	-	ID HUMAN SERVICES					MAPPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					<u> </u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	COM	E SURVEY PLETED	
		345010	B. WING				C / <b>03/2017</b>	
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
				5	500 BEAVERDAM ROAD			
GOLDEN	IVINGCENTER - ASHEV				ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N SHOULD BE COMPL E APPROPRIATE DAT		
F 000	INITIAL COMMENTS		F	000	,			
	Resident #59 was ver Immediate Jeopardy when the facility provi acceptable credible a facility remains out of scope and severity of harm with potential for that is not immediate education and ensure place are effective rel be free from abuse. 2. 483.12 (F225) at J Immediate Jeopardy Director of Nursing (E Assistant (PCA) #1 w abuse Resident #59, report the verbal abus Jeopardy was remove facility provided and in credible allegation of remains out of compli severity of D (isolated potential for more that immediate jeopardy) ensure monitoring sys effective related to inf of witnessed or allege 3. 483.12 and 483.95 Immediate Jeopardy facility did not follow i report a verbal threat (ED) #1 to abuse Res	began on 02/22/17 when the bally abused by ED #1. was removed on 03/03/17 ided and implemented an llegation of compliance. The compliance at a lower D (isolated with no actual r more than minimal harm, jeopardy) to complete e monitoring systems put into ated to residents rights to began on 02/22/17 when the DON) and Patient Care itnessed the ED verbally but did not immediately se to the AVP. Immediate ed on 03/03/17 when the mplemented an acceptable compliance. The facility ance at a lower scope and I with no actual harm with n minimal harm, that is not to complete education and stems put into place are forming the ED and/or AVP ed incidents of abuse.						
LABORATORY	DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATUR	 E		TITLE		(X6) DATE	

**Electronically Signed** 

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.

03/24/2017

PRINTED: 03/29/2017

		MEDICAID SERVICES	0.00			IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	TE SURVEY MPLETED
			A. DOILDIN			С
		345010	B. WING		03/03/2017	
NAME OF P	ROVIDER OR SUPPLIER	•	1	STREET ADDRESS, CITY, STATE, ZIP COD	·	
	LIVINGCENTER - ASHE	/!!! =		500 BEAVERDAM ROAD		
GOLDEN	EIVINGGENTER - ASHE			ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 000	Continued From page	<b>-</b> 1	FO	00		
		Patient Care Assistant (PCA)				
		dent but did not immediately				
		se to the AVP as required				
	-	ity's abuse policy. The DON				
		or to remain in the building				
	without supervision for					
		was removed on 03/03/17 ided and implemented an				
		illegation of compliance. The				
		f compliance at a lower				
	-	f D (isolated with no actual				
		or more than minimal harm,				
		jeopardy) to complete				
		e monitoring systems put into lated to protecting residents				
	-	nd following the abuse				
	policy.					
	4. 483.70 (F490) at J					
		began on 02/22/17 at 4:00				
		59 was verbally abused by				
		of Nursing (DON) and				
		nt (PCA) #1 witnessed ED #1				
		sident #59. The DON allowed				
		nain in the building without itional hours. Neither the				
		ied the AVP immediately of				
		ate Jeopardy was removed				
		PM when the facility provided				
	and implemented an	-				
		nce. The facility remains out				
	-	wer scope and severity of D al harm with potential for				
	-	arm, that is not immediate				
		e education and ensure				
	monitoring systems p	out into place are effective				
		residents from being abuse,				
		I following the facility's abuse				
	policy and procedure					

Facility ID: 922979

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/29/20 FORM APPROV OMB NO. 0938-03		
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345010	B. WING		C 03/03/2017		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN I	-IVINGCENTER - ASHE\	/ILLE		500 BEAVERDAM ROAD ASHEVILLE, NC 28804			
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIC		
F 000	Continued From page	e 2	F 00	00			
	facility's recertification	was conducted as part of the n and complaint investigation 6/17 through 03/03/17. Event					
F 223 SS=J		ROM	F 22	23	4/4/17		
	neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to					
	abuse, corporal punis seclusion;	must- , mental, sexual, or physical shment, or involuntary <sup>-</sup> is not met as evidenced					
	Based on resident in staff interviews, the fa 3 sampled residents' abuse (Resident #59) (ED) #1 threatened to of 7 residents who wi	terviews, record review and acility failed to maintain 1 of right to be free from verbal ) when Executive Director o hit Resident #59 causing 4 tnessed the incident to be nxious (Residents #22, #59,		Preparation, submission and implementation of this Plan of Correct does not constitute admission or agreement by the provider of the tru the state of deficiencies. The plan of correction is prepared and/or execu- solely because it required by provision federal and state law.	ith of f ted		
		began on 02/22/17 when rbally abused by ED #1.		Golden Living Center-Asheville has policies and procedures that prohibi			

Facility ID: 922979

If continuation sheet Page 3 of 56

						OMB NC	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	PLETED
							С
		345010	B. WING			03/03/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ASHEV	/ILLE					
				A	SHEVILLE, NC 28804		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 223	Continued From page	e 3	F 22	23			
		was removed on 03/03/17			mistreatment, neglect, exploitation and		
		ided and implemented an			abuse of resident and misappropriation		
		llegation of compliance. The			resident property.		
		compliance at a lower					
		D (isolated with no actual			1.Resident #59 has been discharged fr	om	
		r more than minimal harm,			facility on 2/22/17. Resident #59 has		
		jeopardy) to complete			visited the facility since discharge with	no	
		e monitoring systems put into			concerns about safety of fear.		
	be free from abuse.	lated to residents rights to			2.Residents #29 and #72 have been discharged from the facility on 3/8/17.		
					Before discharged were asked if they for	elt	
	The findings included	:			safe or had any fears and they did not.		
					Residents #22, #66, #86, were		
	Resident #59 was ad	mitted to the facility on			interviewed on 2/24/17 to make sure th	ney	
	01/03/17 with diagnos	ses that included chronic			feel safe. All other residents have the		
		y disease, pneumonia,			potential to be affected.		
	hypertension and ma	jor depressive disorder.			3.Staff was educated on the different		
	The estado in Minim				types of abuse, and the Golden Living		
		um Data Set (MDS) dated dent #59 as having intact			Abuse Polices and Procedures, by Soc Worker, ADNS and DNS. Beginning	lai	
		4 out of 15 on the Brief			2/23/17,2/24/17 and ongoing to be		
		Status, which measures long			completed by 3/31/17 or any that have	not	
		bry and temporal orientation.			completed will not be eligible to work.		
		iderstanding others and			Included in this education is how to		
		e was coded as having no			identify and how to respond if an actua	l or	
	psychosis, behaviora	l symptoms or rejection of			allegation of abuse is identified,		
	care.				regardless of who the alleged perpetra		
					is. Abuse training is part of the orientat		
	-	Norker (SW) dated 02/22/17			process for new staff and reviewed with		
		that Resident #59 was outside the West Wing exit			staff annually. In-services began 2/23/1 with all staff to be completed by 3/31/1		
		en two bushes smoking.			All staff received copy of Golden Living		
		tinguish her cigarette and			Center Abuse and Neglect Policies and		
		area at the front entrance to			re-educated and any staff that has not		
		e her to an appointment.			completed will not be eligible for work,		
	According to the note				training provided by DNS/BOM and		
	informed that her smo	oking privileges were			BOMA. The Business Office		
	revoked.				Manager(BOM)or designee will check		
					Monday thru Friday to make sure all		1

