Supervisor, Rehab Director, Social Services, and Central Supply Coordinator) On identifying the signs and symptoms of stress and burnout. Coping strategies for coping with stress and burnout and we have EAP (employee assistance program) available for additional support. Education also included strategies for working with residents that can present challenging behaviors and identification of strategies work with these residents.</p> <p>5 Other staff will receive the education by DNS by 3/31/17 on identifying the signs and symptoms of stress and burnout. Coping strategies for coping with stress and burnout EAP (employee assistance program) available for all staff for additional support. Education included for</p> | | |

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| F 225 | <p>Continued From page 18</p> <p>revoked and she became upset and stated she wanted to leave that day.</p> <p>An interview with the Director of Nursing (DON) on 02/26/17 at 2:05 PM revealed Resident #59 was observed on 02/22/17 about 9:00 AM near the West Wing emergency exit in the shrubbery smoking and was asked by the SW and ED #1 to extinguish the cigarette and ED #1 informed Resident #59 that her smoking privileges were revoked. The DON stated she and ED #1 met with the department managers at 3:00 PM on 02/22/17 to discuss Resident #59's violation of the smoking policy and she scheduled a meeting for 4:00 PM on 02/22/17 with all the residents who smoked and asked ED #1 to be at the meeting to reinforce the smoking rules.</p> <p>The DON stated she and ED #1 walked outside to the smoking area around 4:00 PM and observed Resident #59 was smoking a cigarette. The DON stated ED #1 asked Resident #59: "What are you doing out here? Why are you smoking?" and Resident #59 replied: "I'm just out here smoking one last time with my family (referring to the other residents) before I go." The DON stated that ED #1 then told Resident #59: "You need to leave. I want you to leave right now." The DON reported that Resident #59 continued to smoke and said: "I'm going; I'm going; I'm leaving." Then ED #1 told Resident #59: "You need to leave before I hit you." The DON stated she assured the residents that no one was going to hit any of them and asked Resident #59 to go inside and told ED #1 that he needed to relax and that no one was going to hit anybody. The DON stated she could tell that Resident #59 was scared and Resident #59 went inside the facility. The DON stated ED #1 remained outside in the</p> | F 225 | <p>strategies for working with residents that can present with challenging behaviors effectively.</p> <p>6. Monitoring for compliance Interim ED/DNS Designee and Activity Director will conduct Resident Council meetings weekly for 4 ,then bi weekly for one month then resume monthly to review abuse policies and see if residents feel safe. The Interim ED will conduct random resident interviews of residents that do not attend the Resident Council Meetings. he Interim ED will conduct five random staff audits weekly for 4 weeks of the Abuse and Neglect Policies and Procedures to include what to do if an allegation or actual abuse /neglect situation is identified. The results of the audits will be reviewed at QAPI monthly meetings to review and analyze for patterns and trends. The AVP(Area Vice President) and or the DFCS(Director of Field Clinical Services) will attend the QAPI meeting either in person or via Web EX. The QAPI team will evaluate the results and implement additional interventions as indicated to ensure continued compliance. Correction date for substantial compliance is 4/4/17. The Interim ED/DNS/SW responsible for compliance.</p> | | |

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| F 225 | <p>Continued From page 19</p> <p>smoking area with her and the other residents while she reviewed the facility's smoking policy and ED #1 talked about safety concerns related to residents smoking in non-designated areas. The DON stated she and ED #1 went back inside but the residents remained outside for their smoke break with other staff. The DON stated she went to look for Resident #59 to make sure she was all right. The DON stated she was in the hall near the door to the outside smoking area and heard the residents outside in smoking area talking about being upset about what happened. The DON stated ED #1 went back out to the smoking area, without her knowledge, and told the residents he was going to call the Ombudsman about the incident. The DON stated she called the Ombudsman about 5:00 PM and left a message then called the Area Vice President (AVP) from ED #1's office and informed him of the incident. The DON stated the AVP immediately suspended ED #1 pending further investigation of the incident.</p> <p>An interview on 02/27/17 at 10:53 AM with Resident #72, who was cognitively intact, revealed she was in the outside smoking area on 02/22/17 at 4:00 PM when Resident #59 was outside with the other residents smoking. Resident #72 stated ED#1 came raging through the door and around to the table where Resident #59 was sitting and told her to get out of his building before he hit her. Resident #72 stated ED #1's fist was clenched but then he unclenched his fist and didn't do anything. Resident #72 stated she was frightened because ED #1 was in such a rage and raised his voice and she wasn't sure what he was going to do. Resident #72 stated she didn't feel threatened now but would feel scared if ED #1 came back to the facility.</p> | F 225 | | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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| F 225 | <p>Continued From page 20</p> <p>An interview on 02/27/17 at 10:55 AM with Resident #29, who was cognitively intact, revealed she was in the outside smoking area on 02/22/17 at the 4:00 PM smoke break with other residents for a meeting with the DON and ED #1. Resident #29 stated she saw Resident #59 smoking when she went outside and none of the other residents had their cigarettes. Resident #29 stated when ED #1 came out and saw Resident #59 smoking he asked her what she was doing and where she got her cigarettes. Resident #29 stated ED #1 then told Resident #59 to get out of his building right now before he hit her and his fists were balled up. Resident #29 stated the DON very quickly said: "No one is going to hit anybody." Then, ED #1 told Resident #59 that he wasn't going to hit her. Resident #29 stated the DON and ED #1 went ahead with the meeting to discuss the smoking rules then they both went back in the facility. Resident #29 stated she and the other residents were discussing calling the Ombudsman and ED #1 came back outside and told them that he was going to call the Ombudsman about the incident. Resident #29 stated when she came in from the smoking area and past the front entrance ED #1 was at the front door with the men who were working on the door. Resident #29 stated she didn't see ED #1 after that time.</p> <p>An interview on 02/27/17 at 11:06 AM with Resident #86, who was cognitively intact, revealed she was in the outside smoking area on 02/22/17 at the 4:00 PM smoke break with the other residents. Resident #86 stated ED #1 came out the door shouting at Resident #59 and asked her why she was out there and where she got the cigarettes. Resident #86 stated ED #1 was sort of</p> | F 225 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/29/2017
FORM APPROVED
OMB NO. 0938-0391

