**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
GOLDEN LIVINGCENTER - GREENVILLE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
2910 MACGREGOR DOWNS
GREENVILLE, NC  27834

**SUMMARY STATEMENT OF DEFICIENCIES**
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<td>F 000</td>
<td>INITIAL COMMENTS</td>
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<td>F 157</td>
<td>483.10(b)(11) NOTIFY OF CHANGES</td>
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<td>5/15/14</td>
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**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**
 Electronically Signed

05/02/2014

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.
Continued From page 1

This REQUIREMENT is not met as evidenced by:

Based on record review and staff and physician interviews the facility failed to notify the physician of 7 missed doses of an antihypertensive medication for 1 of 6 (Resident #299) sampled residents whose medications were reviewed. Findings included:

Resident #299 was admitted to the facility on 01/22/14 with cumulative diagnoses of hypertension, reflux, and muscle weakness.

Resident #299's Admission Minimum Data Set (MDS), dated 01/29/14, showed that Resident #299 was cognitively aware.

Review of the Medication Administration Record (MAR) for March 2014 showed that from 03/05/14-03/08/14 seven doses of Terazosin 1 milligram had a code of 7. Per the legend on the MAR, 7 = Other / See Nurse Notes.

Review of the Physician Telephone Orders, dated 03/03/14, showed an order to start Amlodipine (an antihypertensive) 5 milligrams daily.

Review of the Physician Telephone Orders, dated 03/04/14, showed an order to discontinue the Amlodipine and start Terazosin 1 milligram twice daily.

Review of the Progress Notes, dated 03/05/14 at 8:36 AM, showed the Terazosin was a new medication and was not in from the pharmacy yet.

Review of the Progress Notes, dated 03/05/14 at 5:41 PM, showed the medication was not in from

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

F157 Notification of Changes
The facility will continue to notify the physician and the resident's legal representative when there is a change in condition or a change to the treatment plan.

1. Unable to correct alleged deficient practice for resident #299 because she was discharged home on 3/19/2014. Home Health services arranged, and discharge instructions were provided to the resident.

2. All residents have the potential to be affected by alleged deficient practice therefore nurses will be educated on notifying the doctor and family whenever they are unable to follow through on an order as given, especially as it relates to medication unavailability. They will also be educated on the importance of follow-up assessment of residents when started on new medications. Nurses will also be instructed to notify DNS, Unit Manager or designee if they are having a problem.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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GOLDEN LIVINGCENTER - GREENVILLE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
2910 MAGGREGOR DOWNS
GREENVILLE, NC  27834

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F 157 | Continued From page 2 | the pharmacy yet. | F 157 | getting medications from pharmacy. In-service to stress the importance of not to document medication not available without follow-up and notification of the doctor.

Review of the Progress Notes, dated 03/06/14 at 10:22 AM, showed the Terazosin was not in from the pharmacy yet.

Review of the Progress Notes, dated 03/06/14 at 4:23 PM, showed the medication was not in from the pharmacy yet.

Review of the Progress Notes, dated 03/07/14 at 9:50 AM, showed the Terazosin was not in from the pharmacy yet.

Review of the Progress Notes, dated 03/07/14 at 5:57 PM, showed the medication was not in from the pharmacy yet.

Review of the Progress Notes, dated 03/08/14 at 10:33 AM, showed the pharmacy was called and the order for the medication was faxed again and should arrive during the 7-3 shift.

In an interview on 04/16/14 at 3:20 PM, Nurse #1 stated a code of 7 on the MAR meant the explanation could be found in the nursing notes. After reviewing the MAR and the progress notes she indicated Resident #299 had not received the Terazosin seven times. She stated that by not getting the antihypertensive medication Resident #299's blood pressure could have increased causing a stroke.