Facility ID: 922979

If continuation sheet Page 4 of 56

	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUITIP	LE CONSTRUCTION	(X3) DA	ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · · ·	MPLETED
						С
		345010	B. WING			03/03/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
		<i></i>		500 BEAVERDAM ROAD		
GOLDEN	IVINGCENTER - ASHE	VILLE		ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 223	Continued From page	e 4	F 22	3		
		Director of Nursing (DON)		employees compliance trair	ning on abuse	
		<sup>o</sup> M revealed Resident #59		is completed and up to date	-	
		22/17 about 9:00 AM near		4.Department Managers are		
		gency exit in the shrubbery		residents and do daily room		
	smoking and was ask			Monday thru Friday asking		
		D) #1 to extinguish the		they know what abuse is an		
	-	informed Resident #59 that		safe and if they have any at		
		es were revoked. The DON		and discuss at Stand up and		
		ning Resident #59's physician		meetings Monday thru Frida		
		e smelled a strong odor of		5. Starting on 3/1/17 during social service or designee		
		esident #66's room, the sident #59's room. The DON		residents and families if the		
		' rooms were searched and		have any abuse to report ar	•	
		in 2 packs of cigarettes and		abuse is.		
		tated Resident #59 was		Director of Field Clinical Ser	rvices for	
	-	de smoking area at 2:00 PM		Golden Living educated the	Department	
	smoking with the other	er residents. The DON		Managers on 3/22/17(ED,D	NS,MDS	
		1 met with the department		Coordinator ,BOM, Admissi		
	•	1 on 02/22/17 to discuss		Coordinator, Dietitian, Dieta		
		ion of the smoking policy and		Housekeeping Supervisor, I	Rehab	
	she scheduled a mee			Director,		
		residents who smoked and		Social Services, and Centra		
		the meeting to reinforce the		Coordinator) On identifying	-	
	smoking rules.			symptoms of stress and bur strategies for coping with st		
	The DON stated she	and ED #1 walked outside		burnout and we have EAP(e		
	to the smoking area a			assistance program) availat		
	-	59 was smoking a cigarette.		additional support. Education		
		#1 asked Resident #59:		included strategies for work		
		out here? Why are you		residents that can present		
		lent #59 replied: "I'm just out		behaviors and identification	of strategies	
	-	st time before I go." The		work with these residents.		
		#1 then told Resident #59:		6.Other staff will receive the	•	
		want you to leave right now."		4/4/17 on identifying the sig		
	-	at Resident #59 continued to		symptoms of stress and bur	-	
	smoke and said: "I'm			by Psychologist, DNS, and		
	-	told Resident #59: "You		strategies for coping with st		
	need to leave before	I hit you." The DON stated		burnout EAP(employee ass	ISIGNCE	

Facility ID: 922979

If continuation sheet Page 5 of 56

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	· · ·	TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CO	MPLETED
						С
		345010	B. WING		(	3/03/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
	IVINGCENTER - ASHE	// / E		500 BEAVERDAM ROAD		
GOLDEN	IVINGCENTER - AGHEN			ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 223	Continued From page	9 5	F 22	23		
	to hit any of them and	asked Resident #59 to go		additional support. Education		
		that he needed to relax and		strategies for working with		
		g to hit anybody. The DON		can present with challeng	ing behaviors	
		hat Resident #59 was #59 went inside the facility.		effectively. 7.Monitering for compliant	ce Interim	
		#1 remained outside in the		ED/DNS Designee and A		
		r and the other residents		will conduct Resident Cou	•	
		e facility's smoking policy		weekly for 4 weeks begin	•	
		out safety concerns related		and then bi-weekly times		
	-	in non-designated areas.		resume monthly meetings		
		and ED #1 went back inside		policies and see if residen		
		ained outside for their er staff. The DON stated		Interim Ed will conduct ra interviews of residents that		
		Resident #59 to make sure		the Resident Council Mee		
		heard the residents outside		random staff audits week		
	-	ng about being upset about		the Abuse and Neglect Po	-	
	what happened.			Procedures to include what	at to do if an	
				allegation or actual abuse	•	
		7/17 at 3:12 PM with Patient		situation is identified. The		
		#1 revealed she was		audits will be reviewed at	•	
	the 4:00 PM smoke b	ne residents on 02/22/17 at		meetings to review and ar patterns and trends. The		
		ut with the other residents		President) and or the DFC		
		wasn't allowed to smoke		Field Clinical Services) wi		
	because her privilege	es had been revoked. PCA		QAPI meeting either in pe		
	#1 stated Resident #	59 told her she was just		EX. The QAPI team will e	valuate the	
	U	the other residents. PCA #1		results and implement add		
	stated she was lightin	-		interventions as indicated		
		D #1 tell Resident #59 to		continued compliance. Co substantial compliance is		
	-	e I hit you." PCA #1 stated ent #59 smoking. PCA #1		Interim ED/DNS/SW resp		
		ed closer to ED #1 and		compliance.		
		ack in the building. PCA #1				
		#29 told ED #1 that she was				
		udsman and he got mad				
		facility. PCA #1 stated the				
	DON reviewed the sn	-				
		ent in the building. PCA #1 es later ED #1 came back				

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	IE SURVEY MPLETED
						С
		345010	B. WING		0	3/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				500 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHE	VILLE		ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 223	Continued From pag	ie 6	F 22	3		
1 220			F 22	3		
	outside for a split second and told the residents he was going to call the Ombudsman about the					
		at he said was wrong.				
		vith the DON on 02/28/17 at				
		residents were outside in				
	-	02/22/17 at 4:00 PM. The				
		dents told her that ED #1 had				
		out she didn't observe ED #1 ated she met Resident #59				
		to her office with Resident				
		ettes and lighter then walked				
	• •	entrance. The DON stated				
	Resident #59 wanted	d to say good-bye to a friend				
	on the West Wing ar	nd as they passed ED #1's				
		n the hall and apologized to				
	Resident #59. The D	OON stated Resident #59 left.				
	An interview with FD	) #1 on 02/28/17 at 5:00 PM				
		tside to the smoke area on				
	02/22/17 at 4:00 PM	after a staff member				
	reported seeing Res	ident #59 smoking in the				
		a with other residents. ED #1				
		sident #59: "What are you				
		n't respond. ED #1 stated he				
		t #59: "Where did you get that still didn't respond. ED #1				
	•	o Resident #59: "I can't				
		ere smoking" and Resident				
	-	d one last cigarette. ED #1				
	stated he then told F	Resident #59: "You need to				
		t and you need to leave the				
	•	esident #59 didn't say				
		leave. ED #1 stated he was				
	-	12 feet away from Resident				
		e then told Resident #59:				
		and leave now before I hit				
	VOU " ED #1 stated b	e couldn't believe what he				