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| F 225 | <p>Continued From page 21</p> <p>wild-looking and told Resident #59 to get out of the smoking area before he hit her. Resident #86 stated ED #1's face was red and his fist was clenched at his side. Resident #86 stated she was nervous and anxious because she didn't know what he was going to do.</p> <p>An interview on 02/27/17 at 11:38 AM with Resident #66, who was cognitively intact, revealed she was in the outside smoking area with other residents on 02/22/17 at the 4:00 PM smoke break and heard ED #1 tell Resident #59 to get off the premises before he hit her but he then apologized as soon as he said it. Resident #66 stated it didn't scare her and she didn't feel like ED #1 was going to hit Resident #59.</p> <p>An interview on 02/27/17 at 3:12 PM with Patient Care Assistant (PCA) #1 revealed she was outside supervising the residents on 02/22/17 at the 4:00 PM smoke break. PCA #1 stated Resident #59 came out with the other residents and she told her she wasn't allowed to smoke because her privileges had been revoked. PCA #1 stated Resident #59 told her she was just coming out to talk to the other residents. PCA #1 stated she was lighting another resident's cigarette and heard ED #1 tell Resident #59 to "get out of here before I hit you." PCA #1 stated she didn't see Resident #59 smoking. PCA #1 stated the DON moved closer to ED #1 and Resident #59 went back in the building. PCA #1 stated that Resident #29 told ED #1 that she was going to call the Ombudsman and he got mad and went back in the facility. PCA #1 stated the DON reviewed the smoking rules with the residents then she went in the building. PCA #1 stated about 5 minutes later ED #1 came back outside for a split second and told the residents</p> | F 225 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 225 | <p>Continued From page 22</p> <p>he was going to call the Ombudsman about the incident because what he said was wrong.</p> <p>An interview on 02/27/17 at 3:27 PM with the SW revealed she and ED #1 were informed by NA #1 on 02/22/17 at 8:30 AM that Resident #59 was outside the West Wing emergency exit smoking. The SW stated she and ED #1 went to investigate and found Resident #59 squatting down between the bushes and the building smoking a cigarette. The SW stated ED #1 then told Resident #59 to extinguish the cigarette and return to the front of the building to wait for transit to take her to an appointment. The SW stated ED #1 also informed Resident #59 that her smoking privileges were revoked. The SW stated she didn't have any first hand knowledge of the incident that occurred in the outside smoking area on 02/22/17 at 4:00 PM.</p> <p>An interview on 02/27/17 at 3:05 PM with Resident #22, who was cognitively intact, revealed she was in the outside smoking area on 02/22/17 at the 4:00 PM smoke break and was sitting beside Resident #59. Resident #22 stated that ED #1 saw Resident #59 smoking and yelled at her that he was so mad he could hit her. Resident #22 said the residents in the smoking area after the incident were discussing calling the Ombudsman when ED #1 came back outside and screamed out at them that he was calling the Ombudsman himself. Resident #22 stated she was upset for 2 days.</p> <p>A second interview with the DON on 02/28/17 at 9:12 AM revealed 11 residents were outside in the smoking area on 02/22/17 at 4:00 PM. The DON stated the residents told her that ED #1 had come back outside but she didn't observe ED #1</p> | F 225 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/29/2017
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| F 225 | <p>Continued From page 23</p> <p>outside. The DON stated she met Resident #59 in the hall and went to her office with Resident #59 to get her cigarettes and lighter then walked with her to the front entrance. The DON stated Resident #59 wanted to say good-bye to a friend on the West Wing and as they passed ED #1's office, he came out in the hall and apologized to Resident #59. The DON stated Resident #59 left the building then she and ED #1 went in his office and she called the Ombudsman around 5:00 PM. The DON stated she then called the AVP and reported the incident and the AVP suspended ED #1. The DON stated ED #1 left the building before 5:30 PM.</p> <p>A third interview with the DON on 02/28/17 at 3:07 PM about the facility's abuse policy revealed the DON was familiar with the policy. When asked if she considered ED #1's threat to hit Resident #59 abuse, the DON stated she considered it verbal abuse. When the DON was asked about the facility's policy regarding immediate suspension of an employee who was observed or accused of abusing a resident, she stated she felt like she needed to call the AVP because the staff involved was the administrator. The DON stated if the perpetrator had been any other employee she and the administrator would have gotten the employee's statement and placed them on suspension pending the investigation and immediately removed the employee from the facility. The DON was unable to offer any further explanation as to why she didn't immediately call the AVP and constantly observe ED #1.</p> <p>An interview with ED #1 on 02/28/17 at 5:00 PM revealed he went outside to the smoke area on 02/22/17 at 4:00 PM after a staff member reported seeing Resident #59 smoking in the</p> | F 225 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 225 | Continued From page 24 outside smoking area with other residents. ED #1 stated he asked Resident #59: "What are you doing?" and she didn't respond. ED #1 stated he then asked Resident #59: "Where did you get that cigarette?" and she still didn't respond. ED #1 stated he then said to Resident #59: "I can't believe you're out here smoking" and Resident #59 replied: "I wanted one last cigarette with my family"(referring to the other residents.) ED #1 stated he then told Resident #59: "You need to put that cigarette out and you need to leave the smoking area" but Resident #59 didn't say anything or get up to leave. ED #1 stated he was standing about 10 - 12 feet away from Resident #59. ED #1 stated he then told Resident #59: "You need to get up and leave now before I hit you." ED #1 stated he couldn't believe what he had just said and immediately told Resident #59: "I just violated your rights. I'm so sorry. I didn't mean that." ED #1 stated Resident #59 left the smoking area and went in the facility. ED #1 stated he remained outside with the DON while she reviewed the smoking rules but he didn't say anything further. ED #1 stated he and the DON came back in the building around 4:30 PM and he told her they needed to report the incident. ED #1 stated someone told him they heard the residents in the smoking area talking about calling the Ombudsman so he stepped back outside in the smoking area briefly to tell the residents he was going to notify the Ombudsman of the incident himself. He was unable to recall the exact time that he went back outside but stated it was between 4:30 PM and 5:00 PM. The ED stated about 5:00 PM he saw Resident #59 in the hall near the West Wing nurses station and he went out to apologize. ED #1 stated the DON called the Ombudsman from his office around 5:20 PM then called the AVP. ED #1 stated he thought he left | F 225 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 225 | <p>Continued From page 25</p> <p>the facility about 6:30 PM. When asked what the Abuse Policy specified as to when he should have left the facility after the incident, he stated he should have left immediately.</p> <p>During a telephone call on 02/28/17 at 7:59 PM, Resident #59 stated she was outside waiting to go to an appointment the morning of 02/22/17 and smoked and staff caught her. Resident #59 stated staff changed her smoking privileges from unsupervised to supervised because it was part of the smoking rules. Resident #59 stated staff were respectful when they told her about the restriction. Resident #59 stated she was in the outside smoking area on 02/22/17 at 4:00 PM and was smoking. She stated she wasn't threatened but was asked to go back inside which she did. Resident # 59 stated she knew she wasn't supposed to be out in the smoking area and she knew they were just setting an example for the other residents. Resident #59 stated ED #1 didn't threaten to hit her. She stated he just told her to go back inside. Resident #59 stated she didn't feel afraid that ED #1 was going to hit her.</p> <p>An interview on 03/01/17 at 1:51 PM with PCA #1 revealed she received training on abuse during her orientation in January 2017 and was instructed to report any observed or alleged abuse immediately to her supervisor. When asked if she thought ED #1's statement to Resident #59 on 02/22/17 at 4:00 PM was abuse, PCA #1 stated she thought it was verbal abuse. PCA #1 stated she didn't report it to anyone because the DON also witnessed the incident.</p> <p>An interview on 03/01/17 at 12:11 PM with the AVP revealed his expectation was that any</p> | F 225 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 225 | <p>Continued From page 26</p> <p>witnessed or alleged abuse of a resident should be reported immediately and the person accused of abusing a resident should be removed from the facility immediately and the residents protected. The AVP stated he should have been notified immediately after the incident on 02/22/17 at 4:00 PM when ED #1 threatened to hit Resident #59. The AVP stated he was notified on 02/22/17 at 6:16 PM of the incident that occurred on 02/22/17 at 4:00 PM when ED #1 threatened to hit Resident #59. The AVP stated he placed ED #1 on immediate suspension.</p> <p>Another interview on 03/01/17 at 3:15 PM with the DON about the incident on 02/22/17 at 4:00 PM when ED #1 threatened to hit Resident #59, revealed she should have told ED #1 to leave the building and should have made sure he left right away. The DON stated she should have called the AVP immediately following the incident.</p> <p>In an interview on 03/01/17 at 2:14 PM with Resident #59 in the facility, she stated she didn't tell the truth about ED #1 during the phone interview on 02/28/17 because she was afraid of getting in trouble for smoking and also afraid of getting the DON in trouble. Resident #59 stated ED #1 came out in the smoking area and asked her: "What are you doing?" Resident #59 stated she told him she was having one last smoke break with her family (referring to her friends at the facility). Resident #59 stated ED #1 asked her: "Where did you get that cigarette?" She said she told him it fell out in her purse. She said ED #1 then told her: "You get in there before I hit you." Resident #59 stated ED #1 had his fists clenched at his side and it really scared her. Resident #59 stated the DON was in the smoking area with them and told her that ED #1 wouldn't</p> | F 225 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 225 | <p>Continued From page 27</p> <p>hit her. Resident #59 stated she was still shaking when her sister arrived to pick her up. Resident #59 stated she was getting ready to leave when ED #1 apologized to her at the West Wing nurse's station.</p> <p>Review of the 24 hour report which was submitted by the facility to the NCHCPI revealed it was signed as completed by the SW on 02/23/17. Review of the fax transmission report revealed it was faxed to the NCHCPI on 02/23/17 at 1:01 PM which was approximately 21 hours after the incident of verbal abuse occurred.</p> <p>On 03/01/17 at 9:14 AM, ED #2 was informed of Immediate Jeopardy. The Administration provided an acceptable allegation of compliance on 03/03/17 at 2:45 PM.</p> <p>Allegation of Compliance GLC Asheville March 3rd, 2017 F 225</p> <p>02/22/17 at or around 4 PM, the Executive Director (ED) entered the facility outside smoking area and approached resident #59 for smoking after her privileges had been revoked. He then proceeded to become verbally abusive to resident #59 by stating to her if she did not leave the facility he would hit her. This was witnessed by Director of Nurses who immediately had resident #59 come to her side and addressed resident #59 and the other residents on the smoking patio: #29, #72, #86, #10, #23, #79, #67, #66, #22, #28 and #75 saying no one was going to hit anyone and reviewed the smoking policy and asked if they felt secure and safe and they replied yes. The Executive Director and Director of Nurses came back into the building and The ED went towards his office. The Director of Nurses failed</p> | F 225 | | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 225 | <p>Continued From page 28</p> <p>to follow facility abuse policy and did not have him removed from facility immediately. The Executive Director then went to outside smoking door, opened it, and stated to smoking residents that he was going to report himself to the ombudsman. When the Director of Nurses heard the outside smoking group talking loudly she then went back outside to smoking area and asked if residents were ok and felt safe, and they told the Director Of Nurses that the Executive Director had come back to door way and stated he was reporting himself. She asked if they were ok and all replied yes and she explained to them not to worry as she was going to report to all appropriate agencies.</p> <p>When she came back into facility Resident #59 was discharging home as previously planned and needed her belongings that were locked in the Director of Nurses office. The Director of Nurses completed this task. While she was completing this task the MDS Coordinator stayed with the Executive Director till she was finished.</p> <p>The Director of Nurses then took Executive Director to his office and then she called the North Carolina Ombudsman and left voice mail of incident. She then called the Executive Director's superior Regional Vice President of Operations and explained the incident and he suspended the Executive Director effective immediately pending investigation and he left building with Director of Nurses supervising that he didn't go anywhere else in facility. He was officially terminated on 02/27/17 at 7:45 AM</p> <p>On 02/23/17 the Social Service Director began 24 hour reportable and completed and sent to North Carolina Health and Human Services by 4 PM.</p> <p>The new Interim Executive Director started on 02/27/17 at or around 11 AM and was educated on the Abuse and Neglect Policy and the</p> | F 225 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| F 225 | <p>Continued From page 29</p> <p>Grievance Policy, by the Field Service Clinical Director on 03/01/17.</p> <p>All other residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. On 3/1/17 the department managers interviewed all other interviewable residents for any signs of abuse, understanding of abuse, if know how to report abuse, and if they have any abuse they would like to report. Beginning 03/01/17 department managers or designee will monitor with daily room rounds with asking if they felt safe, if they had anything to report, any abuse that they want to report. Beginning 03/01/17 during their care plans Social Worker will ask residents if they feel safe, if they know what abuse is, if they know who to report to and if they have any abuse to report.</p> <p>Abuse and Neglect training initiated to all staff on 02/23/17 including: nursing, environmental services, dietary personnel, therapy, and department managers. This in-service was conducted by Social Worker and Assistant Director of Nurses. Training continues to be ongoing for current employees who were not present on 02/23/17 and includes the types of abuse, mandated reporting requirements and immediate steps to ensure the residents safety. Any staff that has not completed training will not be able to work until training is complete.</p> <p>The 5 day reportable was completed by Social Services Director on 3/1/17 and sent to North Carolina Health and Human Services.</p> <p>The Director of Nurses was re-educated on 03/01/17 by Field Service Clinical Director of Golden Living Center on the Abuse/Neglect policy including the immediate removal of the alleged perpetrator from the building, chain of command and even if it is your superior you have the right to</p> | F 225 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| F 225 | <p>Continued From page 30</p> <p>ask them to leave and notify their superior which is Regional vice President of Operations. Graph of chain of command for Golden Living Center with names, titles, contact numbers and their responsibilities was posted at time clock for all staff effective 03/2/17 by 4 PM.</p> <p>Staff will receive education on the Abuse and Neglect Policy upon hire, and will be reviewed quarterly. This will be conducted by Director of Nursing Services, Assistant Director of Nursing Services and Business Office Specialist</p> <p>A Resident Council Meeting was held on 3/1/17 to review resident rights, reporting of abuse and neglect. Resident Council meeting was conducted by Activity Director and interim Executive Director. Approximately 12 residents were in attendance. No concerns or complaints were voiced and all felt safe since the Executive Director was gone and happy with new interim Executive Director. The results of the Resident Council Meeting Minutes will be reviewed at Quality Assurance Performance Improvement meeting monthly.</p> <p>On 03/01/17 an audit of current Golden Living Center employees was conducted and asked if they felt stressed or burnt out, if they felt unsafe, knew of any abuse or desire to abuse residents. Did they know how to report abuse and who to report it to? The new chain of command was reviewed with employees. All employees that were interviewed in person or by phone did not feel stressed or burnt out and knew how to report any signs of abuse.</p> <p>This incident was reported by Interim Executive Director to Adult Protective Service on 03/01/17 at 7:30 PM.</p> <p>The incident was reported by Interim Executive Director to North Carolina Board of Administrators on 03/01/17 at 7 PM</p> | F 225 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 225 | Continued From page 31 The Director of Nurses was re-educated on 03/02/17 at 3:16 PM on 24 hour reportable process according to Federal Regulations through established procedures with reporting abuse immediately. Immediate Jeopardy was removed on 03/03/17 at 5:09 PM when interviews with nursing staff, administrative staff and non-nursing staff confirmed they had received in-service training and knew the different types of abuse and the requirement that any observed or alleged abuse of a resident should be reported immediately to the ED or DON and if the perpetrator was the ED it should be reported to the AVP. Staff confirmed they were provided with a copy of the facility's abuse policy and the chain of command. | F 225 | | | |
| F 226 SS=J | 483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation | F 226 | | 4/4/17 | |