In an interview on 04/16/14 at 5:10 PM, Nurse #2 stated several calls were made to the pharmacy for the missing Terazosin but it did not come in. The pharmacy was also faxed several times. No call was made to Resident #299's physician regarding the missing medication.
### Statement of Deficiencies and Plan of Correction

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GOLDEN LIVINGCENTER - GREENVILLE

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
2910 MACGREGOR DOWNS, GREENVILLE, NC 27834

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<td>F 157</td>
<td>In an interview on 04/17/14 at 9:50 AM, Nurse Supervisor #1 stated Resident #299’s physician was an in-house physician. She indicated one of the nurses could have told the physician about the missing medications and had just not charted it. She stated she did not notify the physician of the missing medications. Nurse Supervisor #1 indicated that missing 7 doses of an antihypertensive medication was a problem.</td>
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<td>F 281</td>
<td>SS=D</td>
<td>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</td>
<td>F 281</td>
<td>5/15/14</td>
<td>The services provided or arranged by the facility</td>
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**DATE SURVEY COMPLETED:**
04/17/2014
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<td>must meet professional standards of quality.</td>
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This REQUIREMENT is not met as evidenced by:
Based on record review and staff and physician interviews the facility failed to monitor blood pressures for 1 of 1 (Resident #299) sampled residents whose antihypertensive medications were not given. Findings included:

Resident #299 was admitted to the facility on 01/22/14 with cumulative diagnoses of hypertension, reflux, and muscle weakness.

Resident #299’s Admission Minimum Data Set (MDS), dated 01/29/14, showed that Resident #299 was cognitively aware.

Review of the Medication Administration Record (MAR) for March 2014 showed that from 03/05/14-03/08/14 seven doses of Terazosin 1 milligram were not given.

Review of the Physician Telephone Orders, dated 03/03/14, showed an order to start Amlodipine (an antihypertensive) 5 milligrams daily.

Review of the Physician Telephone Orders, dated 03/04/14, showed an order to discontinue the Amlodipine and start Terazosin 1 milligram twice daily.

Review of the Progress Notes, dated 03/05/14 at 10:47 PM, showed Resident #299 had a blood pressure reading of 119/67. No other blood pressure readings were recorded in the progress notes during the times the Terazosin was not given.

1. Unable to correct alleged deficient practice for resident #299 because she was discharged home from facility on 3-19-2014. Home health services were arranged and discharge instructions were provided to resident. Medication error report was done and doctor was notified. Medication error also discussed with Medical Director.

2. All residents have the potential to be affected deficient practice therefore nurses will be educated by DCE and or designee on the importance of follow-up documentation when there’s a change in condition or change in treatment plan, especially as it relates to the
### Summary Statement of Deficiencies

#### F 281

**Continued From page 5**

Review of the Weights and Vitals Summary showed no blood pressure readings between February 19 and March 12, 2014 for Resident #299.

In an interview on 04/16/14 at 5:10 PM, Nurse #2 stated antihypertensives were very important medications to take. She indicated that not taking them could have caused Resident #299 to experience increased blood pressure or to have a stroke.

In an interview on 04/17/14 at 11:08 AM, Resident #299's physician stated she had been unaware that Resident #299 had missed seven doses of her antihypertensive medication. The physician stated she considered it to be common sense for a nurse to monitor the blood pressure when antihypertensive medications were missed. She indicated it was a problem that the blood pressure was not monitored.

In an interview on 04/17/14 at 11:22 AM, Nurse Supervisor #2 stated she considered not monitoring Resident #299's blood pressure to be a problem.

In an interview on 04/17/14 at 11:51 AM, the Director of Nursing (DON) indicated that under standard nursing practice, Resident #299's blood pressure should have been monitored and documented in the medical record when the antihypertensive medications were not given.

**F 281**

F 281 documentation of vital signs on resident's medical record.

3. The DNS, DCE, ADNS, and or designees will review 24 hour reports and documentation review during morning start-up to determine if there are any acute change of conditions or medication orders which warrants monitoring of vital signs. Concerns will be addressed and corrected. This audit will be done 5 times a week x 1 month then 3 times a week x 1 month then twice a month.

4. DNS, ADNS, DCE, and Unit Managers will report any unresolved concerns in the scheduled Quality Assurance Performance Improvement Meeting until substantial compliance is achieved and or committee recommend to discontinue monitoring.