If continuation sheet Page 7 of 56

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/29/2017 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345010	B. WING					C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE,	ZIP CODE		
	LIVINGCENTER - ASHEV	/!! ! E		5	00 BEAVERDAM ROAD			
GOLDEN				Α	SHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVI CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 223	mean that." ED #1 sta smoking area and we stated he remained of she reviewed the smo anything further. ED came back in the built told her they needed stated someone told h in the smoking area ta Ombudsman so he st smoking area briefly t going to notify the Om himself. He was unal that he went back out between 4:30 PM and about 5:00 PM he say near the West Wing m out to apologize. During a telephone ca with Resident #59 wh was abused while she facility, she stated no anything happened of 4:00 PM smoke break Resident #59 stated s was asked to go back Resident # 59 stated s other residents. When to hit her- Resident #4 to hit her. She stated inside. When asked if #1 was going to hit he afraid that he was goi	ghts. I'm so sorry. I didn't ated Resident #59 left the int in the facility. ED #1 utside with the DON while oking rules but he didn't say #1 stated he and the DON ding around 4:30 PM and he to report the incident. ED #1 him they heard the residents alking about calling the repped back outside in the to tell the residents he was abudsman of the incident ole to recall the exact time side but stated it was d 5:00 PM. The ED stated w Resident #59 in the hall burses station and he went all on 02/28/17 at 7:59 PM en she was asked if she e was a resident at the she wasn't. When asked if utside on 02/22/17 at the k and if she was threatened, she wasn't threatened but a inside which she did. she knew she wasn't the smoking area and she betting an example for the in asked if ED #1 threatened 59 stated he didn't threaten he just told her to go back is she ever felt afraid that ED er, she stated she didn't feel ing to hit her.	F	223	DEFIC	CIENCY)		
	_	ng to hit her. PM Resident #59 came to						

Facility ID: 922979

If continuation sheet Page 8 of 56

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345010	B. WING				C 103/2017
NAME OF P	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GOLDEN	LIVINGCENTER - ASHEV	/ILLE			500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 223	facility to speak to sur really tell the truth abo interview on 02/28/17 getting in trouble for s getting the DON in tro ED #1 came out in the her: "What are you do she told him she was break. Resident #59 s "Where did you get the told him it fell out in h then told her: "You get Resident #59 stated F at his side and it reall stated the DON was in them and told her that Resident #59 stated s her family arrived to p stated she was gettin #1 apologized to her is station. Resident # 72 was act 01/20/17 with diagnos hypertension, general depression. A signific 01/31/17 coded Resid cognition with a BIMS was coded as unders understood. She was delirium, psychosis, b rejection of care. An interview on 02/27 Resident #72 reveale smoking area on 02/2 ED#1 came raging the to the table where and	rveyor and stated she didn't but ED #1 during the phone because she was afraid of smoking and also afraid of buble. Resident #59 stated e smoking area and asked bing?" Resident #59 stated having one last smoke stated ED #1 asked her: hat cigarette?" She said she er purse. She said ED #1 et in there before I hit you." ED #1 had his fists clenched y scared her. Resident #59 n the smoking area with t ED #1 wouldn't hit her. she was still shaking when bick her up. Resident #59 g ready to leave when ED at the West Wing nurse's Imitted to the facility on ses including: osteomyelitis, lized anxiety disorder and ant change MDS dated dent #72 as having intact is score of 15 out of 15. She tanding others and being coded as having no behavioral symptoms or	F	223			

Facility ID: 922979

If continuation sheet Page 9 of 56

				DI E CONOTRUCTION		
ND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		· · ·	E SURVEY
			A. BUILDIN	G		С
		345010	B. WING			
	ROVIDER OR SUPPLIER	343010		STREET ADDRESS, CITY, STATE, ZIP CODE	0.	3/03/2017
NAME OF FR	OVIDER OR SOFFLIER			500 BEAVERDAM ROAD		
GOLDEN L	IVINGCENTER - ASHE	VILLE		ASHEVILLE, NC 28804		
			<b>I</b>			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 223	Continued From page	e 9	F 22	23		
	her. Resident #72 sta					
1		unclenched his fist and				
		esident #72 stated she was				
		ED #1 was in such a rage				
	-	and she wasn't sure what he				
	was going to do. Res	ident #72 stated she didn't				
	feel threatened now l	out would feel scared if ED				
	#1 came back to the	facility.				
	An interview with Res	sident #29 on 02/27/17 at				
	10:55 AM revealed s	he was in the outside				
	smoking area on 02/2	22/17 at the 4:00 PM smoke				
		dents for a meeting with the				
		sident #29 stated she saw				
		when she went outside and				
		idents had their cigarettes. when ED #1 came out and				
		noking he asked her what				
		here she got her cigarettes.				
	•	ED #1 then told Resident				
		building right now before he				
	-	ere balled up. Resident #29				
		quickly said: "No one is				
	going to hit anybody.	" Then, ED #1 told Resident				
	•	bing to hit her. Resident #29				
		ED #1 went ahead with the				
	-	e smoking rules then went				
		esident #29 stated she and				
		ere discussing calling the				
	told them that he was	#1 came back outside and				
		ne incident. Resident #29				
		he in from the smoking area				
		trance ED #1 was at the				
	-	en who were working on the				
		tated she didn't see ED #1				
	after that time. Resid	ent #29 stated she was				
	angry about what ED	#1 said to Resident #59				

Facility ID: 922979

If continuation sheet Page 10 of 56

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/29/2017 APPROVED ). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION			LETED
		345010	B. WING			-		C 03/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
GOLDEN I	LIVINGCENTER - ASHEV	ILLE			00 BEAVERDAM ROAD SHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 223	12/11/16 with diagnest Mellitus type II, Anem admission MDS dated #86 as having intact of of 15 out of 15. She w others and being und having no delirium, ps symptoms or rejection An interview on 02/27 Resident #86 reveale smoking area on 02/22 break with the other m stated ED #1 came of another resident and there and where she #86 stated ED #1 was told the other resident area before he hit her #1's face was red and side. Resident #86 sta anxious because she going to do. An interview with Res 11:38 AM revealed sh smoking area with oth the 4:00 PM smoke b Resident #59 to get o her but he then apolo Resident #66 stated in didn't feel like ED #1	n to hit a resident. mitted to the facility on ses including Diabetes ia and Depression. An d 12/22/16 coded Resident cognition with a BIMS score vas coded as understanding erstood. She was coded as sychosis, behavioral n of care. 7/17 at 11:06 AM with d she was in the outside t2/17 at the 4:00 PM smoke esidents. Resident #86 ut the door shouting at asked her why she was out got the cigarettes. Resident s sort of wild-looking and t to get out of the smoking C. Resident #86 stated ED d his fist was clenched at his ated she was nervous and didn't know what he was ident #66 on 02/27/17 at	F	223				
		mitted to the facility on ses including congestive						