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| F 226 | <p>Continued From page 32</p> <p>requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-</p> <p>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.</p> <p>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property</p> <p>(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to implement its abuse policy in the areas of protection of the resident and reporting of abuse within 2 hours. The facility failed to separate the perpetrator from the resident, to supervise the alleged perpetrator until he left the facility and to immediately notify the Area Vice President (AVP) of the verbal abuse. This affected 1 of 3 residents sampled for an abuse investigation (Resident #59).</p> <p>Immediate Jeopardy began on 02/22/17 when the facility did not follow its policy to immediately report a verbal threat made by Executive Director (ED) #1 to abuse Resident #59 and did not immediately protect Resident #59. The Director of Nursing (DON) and Patient Care Assistant (PCA) #1 witnessed the incident but did not immediately report the verbal abuse to the AVP as required according to the facility's abuse policy. The DON allowed the perpetrator to remain in the building without supervision for 2 additional hours. Immediate Jeopardy was removed on 03/03/17</p> | F 226 | <p>1. Resident #59 discharged from facility on 2/22/17. Resident #59 has visited the facility since discharge with no concerns about safety of fear.</p> <p>2. Residents #29 and #72 were discharged from the facility on 3/8/17, but were interviewed prior to discharge and asked if they felt safe, had they experienced abuse or neglect during their time at facility and they did not. Residents #22, #66, #86, #10, #79, #87, #28, #75, #23, were interview on 2/22/17 and 2/23/17 by DNS, AD, and SW if they feel safe and if they had experienced any abuse or neglect and none had.</p> <p>3. Staff in-service and education began on 2/23/17 by Social Services, ADNS and DNS and ongoing on the different types of abuse, and the Golden Living Abuse Polices and Procedures. Included in this education is how to identify and how to respond if an actual or allegation of abuse is identified, regardless of who the alleged</p> | | |

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| F 226 | <p>Continued From page 33</p> <p>when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to protecting residents from being abused and following the abuse policy.</p> <p>The findings included:</p> <p>The facility's Abuse and Neglect policy with a revision date of 11/18/16 included:</p> <p>*Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability. Examples of verbal abuse include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that she will never be able to see her family again.</p> <p>*Identification: Incidents identified as potential violations shall be reported as stated in the Reporting Section of this policy.</p> <p>*Protection: If the suspected perpetrator is an employee, the ED shall place the employee on immediate investigatory suspension while completing the investigation.</p> <p>*Reporting: It is the responsibility of each individual employee to immediately report any reasonable suspicion of a crime, and all</p> | F 226 | <p>perpetrator is. Abuse training is part of the orientation process for new staff and reviewed with staff annually monitored by BOM and BOMA. Any staff that has not completed by 3/31/17 will not eligible for work till completed.</p> <p>4. Business Office Manager of designee will check Monday thru Friday to ensure computer training in abuse is completed.</p> <p>5. Director of Field Clinical Services for Golden Living educated the Department Managers on be 3/22/17(ED,DNS,MDS Coordinator ,BOM, Admissions Coordinator, Dietitian, Dietary Manager, Housekeeping Supervisor, Rehab Director, Social Services, and Central Supply Coordinator) On identifying the signs and symptoms of stress and burnout. Coping strategies for coping with stress and burnout and we have EAP(employee assistance program) available for additional support. Education also included strategies for working with residents that can present challenging behaviors and identification of strategies work with these residents.</p> <p>6. Other staff will receive the education by 4/4/17 by the DNS or Designee on identifying the signs and symptoms of stress and burnout and Coping strategies for coping with stress and burnout EAP(employee assistance program) available for all staff for additional support. Education included for strategies for working with residents that can present with challenging behaviors effectively.</p> <p>6. Monitoring for compliance Interim</p> | | |

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| F 226 | <p>Continued From page 34</p> <p>allegations of mistreatment, neglect, abuse, injury of unknown origin and/or misappropriation of resident property to the designated supervisor in charge at the time. For purposes of reporting "immediately" means as soon as possible but not to exceed 2 hours in the event of serious injury or death of patient involved in a report or 24 hours for all other reports or shorter if State law/regulations require a report within a shorter timeframe. It is the responsibility of the designated supervisor to immediately communicate any report of an alleged violation to the ED. The ED shall also notify immediate management. The ED shall ensure that alleged violations are reported promptly to the regional/area Vice President.</p> <p>During an interview on 02/26/17 at 2:05 PM, the DON stated she and ED #1 walked outside to the smoking area around 4:00 PM and observed Resident #59 was smoking a cigarette. Resident #59's smoking privileges had been revoked prior to this time. The DON stated ED #1 asked Resident #59: "What are you doing out here? Why are you smoking?" and Resident #59 replied: "I'm just out here smoking one last time with my family (referring to the other residents) before I go." The DON stated that ED #1 then told Resident #59: "You need to leave. I want you to leave right now." The DON reported that Resident #59 continued to smoke and said: "I'm going; I'm going; I'm leaving." Then ED #1 told Resident #59: "You need to leave before I hit you." The DON stated she assured the residents that no one was going to hit any of them and asked Resident #59 to go inside and told ED #1 that he needed to relax and that no one was going to hit anybody. The DON stated she could tell that Resident #59 was scared and Resident #59 went</p> | F 226 | <p>ED/DNS Designee and Activity Director will conduct Resident Council meetings weekly for 4 weeks then biweekly for month they resume monthly to review abuse policies and see if residents feel safe. The Interim ED will conduct random resident interviews of residents that do not attend the Resident Council Meetings weekly for 4 weeks then bi weekly for month. The Interim ED will do five random staff audits weekly for 4 weeks on the Abuse and Neglect Policies and Procedures to include what to do if an allegation or actual abuse /neglect situation is identified. The results of the audits will be reviewed at QAPI monthly meetings to review and analyze for patterns and trends. The AVP(Area Vice President) and or the DFCS(Director of Field Clinical Services) will attend the QAPI meeting either in person or via Web EX. The QAPI team will evaluate the results and implement additional interventions as indicated to ensure continued compliance. Correction date for substantial compliance is 4/4/17. The Interim ED/DNS/SW responsible for compliance.</p> | | |

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| F 226 | <p>Continued From page 35</p> <p>inside the facility. The DON stated ED #1 remained outside in the smoking area with her and the other residents while she reviewed the facility's smoking policy and ED #1 talked about safety concerns related to residents smoking in non-designated areas. The DON stated she and ED #1 went back inside but the residents remained outside for their smoke break with other staff. The DON stated she went to look for Resident #59 to make sure she was all right then heard the residents outside in smoking area talking about being upset about what happened. The DON stated ED #1 went back out to the smoking area, without her knowledge, and told the residents he was going to call the Ombudsman about the incident. The DON stated she called the Ombudsman about 5:00 PM and left a message then called the Area Vice President (AVP) from ED #1's office and informed him of the incident. The DON stated the AVP immediately suspended ED #1 pending further investigation of the incident.</p> <p>An interview on 02/27/17 at 3:12 PM with PCA #1 revealed she was outside supervising the residents on 02/22/17 at the 4:00 PM smoke break. PCA #1 stated Resident #59 came out with the other residents and she told her she wasn't allowed to smoke because her privileges had been revoked. PCA #1 stated Resident #59 told her she was just coming out to talk to the other residents. PCA #1 stated she was lighting another resident's cigarette and heard ED #1 tell Resident #59 to "get out of here before I hit you." PCA #1 stated she didn't see Resident #59 smoking. PCA #1 stated the DON moved closer to ED #1 and Resident #59 went back in the building. PCA #1 stated that Resident #29 told ED #1 that she was going to call the Ombudsman and he got mad</p> | F 226 | | | |