If continuation sheet Page 11 of 56

		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345010	B. WING				C / <b>03/2017</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ASHEV	ILLE			500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 223	heart failure, hyperter II, anxiety disorder an MDS dated 12/23/16 having intact cognition out of 15. She was co others and being und having no delirium, ps symptoms or rejection An interview on 02/27 Resident #22 reveale smoking area on 02/2 break and was sitting Resident #22 reveale smoking area on 02/2 break and was sitting Resident #22 stated t #59 smoking and yell mad he could hit her. residents in the smok were discussing callir ED #1 came back out them that he was call himself. Resident #22 days. On 03/01/17 at 9:14 <i>A</i> Immediate Jeopardy. an acceptable allegat 03/03/17 at 2:45 PM. Allegation of Complia 3rd, 2017 F 223 Abuse The Immediate Plan to beginning on 2/22/17 be free from verbal, s abuse, corporal punis seclusion. Residents his or her rights. 02/22/17 at or around	hsion, diabetes mellitus type d depression. A quarterly coded Resident #22 as n with a BIMS score of 15 oded as understanding erstood. She was coded as sychosis, behavioral n of care. 7/17 at 3:05 PM with d she was in the outside 22/17 at the 4:00 PM smoke beside Resident #59. hat ED #1 saw Resident ed at her that he was so Resident #22 said the ing area after the incident of the Ombudsman when side and screamed out at ing the Ombudsman e stated she was upset for 2 AM, ED #2 was informed of The Administration provided ion of compliance on nce GLC Asheville March below was implemented to ensure all residents will exual, physical, and mental hment, and involuntary have the right to exercise	F	223	3		

Facility ID: 922979

If continuation sheet Page 12 of 56

	S FOR MEDICARE &		0.0			0.0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING	3		
		345010	B. WING		C 03/03/2017	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP (			03/2017
				500 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHEV	/ILLE		ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 223	Continued From page	e 12	F 22	3		
		a and approached resident	1 22			
	0	her privileges had been				
	-	roceed to verbally abuse				
	#59 by stating to her if she did not leave the facility he would hit her. The Director of Nurses					
		vent and had resident # 59				
		addressed all the smoking #86, #10, #23, #79, #67,				
		'5. The Director of Nurses				
		e was going to be abused,				
		and reviewed smoking				
		ey all replied yes to feeling				
		tive Director and Director of				
		building and the Executive				
		ffice. Then the Director of				
		side smoking group talking outside and they stated the				
		ad come back to the smoking				
		ed I will be calling the				
		t myself. She asked if they				
	were ok and they all	replied yes and she				
		lents not to worry she would				
	be reporting to all app					
		scharging as previously				
	-	her belongings that were Nursing office and the				
		roceeded to assist with her				
		e MDS Coordinator stay with				
		or till she finished assisting				
	resident #59.					
		es then called the North				
		n and then the Executive				
		egional Vice President of				
	-	h know of the incident and he				
		utive Director immediately. as suspended and left the				
			1			
	facility on 02/22/17 at	t or around 6:20 PM pending s terminated on 02/27/17 at				

Facility ID: 922979

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			0.00 10			IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		TE SURVEY MPLETED
			A. BUILDING			С
		345010	B. WING		03/03/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		5/05/2017
				500 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHE	VILLE		ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 223	Continued From pag	o 12	E 00			
F 223			F 223	3		
		es failed to follow facility				
	abuse policy to imme	-				
	Executive Director fro	e, neglect policy and chain of				
		Service Clinical Director on				
	03/01/17 and with ar					
		her superior in the event of				
		investigation pending.				
	Maintaining resident					
		ported by Director of Nurses				
		nan on 02/22/17 via voice				
	mail at or around 6 F					
	The 24 hour reportat					
	-	and sent to North Carolina				
	-	th and Human Services				
		ave the right to be free from				
		cal, and mental abuse,				
		, and involuntary seclusion.				
		agers interviewed all other				
		its for any signs of abuse,				
		use, if they know how to				
	-	hey have any abuse they				
		Beginning on 03/01/17				
		rs or designee will monitor				
		ds by asking the residents if				
		want to report any abuse				
		at abuse is. Beginning				
	-	esidents care plans Social				
		esidents if they feel safe, if				
		se is, who do you report				
		have any abuse to report.				
		raining initiated to all staff on				
		ursing, environmental				
	services, dietary pers					
		rs. This in-service was				
		Worker and Assistant				
		raining continues to be				
	ongoing for current e	mployees who were not				
		including the types of abuse,				

Facility ID: 922979

If continuation sheet Page 14 of 56

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/29/2017 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345010	B. WING			-		C 03/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ASHEV	ILLE			0 BEAVERDAM ROAD SHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	steps to ensure the re- be allowed to work un- neglect is completed. Staff will receive educ Neglect Policy upon h quarterly. This will be Nursing services, Ass Services and Busines A Resident Council M to review resident righ- neglect. Resident Cou- conducted by Activity Director. Approximate attendance. No conc- voiced and all felt safe Director was gone. Th Council Meeting Minu Quality Assurance Pe On 03/01/17 an audit employees was condu- managers and asked out, if they felt unsafe desire to abuse reside report abuse and who This incident was repo Executive Director to 03/01/17 at 7:30 PM. The incident was repo Executive Director to Administrators via voi Immediate Jeopardy V 5:09 PM when intervie administrative staff ar confirmed they had re- and knew the different	equirements, and immediate esidents safety. Staff will not ntil training on abuse and cation on the Abuse and hire, and will be reviewed e conducted by Director of distant Director of Nursing as Office Specialist eeting was held on 03/01/17 nts, reporting of abuse and uncil meeting was Director and Executive ely 12 residents were in erns or complaints were e since the Executive he results of the Resident thes will be reviewed at rformance Improvement. of current nursing home ucted by department if they felt stressed, burnt , knew of any abuse or ents. Did they know how to o to report it to? orted by the new Interim Adult Protective Service on orted by the new Interim North Carolina Board of ce mail on 03/01/17. was removed on 03/03/17 at ews with nursing staff,	F 23	23				

Facility ID: 922979

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/29/2017 / APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMF	SURVEY LETED
		345010	B. WING			_		C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ASHEV	/ILLE			00 BEAVERDAM ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page	e 15	F	225				
F 225 SS=J		(4) INVESTIGATE/REPORT		225				4/4/17
	483.12(a) The facility	must-						
	(3) Not employ or othe who-	erwise engage individuals						
		juilty of abuse, neglect, opriation of property, or urt of law;						
	or her professional lic							
	licensing authorities a actions by a court of I	e nurse aide registry or my knowledge it has of aw against an employee, unfitness for service as a cility staff.						
		egations of abuse, neglect, atment, the facility must:						
	abuse, neglect, explo including injuries of un misappropriation of re reported immediately,							

Facility ID: 922979

If continuation sheet Page 16 of 56

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345010	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				5	500 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHEV	ILLE		4	ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	serious bodily injury, of the events that cause abuse and do not resist the administrator of the officials (including to the adult protective service for jurisdiction in long- accordance with State procedures. (2) Have evidence that thoroughly investigate (3) Prevent further po- exploitation, or mistre investigation is in pro- (4) Report the results administrator or his of representative and to with State law, including Agency, within 5 work if the alleged violation corrective action mus This REQUIREMENT by: Based on resident in staff interviews, the far report verbal abuse of Director (ED) #1 to the and also failed to noti Care Personnel Invest hours of the incident. residents sampled for Immediate Jeopardy ID Director of Nursing (ED)	nvolve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other the State Survey Agency and ces where state law provides term care facilities) in e law through established at all alleged violations are ed. tential abuse, neglect, atment while the gress. of all investigations to the r her designated other officials in accordance ing to the State Survey sing days of the incident, and n is verified appropriate t be taken. is not met as evidenced terviews, record review and acility failed to immediately f a resident by Executive e Area Vice President (AVP) fy the North Carolina Health tigations (NCHCPI) within 2	F	225	1.Resident #59 was discharged from facility on 2/22/17. Resident #59 has visited the facility since discharge with concerns about safety of fear. 2.All other residents have the potential be affected. All actual or potential to be affected. All actual or potential allegation of Abuse or Neglect are reported to the ED, and to the North Carolina Departm of Health and Human Services, APS, a the Ombudsman and investigation to be completed.	to e ons e nent and	