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| F 226 | <p>Continued From page 36</p> <p>and went back in the facility. PCA #1 stated the DON reviewed the smoking rules with the residents then she went in the building. PCA #1 stated about 5 minutes later ED #1 came back outside for a split second and told the residents he was going to call the Ombudsman about the incident because what he said was wrong.</p> <p>An interview with the DON on 02/28/17 at 3:07 PM about the facility's abuse policy revealed the DON was familiar with the policy. When asked if she considered ED #1 threatening to hit Resident #59 abuse, the DON stated she considered it verbal abuse. When the DON was asked about the facility's policy regarding immediate suspension of an employee who was observed or accused of abusing a resident, she stated she felt like she needed to call the AVP because the staff involved was the administrator. The DON stated if the perpetrator had been any other employee she and the administrator would have gotten the employee's statement and placed them on suspension pending the investigation and immediately removed the employee from the facility. The DON was unable to offer any further explanation as to why she didn't immediately call the AVP and constantly observe ED #1.</p> <p>An interview with ED #1 on 02/28/17 at 5:00 PM revealed he was outside in the smoke area on 02/22/17 at 4:00 PM with the DON. ED #1 confirmed that he told Resident #59: "You need to get up and leave now before I hit you." ED #1 acknowledged that he should not have said it. ED #1 stated he stepped back outside in the smoking area briefly to tell the residents he was going to notify the Ombudsman of the incident himself. ED #1 stated he thought he left the facility about 6:30 PM. When asked what the Abuse Policy</p> | F 226 | | | |

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| F 226 | <p>Continued From page 37</p> <p>specified as to when he should have left the facility after the incident, he stated he should have left immediately. He stated he was completing some documentation in his office and that was why he didn't leave immediately.</p> <p>An interview on 03/01/17 at 1:51 PM with PCA #1 revealed she received training on abuse during her orientation in January 2017 and was instructed to report any observed or alleged abuse immediately to her supervisor. When asked if she thought ED #1's statement to Resident #59 on 02/22/17 at 4:00 PM was abuse, PCA #1 stated she thought it was verbal abuse. When asked if she reported it to anyone, PCA #1 stated she didn't report it to anyone because the DON also witnessed the incident.</p> <p>An interview on 03/01/17 at 12:11 PM with the AVP revealed his expectation was that any witnessed or alleged abuse of a resident should be reported immediately and the person accused of abusing a resident should be removed from the facility immediately and the residents protected. The AVP stated he should have been notified immediately after the incident on 02/22/17 at 4:00 PM when ED #1 threatened to hit Resident #59. The AVP stated he was notified on 02/22/17 at 6:16 PM of the incident that occurred on 02/22/17 at 4:00 PM when ED #1 threatened to hit Resident #59. The AVP stated he placed ED #1 on immediate suspension.</p> <p>Another interview on 03/01/17 at 3:15 PM with the DON about the incident on 02/22/17 at 4:00 PM when ED #1 threatened to hit Resident #59, revealed she should have told ED #1 to leave the building and should have made sure he left right away. The DON stated she should have called</p> | F 226 | | | |

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| F 226 | <p>Continued From page 38</p> <p>the AVP immediately following the incident.</p> <p>On 03/01/17 at 9:14 AM, ED #2 was informed of Immediate Jeopardy. The Administration provided an acceptable allegation of compliance on 03/03/17 at 2:45 PM.</p> <p>Allegation of Compliance GLC Asheville March 3rd, 2017</p> <p>F 226 For deficiencies concerning the facility's development of and implementation of policies and procedures:</p> <p>On 03/01/17 The Field Service Clinical Director and the Regional Area Vice President reviewed all the components of the abuse and neglect policy that was revised on 11/18/16 which includes the 2 hour time frame for reporting abuse allegations to the appropriate agencies. The Executive Director, Director of Nurses and Social Service Director will review and educate all employees including contract staff on policies and procedures to protect residents from any form of abuse. The verbal inservices with a copy of the abuse policy was given to all employees who worked 3/1/17. All absent staff will be educated on policies and procedures to protect residents from any form of abuse prior to being allowed to work.</p> <p>*02/22/17 at or around 4 PM, the Executive Director (ED) entered the facility's outside smoking area and approached resident #59 for smoking after her privileges had been revoked. He then proceeded to become verbally abusive to resident #59 by stating to her if she did not leave the facility he would hit her. This was witnessed by Director of Nurses who immediately had resident #59 come to her side and addressed resident #59 and the other residents on the smoking patio: #29, #72, #86, #10, #23, #79, #67,</p> | F 226 | | | |

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| F 226 | <p>Continued From page 39</p> <p>#66, #22, #28 and #75. The Director of Nurses explained that no one was going to hit anyone, reviewed the smoking policy and asked if they felt secure and safe and they replied yes. The Executive Director and Director of Nurses came back into the building and the ED went towards his office.</p> <p>The Director of Nurses failed to follow the facility's abuse policy by not protecting the residents by removing him from facility immediately. The Executive Director then went to outside smoking door opened it and stated to smoking residents that he was going to report himself to the ombudsman. When the Director of Nurses heard the outside smoking group talking loudly she then went back to outside to smoking area and asked if residents were ok and felt safe, and they told the Director of Nurses that the Executive Director had come back to doorway and stated he was reporting himself. She asked if they were ok and all replied yes and she explained to them not to worry as she was going to report to all appropriate agencies.</p> <p>When the Director of Nurses came back into facility Resident #59 was being discharged home as previously planned and needed her belongings that were locked in the Director of Nurses office. While the Director of Nurses was completing this task she had the MDS Coordinator stay with the Executive Director till she was finished.</p> <p>The Director of Nurses then took Executive Director to his office and then she called the North Carolina Ombudsman and left voice mail of incident at or around 6 PM. She then called the Executive Director's superior, Regional Vice President of Operations, and explained the incident and he suspended the Executive Director effective immediately pending investigation with Director of Nurses supervising that he didn't go</p> | F 226 | | | |

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| F 226 | <p>Continued From page 40</p> <p>anywhere else in facility. Executive Director was suspended and left the building on 02/22/17 at or around 6:20 PM. He was officially terminated on 02/27/17 at 7:45 AM.</p> <p>*On 02/23/17 the Social Service Director began 24 hour reportable and completed and sent to North Carolina Health and Human Services by 4 PM.</p> <p>*The new Interim Executive Director started on 02/27/17 at or around 11 AM and was educated on the Abuse and Neglect Policy and the Grievance Policy by the Field Service Clinical Director on 03/01/17.</p> <p>Abuse and Neglect training was initiated to all staff on 02/23/17 including: nursing, environmental services, dietary personnel, therapy, and department managers, this in-service was conducted by Social Worker and Assistant Director of Nurses. Training continues to be ongoing for current employees who were not present on 02/23/17. Training includes the types of abuse, mandated reporting requirements with the 2 hour time frame and immediate steps to ensure the residents safety, and included the 24 hour reporting done by Director of Nurses. Staff will not be allowed to work until training on abuse and neglect has been completed. The Director of Nurses was re-educated on 03/01/17 by Fields Service Clinical Director of Golden Living Center on the Abuse/Neglect policy including the immediate removal of the alleged perpetrator from the facility. This included proper chain of command and her ability to remove her Superior if needed</p> <p>The Director of Nurses was re-educated on 03/02/17 at 3:16 PM on 24 hour reportable process according to Federal Regulations through established procedures with reporting abuse no later than 2 hours after allegation is</p> | F 226 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 226 | <p>Continued From page 41</p> <p>made if the events that cause the allegation involve abuse or result in serious bodily injury. Staff will receive education on the Abuse and Neglect Policy upon hire by Director of Nursing Services, Assistant Director of Nursing Services, Social Service Director and Business Office Specialist. In addition to the computer orientation it will be a person to person in service concerning abuse and neglect allowing employees the opportunity to have an adequate understanding of the policy. The abuse policy will be reviewed quarterly. This will be conducted by Director of Nursing Services, Assistant Director of Nursing Services and Business Office Specialist. All computer orientation will be completed before employee will be allowed to work and will be monitored by Assistant Director of Nursing effective 03/03/17. The Business Office Manager will run compliance report Monday thru Friday to verify all new employees have completed computer training.</p> <p>A Resident Council Meeting was held on 03/01/17 to review resident rights, reporting of abuse and neglect. Resident Council meeting was conducted by Activity Director and interim Executive Director. Approximately 12 residents were in attendance. The results of the Resident Council Meeting Minutes will be reviewed at Quality Assurance Performance Improvement. The residents voiced no complaints or concerns and were very happy that the Executive Director was gone.</p> <p>The Interim Executive Director who started on 02/27/17 was educated on the Abuse and Neglect Policy, the Grievance Policy and chain of command for reporting any allegations of abuse by the Field Service Clinical Director on 03/01/17. On 03/01/17 an audit of current Golden Living Center employees was conducted and asked if</p> | F 226 | | | |