Facility ID: 922979

	OF DEFICIENCIES				(X3) DATE SURVEY
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	COMPLETED
		0.15040			С
		345010	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	03/03/2017
NAME OF PI	ROVIDER OR SUPPLIER				
GOLDEN	LIVINGCENTER - ASHE	/ILLE		500 BEAVERDAM ROAD ASHEVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET
F 225	Continued From page	a 17	F 22	5	
1 220		but did not immediately	F 22	3.Staff were educated beginning	on
		se to the AVP. Immediate		2/23/17 and 2/24/17by the Social	
	-	ed on 03/03/17 when the		DNS and ADNS and ongoing till a	
		mplemented an acceptable		have completed in-services on th	
		compliance. The facility		different types of abuse, and the	
		iance at a lower scope and		Living Abuse Polices and Proced	-
		d with no actual harm with		3/31/17 or they will not be eligible	
		IN minimal harm, that is not to complete education and		Included in this education is how identify and how to respond if an	
		stems put into place are		allegation of abuse is identified,	
		forming the ED and/or AVP		regardless of who the alleged per	petrator
	of witnessed or allege	ed incidents of abuse.		is. Abuse training is part of the or	ientation
				process for new staff and reviewe	ed with
	The findings included			staff annually.	
	Resident #59 was admitted to the facility on			4.Director of Field Clinical Service Golden Living educated the Depa	
		ses that included chronic		Managers on 3/22/17(ED,DNS,M	
	•	y disease, pneumonia,		Coordinator ,BOM, Admissions	
		o use and major depressive		Coordinator, Dietitian, Dietary Ma Housekeeping Supervisor, Rehat	
	The edmission Minim	www.Data.Sat (MDS) datad		Director,	nh (
		um Data Set (MDS) dated dent #59 as having intact		Social Services, and Central Sup Coordinator) On identifying the si	
		anding others and being		symptoms of stress and burnout.	
	understood. She was			strategies for coping with stress a	
	psychosis, behaviora	I symptoms or rejection of		burnout and we have EAP(emplo	
		pervision of one person for		assistance program) available for	
		ving except eating for which		additional support. Education also	
	she was independent	I.		included strategies for working wi residents that can present challe	
	A note by the Social V	Worker (SW) dated 02/22/17		behaviors and identification of str	
		that Resident #59 was		work with these residents.	
		outside the West Wing exit		5 Other staff will receive the educ	ation by
		en two bushes smoking.		DNS by 3/31/17 on identifying the	e signs
		tinguish her cigarette and		and symptoms of stress and burn	
		area at the front entrance to		Coping strategies for coping with	
	According to the note	e her to an appointment.		and burnout EAP(employee assis program) available for all staff for	
	informed that her smo			program available for all stall for	

Facility ID: 922979

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
					С	
		345010	B. WING		03/03/2017	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - ASHE	/ILLE		500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO	
F 225	Continued From page	<u>- 18</u>	F 22	5		
	revoked and she beck wanted to leave that of An interview with the on 02/26/17 at 2:05 F was observed on 02/2 the West Wing emerg smoking and was ask extinguish the cigared Resident #59 that her revoked. The DON s with the department r 02/22/17 to discuss F the smoking policy ar for 4:00 PM on 02/22 who smoked and ask meeting to reinforce to The DON stated she to the smoking area a observed Resident #8 The DON stated ED a "What are you doing	ame upset and stated she day. Director of Nursing (DON) PM revealed Resident #59 22/17 about 9:00 AM near gency exit in the shrubbery ked by the SW and ED #1 to the and ED #1 informed r smoking privileges were tated she and ED #1 met managers at 3:00 PM on Resident #59's violation of nd she scheduled a meeting /17 with all the residents ted ED #1 to be at the the smoking rules. and ED #1 walked outside around 4:00 PM and 59 was smoking a cigarette. #1 asked Resident #59: out here? Why are you lent #59 replied: "I'm just out		strategies for working with residents can present with challenging behavior effectively. 6.Monitering for compliance Interim ED/DNS Designee and Activity Direct will conduct Resident Council meetir weekly for 4 ,then bi weekly for one of then resume monthly to review abus policies and see if residents feel safe Interim ED will conduct random resid interviews of residents that do not at the Resident Council Meetings. he Interim ED will conduct five random audits weekly for 4 weeks of the Abu and Neglect Policies and Procedures include what to do if an allegation or actual abuse /neglect situation is identified. The results of the audits w reviewed at QAPI monthly meetings review and analyze for patterns and trends. The AVP(Area Vice Presiden or the DFCS(Director of Field Clinica Services) will attend the QAPI meeti either in person or via Web EX. The team will evaluate the results and	ors ctor ngs month e e. The dent tend staff use s to vill be to t) and al ng	
	(referring to the other DON stated that ED # "You need to leave. I The DON reported th smoke and said: "I'm leaving." Then ED #1 need to leave before she assured the resid to hit any of them and inside and told ED #1 that no one was going stated she could tell t scared and Resident	residents) before I go." The #1 then told Resident #59: want you to leave right now." at Resident #59 continued to		implement additional interventions a indicated to ensure continued compliance. Correction date for substantial compliance is 4/4/17. The Interim ED/DNS/SW responsible for compliance.	e	

Facility ID: 922979

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345010	B. WING				C / <b>03/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN	LIVINGCENTER - ASHEV	/ILLE			00 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 225	while she reviewed th and ED #1 talked abor to residents smoking The DON stated she but the residents remains moke break with oth she went to look for R she was all right. The hall near the door to t and heard the resident talking about being up The DON stated ED # smoking area, without the residents he was Ombudsman about the she called the Ombud left a message then c President (AVP) from him of the incident. T immediately suspend investigation of the inci- An interview on 02/27 Resident #72, who wa revealed she was in t 02/22/17 at 4:00 PM v outside with the other Resident #72 stated E the door and around t #59 was sitting and to building before he hit ED #1's fist was clear his fist and didn't do a stated she was frighte such a rage and raise sure what he was goi stated she didn't feel	r and the other residents he facility's smoking policy but safety concerns related in non-designated areas. and ED #1 went back inside ained outside for their er staff. The DON stated Resident #59 to make sure DON stated she was in the he outside smoking area obset about what happened. #1 went back out to the t her knowledge, and told going to call the he incident. The DON stated dsman about 5:00 PM and called the Area Vice ED #1's office and informed The DON stated the AVP ed ED #1 pending further cident.	F	225			