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| F 226 | <p>Continued From page 42</p> <p>they felt unsafe, knew of any abuse or have the desire to abuse residents. Did they know how to report abuse and who to report it too? This was conducted by Nursing managers.</p> <p>Immediately after the incidence occurred on 02/22/17 the Executive Director verbalized to the Director of Nursing and MDS Coordinator that he was frustrated with Resident #59 and her continuous non-compliant behavior to rules and regulations happening over and over had increased his stress level.</p> <p>This incident was reported to ombudsman on 2/22/17 via voice mail at or around 6pm A 24 hour reportable was completed on 02/23/17 and sent to North Carolina Department of Health and Human Services.</p> <p>The 5 day reportable Investigation was completed 03/01/17 and was sent to North Carolina Department of Health and Human Services.</p> <p>This incident was reported to Adult Protective Service on 03/01/17 at 7:30 PM.</p> <p>The incident was reported to North Carolina Board of Administrators via voice mail on 03/01/17.</p> <p>Immediate Jeopardy was removed on 03/03/17 at 5:09 PM when interviews with nursing staff, administrative staff and non-nursing staff confirmed they had received in-service training and knew the different types of abuse and the requirement that any observed or alleged abuse of a resident should be reported immediately to the ED or DON and if the perpetrator was the ED it should be reported to the AVP. Staff confirmed they were provided with a copy of the facility's abuse policy and the chain of command.</p> <p>Interviews with the DON, ED #2 and Field Service Clinical Director revealed training was provided to</p> | F 226 | | | |

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| F 226 | Continued From page 43 ED #2 and the DON on the requirement that any observed or alleged abuse by the ED should be immediately reported to the AVP and the accused perpetrator should immediately be removed from the facility. | F 226 | | | |
| F 325 SS=D | 483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with resident and staff, the facility failed to implement the therapeutic diet that was recommended for a resident receiving dialysis for 1 of 1 resident reviewed for nutrition (Resident #90). The findings included: Resident #90 was admitted to the facility on | F 325 | 1. The facility was contacted by the Dialysis Center RD (registered dietitian) regarding resident #90 diet. The Dialysis RD's recommendations were sent to the primary MD for approval. Resident #90 is receiving the diet recommended by Dialysis Center RD. 2. There are no other residents in the facility that are receiving dialysis at this time. If a current resident were identified | 4/4/17 | |

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| F 325 | <p>Continued From page 44</p> <p>02/13/17 with diagnoses that included Diabetes Mellitus, hypertension (HTN) and End Stage Renal Disease (ESRD). Review of Resident #90's physician's orders revealed he was on a carbohydrate controlled (Con CHO) diet which was ordered on 02/13/17.</p> <p>Review of Resident #90's dialysis communication book revealed a note from the Registered Dietician (RD) at the dialysis center dated 02/14/17 which indicated his diet was to be changed to high protein and low potassium.</p> <p>An admission Minimum Data Set (MDS) assessment dated 02/20/17 indicated Resident #90 was cognitively intact for daily decision making and had no delirium, psychosis, behavioral symptoms or rejection of care. The MDS indicated Resident #90 required limited assistance with all activities of daily living except eating for which he required supervision. The MDS coded Resident #90 as receiving a therapeutic diet and dialysis.</p> <p>A comprehensive care plan dated 02/22/17 addressed Resident #90's diet alteration related to diagnoses of ESRD and HTN with fluctuating weights due to dialysis, alteration in kidney function and risk for infection at fistula site. The goal was for Resident #90 to maintain nutritional status and body weight. Interventions included: educate patient on nutrient restriction in relation to medical condition/diagnoses, communication with dialysis center RD as needed, diet as ordered, educate patient on risks of diet restrictions and monitor meal consumption daily.</p> <p>Review of a dietary note dated 02/22/17 revealed the following entry: "receives a Con CHO End</p> | F 325 | <p>as needing dialysis, or admitted to facility on dialysis, the Dialysis RD would be contacted for diet recommendations.</p> <p>3. Other residents could be affected if the dining tray card does not match the current diet order in Point Click Care.</p> <p>4. Monitoring for compliance an audit was conducted by Dietary Manager, MDS, DNS, Registered Dietician and ADNS and will be completed by 3/28/17 on all residents diet, dining tray cards to make sure match the current Point Click Care order from MD. Audits to be conducted by Department Managers of residents at meal time in dining room and on the hall for those that chose to eat in room to ensure they are receiving the correct diet order after initial audit to begin 3/29/17. The audit will be done 5 times week for 4 weeks then 3 times week for 4 weeks then weekly. The audit will be a joint effort between Department Nursing Managers, Dietary Manager and Dietary Manager Assistant. All audits will be reviewed in the QAPI monthly meeting. The whole house audit will be done as stated above until cleared by QAPI committee. Audits will be then done on quarterly by CDM(Certified Dietary Manager)and reviewed at QAPI. Correction date for substantial compliance is 4/4/17. Person responsible for compliance is Interim ED/ADNS/DSM.</p> <p>5. Licenssed staff will be educated by DNS, Nursing Managers and Dietary Manager by 4/4/17 on correctly sending a dietary communication slip to the dietary department each time there is change in residents diet. Review of new orders will</p> | | |

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| F 325 | <p>Continued From page 45</p> <p>Stage Renal diet, goes to dialysis 3 times a week."</p> <p>Resident #90 was observed on 03/01/17 at 12:22 PM eating lunch in his room which consisted of roast beef, Brussels sprouts and dessert. The tray card indicated he was on a renal diet.</p> <p>Resident #90 was observed on 03/01/17 at 5:51 PM eating dinner which the tray card indicated was roast turkey, steamed rice, winter mix (chopped broccoli), sesame wheat roll, chicken noodle soup and pears.</p> <p>An interview with Resident #90 on 03/01/17 at 5:51 PM revealed he was not aware of any diet restrictions. He stated he was supposed to be on a renal diet but didn't know what that meant.</p> <p>An interview was conducted with the Dietary Manager (DM) on 03/02/17 at 7:17 AM about the facility's process for ensuring that residents receiving dialysis are provided the therapeutic diet that is recommended by the RD at the dialysis center. The DM stated the nurse sends the dietary department a diet order slip that indicates the type of diet that is ordered and the days and schedule that the resident goes to dialysis. When asked how a renal diet differed from a dialysis diet the DM stated there is a difference in how much phosphorous, potassium and protein the resident is allowed. She stated she uses a spreadsheet for each type of diet to determine what the resident is served. The DM stated she also talks to the RD at the dialysis center if there are changes recommended. When asked about the meal that Resident #90 was served on 03/01/17 at dinner which appeared to be the same as the regular diet that his</p> | F 325 | <p>be reviewed in Clinical Start Up beginning 3/29/17 after audit completed on all residents by Nursing Managers and Dietary Supervisor.</p> | | |