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		MEDICAID SERVICES				<u>D. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY PLETED
			A. BUILDING	G		С
		345010	B. WING			03/2017
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			103/2011
			500 BEAVERDAM ROAD			
GOLDEN	LIVINGCENTER - ASHE	VILLE		ASHEVILLE, NC 28804		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF C		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	DATE
F 225	Continued From page	e 20	F 22	25		
	An interview on 02/2	7/17 at 10:55 AM with				
	Resident #29, who w					
		the outside smoking area on				
		PM smoke break with other				
		ng with the DON and ED #1.				
		she saw Resident #59				
		ent outside and none of the				
		heir cigarettes. Resident #29 ame out and saw Resident				
		ed her what she was doing				
	-	er cigarettes. Resident #29				
	-	ld Resident #59 to get out of				
		before he hit her and his				
	-	Resident #29 stated the				
		d: "No one is going to hit				
		#1 told Resident #59 that he				
		er. Resident #29 stated the				
		t ahead with the meeting to				
	-	rules then they both went esident #29 stated she and				
	-	ere discussing calling the				
		#1 came back outside and				
	told them that he was					
		he incident. Resident #29				
		ne in from the smoking area				
		trance ED #1 was at the				
		en who were working on the				
	after that time.	tated she didn't see ED #1				
	An interview on 02/2	7/17 at 11:06 AM with				
	Resident #86, who w					
		the outside smoking area on				
		PM smoke break with the				
		dent #86 stated ED #1 came				
	-	at Resident #59 and asked				
	her why she was out	there and where she get the	1			1
		#86 stated ED #1 was sort of				

Facility ID: 922979

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						O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · · ·	E SURVEY IPLETED	
			A. BUILDING			С	
		345010	B. WING		0.	3/03/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				500 BEAVERDAM ROAD			
GOLDEN	IVINGCENTER - ASHE	VILLE		ASHEVILLE, NC 28804			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETION	
F 225	Continued From pag	e 21	F 22	5			
		Resident #59 to get out of					
	5	fore he hit her. Resident #86					
	U	was red and his fist was					
	clenched at his side.	Resident #86 stated she					
		kious because she didn't					
	know what he was go	ping to do.					
	An interview on 02/2	7/17 at 11:38 AM with					
	Resident #66, who w						
		the outside smoking area					
		on 02/22/17 at the 4:00 PM					
		ard ED #1 tell Resident #59					
	to get off the premise	es before he hit her but he					
		oon as he said it. Resident					
	#66 stated it didn't so	care her and she didn't feel					
	like ED #1 was going	to hit Resident #59.					
	An interview on 02/2	7/17 at 3:12 PM with Patient					
	Care Assistant (PCA	) #1 revealed she was					
		he residents on 02/22/17 at					
		oreak. PCA#1 stated					
		out with the other residents					
		wasn't allowed to smoke					
		es had been revoked. PCA					
		59 told her she was just the other residents. PCA #1					
	•	ng another resident's					
		ED #1 tell Resident #59 to					
		re I hit you." PCA #1 stated					
		ent #59 smoking. PCA #1					
		ed closer to ED #1 and					
		ack in the building. PCA #1					
		#29 told ED #1 that she was					
		budsman and he got mad					
		facility. PCA #1 stated the					
		moking rules with the					
		ent in the building. PCA#1 es later ED#1 came back					
	sialed about 5 minut	estater FD #1 Came Dack	1			1	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345010	B. WING				03/2017
NAME OF PI	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ASHEV	/ILLE			500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 225	incident because what An interview on 02/27 revealed she and ED on 02/22/17 at 8:30 A outside the West Win The SW stated she at investigate and found down between the bu smoking a cigarette. told Resident #59 to a return to the front of th to take her to an apport #1 also informed Ress privileges were revok didn't have any first h incident that occurred area on 02/22/17 at 4 An interview on 02/27 Resident #22, who wa revealed she was in t 02/22/17 at the 4:00 F sitting beside Resider that ED #1 saw Reside at her that he was so Resident #22 said the area after the inciden Ombudsman when El screamed out at them Ombudsman himself. was upset for 2 days. A second interview wi 9:12 AM revealed 11 the smoking area on DON stated the reside	he Ombudsman about the at he said was wrong. 7/17 at 3:27 PM with the SW #1 were informed by NA #1 M that Resident #59 was g emergency exit smoking . Ind ED #1 went to Resident #59 squatting shes and the building The SW stated ED #1 then extinguish the cigarette and he building to wait for transit bintment. The SW stated ED ident #59 that her smoking ed. The SW stated she and knowledge of the 1 in the outside smoking :00 PM. 7/17 at 3:05 PM with as cognitively intact, he outside smoking area on PM smoke break and was at #59. Resident #22 stated lent #59 smoking and yelled mad he could hit her. e residents in the smoking t were discussing calling the D #1 came back outside and a that he was calling the Resident #22 stated she with the DON on 02/28/17 at residents were outside in 02/22/17 at 4:00 PM. The ents told her that ED #1 had	F	225			
	DON stated the reside						

Facility ID: 922979

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/29/201 FORM APPROVEI OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345010	B. WING		C 03/03/2017
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	
		<i></i>			
GOLDEN	LIVINGCENTER - ASHEV			ASHEVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 225	outside. The DON stating the hall and went to the hall and went to the front error office, he came out in Resident #59 wanted on the West Wing an office, he came out in Resident #59. The DO the building then she and she called the Or The DON stated she reported the incident #1. The DON stated she reported the incident #1. The DON stated F 5:30 PM. A third interview with 3:07 PM about the fact the DON was familiar asked if she consider Resident #59 abuse, considered it verbal asked about the facili immediate suspensio observed or accused stated she felt like sh because the staff invor The DON stated if the other employee she a have gotten the empl them on suspension pand immediately remufacility. The DON was explanation as to why the AVP and constant An interview with ED revealed he went out 02/22/17 at 4:00 PM.	ated she met Resident #59 o her office with Resident tes and lighter then walked ntrance. The DON stated to say good-bye to a friend ad as they passed ED #1's the hall and apologized to ON stated Resident #59 left and ED #1 went in his office mbudsman around 5:00 PM. then called the AVP and and the AVP suspended ED ED #1 left the building before the DON on 02/28/17 at cility's abuse policy revealed with the policy. When ed ED #1's threat to hit the DON stated she ubuse. When the DON was ty's policy regarding n of an employee who was of abusing a resident, she e needed to call the AVP olved was the administrator. e perpetrator had been any and the administrator would oyee's statement and placed pending the investigation oved the employee from the s unable to offer any further y she didn't immediately call thy observe ED #1.	F 2		