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| F 325 | <p>Continued From page 46</p> <p>roommate received, the DM stated the entree may have looked the same but Resident #90 only had turkey and rice in the casserole and his roommate's casserole contained cheese.</p> <p>An interview with Nurse #1 on 03/02/17 at 4:22 PM about the facility's system for communicating with the dialysis center revealed each resident receiving dialysis had a communication book that was sent to and from dialysis and was used for communication between facility staff and the dialysis center staff. When Nurse #1 was asked about the note from the dialysis center dated 02/14/17 which recommended changing Resident #90's diet to a high protein/low potassium diet, Nurse #1 stated it should have been written as a physician's order on Resident #90's electronic record. Nurse #1 checked the physician's orders in the computer and stated the order for the diet change wasn't in the computer. Nurse #1 stated he should have written the recommendation as a physician's order but he didn't always see the communication book when Resident #90 returned from dialysis. When asked who was responsible for checking the book for order changes, Nurse #1 stated the nurse who was on duty when the resident returned from dialysis was responsible for checking the dialysis communication book. Nurse #1 confirmed that he was the nurse on duty on 02/14/17 when Resident #90 returned from dialysis.</p> <p>In a second interview with the DM on 03/02/17 at 5:32 PM about the difference between a Con CHO diet and a renal diet, the DM stated the renal diet had sodium, potassium, phosphorous and some protein restrictions. When asked if she was aware of the recommendation for a diet change from the dialysis center RD dated</p> | F 325 | | | |

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| F 325 | <p>Continued From page 47</p> <p>02/14/17, the DM stated the only diet order slip she had received from nursing was dated 02/13/17 which ordered a carbohydrate controlled diet. When asked how a high protein, low potassium diet would be different from the Con CHO diet, the DM stated he would have gotten extra meat and limited foods that were high in potassium such as green, leafy vegetables.</p> <p>An interview on 03/02/17 at 6:23 PM with the Director of Nursing (DON) about the facility's system for communicating with the dialysis center, revealed each resident who receives dialysis has their own communication book that is sent with the resident to and from dialysis. The DON explained that a standardized form is used which contains a section for the nursing staff at the facility to record notes to dialysis and a section for dialysis staff to record notes to the nursing staff at the facility. The DON stated all the nurses are trained in the use of the form. When asked what her expectation was in regard to nurses checking the communication book for order changes, the DON stated she expected the nurse who was on duty when the resident returned from dialysis to check the book for any new orders and to put any new orders in the resident's electronic record.</p> <p>An interview on 03/03/17 at 9:30 AM with the facility RD revealed she had conferred with the RD at the dialysis center and confirmed that Resident #90 needed a high protein diet instead of the low protein diet he had been receiving since admission to the facility on 02/13/17.</p> <p>An interview on 03/03/17 at 10:17 AM with Resident #90's physician revealed he considered Resident #90's medical condition very fragile.</p> | F 325 | | | |

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| F 325 | Continued From page 48 When asked about his expectation for recommendations from the dialysis center being implemented, the physician stated he expected the recommendations to be followed and they should have been written on Resident #90's medical record. | F 325 | | | |
| F 490 SS=J | 483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record reviews, the administration failed to protect a resident from abuse when the Executive Director (ED) failed to maintain an abuse free environment when he verbally abused a resident; the Director of Nursing (DON), who was next in charge in the chain of command, did not immediately remove an alleged perpetrator from resident care areas and failed to follow the policy on reporting to the Area Vice President (AVP) immediately a witnessed incident of verbal abuse of a resident. Immediate Jeopardy began on 02/22/17 at 4:00 PM when Resident #59 was verbally abused by ED #1. The Director of Nursing (DON) and Patient Care Assistant (PCA) #1 witnessed ED #1 threatening to hit Resident #59. The DON allowed the perpetrator to remain in the building without supervision for 2 additional hours. Neither the DON or PCA #1 notified the AVP immediately of | F 490 | Golden Living Center Asheville is a facility that is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each resident. 1. The interim ED and DNS have been in-serviced and educated on the Golden Living Abuse and Neglect policies and Procedures including what to do if an actual or allegation of abuse or neglect are identified regardless of who the alleged perpetrator is, who to notify and reporting requirements on 2/27/17 and 3/1/17 by Field Service Clinical Director. 2. Staff have been educated by the DNS,SW,ADNS,BOM and BOMA on the Golden Living Abuse and Neglect Polices and Procedures, this training is included on new hire orientation and reviewed annually. | 4/4/17 | |

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| F 490 | <p>Continued From page 49</p> <p>the incident. Immediate Jeopardy was removed on 03/01/17 at 5:09 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to protecting residents from being abuse, notifying the AVP and following the facility's abuse policy and procedure.</p> <p>The findings included:</p> <p>Cross refer to F 223: Based on resident interviews, record review and staff interviews, the facility failed to maintain 1 of 3 sampled residents' right to be free from verbal abuse (Resident #59) when Executive Director (ED) #1 threatened to hit Resident #59 causing 4 of 7 residents who witnessed the incident to be afraid, nervous and anxious (Residents #22, #59, #72 and #86).</p> <p>Cross refer to F 225: Based on resident interviews, record review and staff interviews, the facility failed to immediately report verbal abuse of a resident by Executive Director (ED) to the Area Vice President (AVP) and also failed to notify the North Carolina Health Care Personnel Investigations (NCHCPI) within 2 hours of the incident. This affected 1 of 3 residents sampled for abuse (Resident #59).</p> <p>Cross refer to F 226: Based on resident and staff interviews and record review, the facility failed to implement its abuse policy in the areas of protection of the resident and reporting of abuse within 2 hours. The facility failed to separate the</p> | F 490 | <p>3. On March 21st,2017, the Psychologist the DNS, and the ICP Psychiatrist reviewed all residents identified with behaviors, change in mood, new admissions, for adjustments and that current care plan interventions were appropriate and current.</p> <p>4.The Psychologist will meet with residents on 4/4/17 to make them aware of the services that are available for dealing with stress, life style changes and coping strategies.</p> <p>5.The Psychologist will be meeting with staff on 4/4/17 coping with stress, burnout and working with residents that pose challenges with their behavior.</p> <p>6.ED/DNS inniated an Employee Engagement Program with the goal to create a cultural atmosphere that is cohesive to residents and employees to prevent the risk of abuse and decrease stress of residents and staff. The first meeting will be held on 3/29/17 and will meet weekly x4 weeks then monthly. The This program will include one staff member from each department and will invite President and Vice President of Resident Council plus 2-3 other long term residents to be on program. The program will meet weekly for 4 weeks then monthly and discuss any stressors, up coming events and plan events to include residents and employees together, to make more of cohesive working environment. With any findings of burnout committee for EAP will work to try to reduce and prevent any type of abuse from occurring.</p> <p>7.All employees will complete "Caring for</p> | | |