Facility ID: 922979

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		10. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	MPLETED
			A. BUILDIN	IG		0
		245040				С
		345010	B. WING			3/03/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
	IVINGCENTER - ASHE			500 BEAVERDAM ROAD		
GOLDEN				ASHEVILLE, NC 28804		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIO DATE
F 225	Continued From page	e 24	F 2	25		
		a with other residents. ED #1				
		ident #59: "What are you				
		I't respond. ED #1 stated he				
		#59: "Where did you get that				
		still didn't respond. ED #1				
	-	o Resident #59: "I can't				
		re smoking" and Resident				
		d one last cigarette with my				
	•	e other residents.) ED #1				
	• • •	esident #59: "You need to				
		and you need to leave the				
		esident #59 didn't say				
	•	leave. ED #1 stated he was				
		2 feet away from Resident				
		e then told Resident #59:				
		and leave now before I hit				
		e couldn't believe what he				
	•	nediately told Resident #59:				
		ghts. I'm so sorry. I didn't				
		ated Resident #59 left the				
	•	ent in the facility. ED #1				
		outside with the DON while				
		oking rules but he didn't say				
		#1 stated he and the DON				
		Iding around 4:30 PM and he				
		to report the incident. ED #1				
		him they heard the residents				
	•	alking about calling the				
		tepped back outside in the				
		to tell the residents he was				
		nbudsman of the incident				
		ble to recall the exact time				
		tside but stated it was				
		d 5:00 PM. The ED stated				
		w Resident #59 in the hall				
		nurses station and he went				
	· •	#1 stated the DON called the				
	Ombudsman from his called the AVP. ED #	s office around 5:20 PM then				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/29/2017 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345010	B. WING				C 103/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ASHEV	/ILLE			00 BEAVERDAM ROAD SHEVILLE, NC 28804		
0(0)15							(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From page	25	E E	225			
		PM. When asked what the					
		d as to when he should					
	have left the facility at he should have left in	fter the incident, he stated nmediately.					
		all on 02/28/17 at 7:59 PM, she was outside waiting to					
		the morning of 02/22/17					
	and smoked and staff	caught her. Resident #59					
		ner smoking privileges from					
		rvised because it was part Resident #59 stated staff					
	were respectful when	they told her about the					
		59 stated she was in the					
	and was smoking. Sh	on 02/22/17 at 4:00 PM					
		sked to go back inside which					
	she did. Resident # 5	9 stated she knew she					
		e out in the smoking area					
	-	ere just setting an example s. Resident #59 stated ED					
		hit her. She stated he just					
	-	side. Resident #59 stated					
	she didn't feel afraid t her.	hat ED #1 was going to hit					
		/17 at 1:51 PM with PCA #1					
		d training on abuse during					
	her orientation in Janu	uary 2017 and was ny observed or alleged					
		her supervisor. When					
	asked if she thought I	ED #1's statement to					
		2/17 at 4:00 PM was abuse, ought it was verbal abuse.					
		dn't report it to anyone					
		o witnessed the incident.					
	An interview on 03/01	/17 at 12:11 PM with the					
	AVP revealed his exp						

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE 8					FOR	D: 03/29/2017 MAPPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345010	B. WING				C 5/03/2017
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
			5	500 BEAVERDAM ROAD		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A	ASHEVILLE, NC 28804		
PREFIX (EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
<ul> <li>witnessed or alleged be reported immedia of abusing a resider facility immediately a The AVP stated he s immediately after the PM when ED #1 three PM when ED #1 three The AVP stated he w 6:16 PM of the incid at 4:00 PM when EE Resident #59. The A on immediate suspect Another interview or DON about the incid when ED #1 threate revealed she should building and should away. The DON stat the AVP immediately</li> <li>In an interview on 02 Resident #59 in the tell the truth about E interview on 02/28/1 getting in trouble for getting the DON in t ED #1 came out in t her: "What are you of she told him she wa break with her family the facility). Residen her: "Where did you she told him it fell ou #1 then told her: "Yo you." Resident #59 stated</li> </ul>	d abuse of a resident should ately and the person accused at should be removed from the and the residents protected. should have been notified e incident on 02/22/17 at 4:00 eatened to hit Resident #59. vas notified on 02/22/17 at ent that occurred on 02/22/17 0 #1 threatened to hit VP stated he placed ED #1 which is a stated he placed ED #1 which is a stated he placed ED #1 which is a stated he placed ED #1 have told ED #1 to leave the have made sure he left right ted she should have called y following the incident. 3/01/17 at 2:14 PM with facility, she stated she didn't iD #1 during the phone 7 because she was afraid of smoking and also afraid of rouble. Resident #59 stated	F	225			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/29/2017 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345010	B. WING		_	03/	C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			5	00 BEAVERDAM ROAD			
GOLDEN	LIVINGCENTER - ASHEV	/ILLE	4	ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page hit her. Resident #59 when her sister arrive #59 stated she was g ED #1 apologized to h nurse's station. Review of the 24 hour submitted by the facili it was signed as comp 02/23/17. Review of the revealed it was faxed at 1:01 PM which was after the incident of ver- On 03/01/17 at 9:14 A Immediate Jeopardy. an acceptable allegat 03/03/17 at 2:45 PM. Allegation of Complia 3rd, 2017 F 225 02/22/17 at or around Director (ED) entered area and approached after her privileges ha proceeded to become #59 by stating to her if facility he would hit he Director of Nurses wh #59 come to her side and the other residen #29, #72, #86, #10, # and #75 saying no on	e 27 stated she was still shaking ed to pick her up. Resident etting ready to leave when her at the West Wing r report which was ity to the NCHCPI revealed oleted by the SW on he fax transmission report to the NCHCPI on 02/23/17 s approximately 21 hours erbal abuse occurred.	F 225				
	The Executive Director came back into the bu	afe and they replied yes. or and Director of Nurses uilding and The ED went e Director of Nurses failed					

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 03/2 FORM APPF MB NO. 0938	ROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING				Y
		345010	B. WING			C 03/03/2017		
NAME OF P	ROVIDER OR SUPPLIER		•	STF	REET ADDRESS, CITY, STATE, ZIP COD	E		
	LIVINGCENTER - ASHEV			500	BEAVERDAM ROAD			
GOLDEN	LIVINGCENTER - ASHEV			AS	HEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMP	(5) LETION ATE
F 225	removed from facility Director then went to opened it, and stated he was going to report ombudsman. When the the outside smoking go went back outside to residents were ok and Director Of Nurses the had come back to do reporting himself. She all replied yes and she worry as she was goi appropriate agencies When she came back was discharging hom needed her belonging Director of Nurses off completed this task. A this task the MDS Co Executive Director till The Director of Nurses Director to his office a North Carolina Ombut incident. She then ca superior Regional Vice and explained the ince Executive Director effi investigation and he I Nurses supervising the else in facility. He wa 02/27/17 at 7:45 AM On 02/23/17 the Soci hour reportable and of Carolina Health and H The new Interim Executive Executive Executive North Carolina Carolina Health and H	e policy and did not have him immediately. The Executive outside smoking door, to smoking residents that rt himself to the the Director of Nurses heard group talking loudly she then smoking area and asked if d felt safe, and they told the at the Executive Director or way and stated he was ie asked if they were ok and e explained to them not to ng to report to all 	F	225				

Facility ID: 922979

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		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 03/29/201 ORM APPROVEI 3 NO: 0938-039	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED	
		345010	B. WING			C 03/03/2017		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	LIVINGCENTER - ASHEV			50	00 BEAVERDAM ROAD			
GOLDEN	LIVINGCENTER - ASHE			A	SHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 225	Continued From page		F	225				
	Director on 03/01/17.							
		ive the right to be free from cal, and mental abuse,						
		and involuntary seclusion. ment managers interviewed						
		e residents for any signs of						
		g of abuse, if know how to						
		hey have any abuse they						
	would like to report. E	s or designee will monitor						
		ds with asking if they felt						
		hing to report, any abuse						
		ort. Beginning 03/01/17						
		is Social Worker will ask safe, if they know what						
		who to report to and if they						
	have any abuse to re							
	, under the second seco	raining initiated to all staff on						
		ursing, environmental						
	services, dietary pers	s. This in-service was						
		Worker and Assistant						
	· ·	raining continues to be						
		mployees who were not						
		and includes the types of						
		oorting requirements and nsure the residents safety.						
		t completed training will not						
	be able to work until							
	The 5 day reportable	was completed by Social						
		3/1/17 and sent to North						
	Carolina Health and I							
		es was re-educated on rvice Clinical Director of						
	· ·	on the Abuse/Neglect policy						
	-	ate removal of the alleged						
	perpetrator from the I	building, chain of command						
	and even if it is your	superior you have the right to						