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| F 490 | <p>Continued From page 50</p> <p>perpetrator from the resident, to supervise the alleged perpetrator until he left the facility and to immediately notify the Area Vice President (AVP) of the verbal abuse. This affected 1 of 3 residents sampled for an abuse investigation (Resident #59).</p> <p>On 03/01/17 at 9:14 AM, ED #2 was informed of Immediate Jeopardy. The Administration provided an acceptable allegation of compliance on 03/03/17 at 2:45 PM.</p> <p>Allegation of Compliance GLC Asheville March 3rd, 2017</p> <p>F 490 a facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain, the highest physical, mental, psychosocial well-being of each resident</p> <p>2/22/17 at or around 4pm, the Executive Director (ED) entered the facility outside smoking area and approached resident #59 for smoking after her privileges had been revoked. He then proceeded to become verbally abusive to resident #59 by stating to her if she did not leave the facility he would hit her. This was witnessed by Director of Nurses who immediately had resident #59 come to her side and addressed resident #59 and the other residents on the smoking patio: #29, #72, #86, #10, #23, #79, #67, #66, #22, #28 and #75. The Director of Nurses assured them that no one was going to hit anyone and reviewed the smoking policy and asked if they felt secure and safe and they replied yes. The Executive Director and Director of Nurse came back into the building and ED went towards his office. The Director of Nurses failed to follow facility abuse policy and did not have him removed from facility immediately. The Executive Director then went to</p> | F 490 | <p>the Caregiver" in-service by 3/31/17..The in-service goal is to inform the staff of the challenges that they can face as a caregiver, and ways to cope and reduce stress and foster teamwork. In-service provided by DNS,BOM and BOMA. Any employee who has not completed by 3/31/17will not be eligible for work till completed.</p> <p>8. Monitoring for compliance, the results of the EEP(Employee Engagement Program) will be reviewed monthly at the QAPI meeting. The AVP(Area Vice President) and or the DFCS(Director of Field Clinical Services) will attend the QAPI meeting either in person or via Web EX. The QAPI team will evaluate the results and implement additional interventions as indicated to ensure continued compliance. Correction date for substantial compliance is 4/4/17. The Interim ED/DNS responsible for compliance.</p> | | |

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| F 490 | Continued From page 51 outside smoking door opened it and stated to smoking residents that he was going to report himself to the ombudsman. When the Director of Nurses heard the outside smoking group talking loudly she then went back to outside to smoking area and asked if residents were ok and felt safe. They told the Director Of Nurses that the Executive Director had come back to doorway and stated he was reporting himself. She asked if they were ok and all replied yes and she explained to them not to worry as she was going to report to all appropriate agencies. When she came back into facility Resident #59 was discharging home as previously planned and needed her belongings that were locked in the Director of Nurses office she completed this task. While she was completing this task the MDS so Coordinator stayed with the Executive Director till she was finished. The Director of Nurses then took Executive Director to his office and called the North Carolina Ombudsman and left voice mail of incident. She then called the Executive Director's superior, Regional Vice President of Operations, and explained the incident and he suspended the Executive Director effective immediately pending investigation and he left building at or around 6:20 PM with Director of Nurses supervising that he didn't go anywhere else in facility. He was officially terminated on 02/27/17 at 7:45 AM. The new Interim Executive Director started on 02/27/17 at or around 11 AM and was educated on the Abuse and Neglect Policy and the Grievance Policy by the Field Service Clinical Director on 03/01/17. The Director of Nurses was re-educated on 03/01/17 by Field Service Clinical Director of Golden Living Center on the Abuse/Neglect policy including the immediate removal of the alleged perpetrator from the | F 490 | | | |

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| F 490 | Continued From page 52 building, chain of command and even if it is your superior you have the right to ask them to leave and notify their superior which is Regional Vice President of Operations, and the Grievance Policy. Graph of chain of command for Golden Living of Asheville with names, titles, contact numbers and their responsibilities was posted at time clock for all staff effective 03/02/17 by 4 PM. -The Area Vice President and Field Service Clinical Director will educate the facility leadership and staff on recognizing signs and symptoms in self and others of being burnt out, frustrated, and angry. Education will include how to develop and implement solutions for addressing signs of being burnt out, frustrated and/or angry with residents. Education will include how to maintain composure when working with residents that pose challenges. Education will include escalating identification of burn out, frustration and anger to the employee's supervisor. This is to begin the week of March 6, 2017 -Facility leadership will meet with resident council to request that they notify someone immediately if they feel they are not being treated respectfully. First meeting was 02/28/17, then 03/01/17 and next scheduled Resident Council meeting will be 03/20/17. The Area Vice President and Field Service Clinical Director will educate the facility leadership and staff on the chain of command and the abuse and neglect protocol, including but not limited to, the remedies for failing to report abuse, neglect and/or mistreatment of a resident. On 03/01/17 the Area Vice President and Field Service Clinical Director reviewed abuse and neglect policies and procedures on visit to Golden Living Center of Asheville and checked the regulations for new information and will continue to do so on monthly basis. They met on 03/01/17 to begin training with | F 490 | | | |

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| F 490 | Continued From page 53 facility leadership on the above. A Graph of chain of command with contact numbers and their responsibilities is posted at time clock that is accessible to all employees. *All other residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. On 03/01/17 the department managers interviewed all other interviewable residents for any signs of abuse, understanding of abuse, if know how to report abuse, and if they have any abuse they would like to report. Beginning 03/01/17 department managers or designee will monitor with daily room rounds with asking if they felt safe, if they had anything to report and any abuse that they want to report. Beginning 03/01/17 during their care plans Social Worker will ask residents if they feel safe, if they know what abuse is, if they know who to report to and if they have any abuse to report. Any staff that has not completed abuse and neglect in-service will not be able to work until training is complete. The facility will review and educate all employees including contract staff on policies and procedures to protect residents from any form of abuse. The verbal in services with a copy of the abuse policy was given to all employees who worked 03/01/17. All absent staff will be educated prior to being allowed to work in facility. To ensure the quality of care is provided to all residents by keeping them safe and free of harm, any staff that has not completed abuse and neglect in-service will not be able to work until training is completed. On 03/01/17 an audit of current Golden Living Center employees was conducted by department managers and asked if they felt stressed or burnt out, if they felt unsafe, knew of any abuse or desire to abuse residents. Did they know how to | F 490 | | | |

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| F 490 | <p>Continued From page 54</p> <p>report abuse and who to report it to? All responses were positive and no one felt unsafe or overly stressed. The facility will have monthly all staff meetings and discuss stressors, the population of our residents and coping mechanisms to deal with challenging residents. A Psychologist for Golden Living of Asheville has agreed to come to facility to meet with the residents and employees separately to discuss burnout, dealing with stress and coping mechanisms. She is setting up schedule for week of March 6, 2017.</p> <p>As changes take place from the corporate standpoint as far as the progression of leasing out Golden Living Center the staff will be kept informed on monthly basis at in-services to keep them up to date and try to prevent any stressors. Golden Living Center of Asheville's Interim Executive Director will be kept up to date by Regional Vice President and will speak to staff monthly.</p> <p>Golden Living of Asheville will form an Employee Engagement Program with a goal to create a cultural atmosphere that is cohesive to residents and employees to help prevent the risk of abuse and decrease stress. We will have one staff member from each department on the committee and will invite the Resident Council President and Vice President, along with 2-3 Long Term Care Residents to be a part of the program. The program will meet monthly and discuss any stressors, upcoming events and plan events to include residents and employees together to make for a more cohesive working environment. All employees will complete a Caring For the Caregiver in-service to inform them of the challenges they are facing as being a caregiver is one of the most challenging jobs and they need ways to cope and reduce stress, and explain</p> | F 490 | | | |

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| F 490 | <p>Continued From page 55</p> <p>useful ways that others can help to reduce stress with teamwork and to encourage employees to ask for help as needed.</p> <p>Immediate Jeopardy was removed on 03/03/17 at 5:09 PM when interviews with residents revealed they were aware of what constituted abuse, felt comfortable reporting abuse and knew to whom they could report abuse. Interviews with nursing staff, administrative staff and non-nursing staff confirmed they had received in-service training and knew the different types of abuse and the requirement that any observed or alleged abuse of a resident should be reported immediately to the ED or DON and if the perpetrator was the ED it should be reported to the AVP. Staff confirmed they were provided with a copy of the facility's abuse policy and the chain of command. Interviews with the DON, ED #2 and Field Service Clinical Director revealed training was provided to ED #2 and the DON on the requirement that any observed or alleged abuse by the ED should be immediately reported to the AVP and the accused perpetrator should immediately be removed from the facility.</p> | F 490 | | | |