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
	D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING B			C 03/2017			
NAME OF P	AVAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE SOD BEAVERDAM ROAD ASHEVILLE, NC 28804       (X4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     D PROVIDER'S PLAN OF COD (EACH ORECTICENCY MUST REGULATORY OR LSC IDENTIFYING INFORMATION)     D PROVIDER'S PLAN OF COD (EACH ORECTICENCY MUST TAG     D PROVIDER'S PLAN OF COD (EACH ORECTICENCY MUST TAG       F 225     Continued From page 30 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. 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 and Business Office Specialist 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 fet tase ince 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. On 03/01/17 an audit of current Golden Living Center employees was conducted and asked if they fet stressed or burnt out, if they fet unsafe,	STREET ADDRESS, CITY, STATE, ZIP CODE					
				5	500 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHEV	ILLE		A	ASHEVILLE, NC 28804		
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 225	ask them to leave and is Regional vice Presi of chain of command with names, titles, cor responsibilities was p staff effective 03/2/17 Staff will receive educ Neglect Policy upon h quarterly. This will be Nursing Services, Ass Services and Busines A Resident Council M review resident rights neglect. Resident Cou conducted by Activity Executive Director. A were in attendance. I were voiced and all fe Director was gone an Executive Director .Th Council Meeting Minu Quality Assurance Pe meeting monthly. On 03/01/17 an audit Center employees was they felt stressed or b knew of any abuse or Did they know how to report it to? The new reviewed with employ were interviewed in po feel stressed or burnt any signs of abuse. This incident was repo Director to Adult Prote 7:30 PM. The incident was repo	d notify their superior which dent of Operations. Graph for Golden Living Center ntact numbers and their osted at time clock for all by 4 PM. cation on the Abuse and nire, and will be reviewed conducted by Director of sistant Director of Nursing is Office Specialist eeting was held on 3/1/17 to reporting of abuse and uncil meeting was Director and interim pproximately 12 residents No concerns or complaints et safe since the Executive d happy with new interim he results of the Resident tes will be reviewed at rformance Improvement of current Golden Living is conducted and asked if urnt out, if they felt unsafe, desire to abuse residents.	F	225			

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	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION		IO. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345010	B. WING		0;	C 3/03/2017
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN I	LIVINGCENTER - ASHE	/ILLE		0 BEAVERDAM ROAD SHEVILLE, NC 28804		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIO
F 225	Continued From page	e 31	F 225			
	The Director of Nurses was re-educated on					
	03/02/17 at 3:16 PM process according to	on 24 hour reportable				
		procedures with reporting				
	Immediate Jeopardy	was removed on 03/03/17 at				
	5:09 PM when intervi	iews with nursing staff,				
	administrative staff and	nd non-nursing staff eceived in-service training				
	-	nt types of abuse and the				
		observed or alleged abuse be reported immediately to				
		f the perpetrator was the ED				
	it should be reported	to the AVP. Staff confirmed				
	they were provided w abuse policy and the	/ith a copy of the facility's chain of command.				
F 226			F 226			4/4/17
SS=J	DEVELOP/IMPLMEN POLICIES	IT ABUSE/NEGLECT, ETC				
	483.12 (b) The facility must (	develop and implement				
	written policies and p					
		ent abuse, neglect, and nts and misappropriation of				
	(2) Establish policies investigate any such	•				
	(3) Include training as §483.95,	s required at paragraph				
	483.95					
		nd exploitation. In addition to use, neglect, and exploitation				

Facility ID: 922979

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/2 FORM APPF OMB NO. 0938	ROVED	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y	
		345010	B. WING		C 03/03/2017		
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
	-IVINGCENTER - ASHE	/II   F	:	500 BEAVERDAM ROAD			
OOLDEN				ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMP	K5) ILETION ATE	
F 226	provide training to the educates staff on- (c)(1) Activities that c exploitation, and miss property as set forth a (c)(2) Procedures for neglect, exploitation, resident property (c)(3) Dementia mana prevention. This REQUIREMENT by: Based on resident at record review, the fac abuse policy in the at resident and reporting The facility failed to s the resident, to super until he left the facility the Area Vice Preside abuse. This affected an abuse investigation Immediate Jeopardy facility did not follow i report a verbal threat (ED) #1 to abuse Res immediately protect F Nursing (DON) and F #1 witnessed the inci report the verbal abus	3.12, facilities must also eir staff that at a minimum onstitute abuse, neglect, appropriation of resident at § 483.12. reporting incidents of abuse, or the misappropriation of agement and resident abuse - is not met as evidenced and staff interviews and cility failed to implement its reas of protection of the g of abuse within 2 hours. eparate the perpetrator from vise the alleged perpetrator / and to immediately notify ent (AVP) of the verbal 1 of 3 residents sampled for in (Resident #59). began on 02/22/17 when the its policy to immediately made by Executive Director sident #59 and did not Resident #59. The Director of Patient Care Assistant (PCA) dent but did not immediately se to the AVP as required ty's abuse policy. The DON	F 226	<ul> <li>1.Resident #59 discharged from on 2/22/17. Resident #59 has w facility since discharge with no about safety of fear.</li> <li>2.Residents #29 and #72 were from the facility on 3/8/17, but w interviewed prior to discharge a they felt safe, had they experied or neglect during their time at fac they did not. Residents #22, #6 #10,#79, #87, #28, #75, #23, w interview on 2/22/17 and 2/23/ DNS,AD, and SW if they feel sat they had experienced any abus neglect and none had.</li> <li>3.Staff in-service and education 2/23/17 by Social Services, AD DNS and ongoing on the differ of abuse, and the Golden Living Polices and Procedures. Includ</li> </ul>	risited the concerns discharged vere and asked if nced abuse acility and 6, #86, rere 17 by afe and if se or n began on NS and ent types g Abuse ed in this		
	allowed the perpetrat without supervision for	or to remain in the building		education is how to identify and respond if an actual or allegation is identified, regardless of who	how to on of abuse		

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 03/29/2017 RM APPROVED IO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		345010	B. WING _			0	C 3/03/2017
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		<i></i>		50	00 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHE	/ILLE		Α	SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	Continued From page	<del>2</del> 33	F:	226			
	when the facility prov acceptable credible a facility remains out of scope and severity of harm with potential for that is not immediate education and ensure place are effective re- from being abused ar policy. The findings included The facility's Abuse a revision date of 11/18 *Verbal abuse is defin written or gestured la disparaging and dero their families, or withi regardless of their ag disability. Examples of are not limited to: thre to frighten a resident, that she will never be again. *Identification: Inciden violations shall be rep Reporting Section of *Protection: If the sus employee, the ED sh- immediate investigato	ided and implemented an illegation of compliance. The is compliance at a lower f D (isolated with no actual or more than minimal harm, jeopardy) to complete e monitoring systems put into lated to protecting residents and following the abuse :	F2	226	perpetrator is. Abuse training is part orientation process for new staff and reviewed with staff annually monitor BOM and BOMA. Any staff that has completed by 3/31/17 will not eligible work till completed. 4.Business Office Manager of design will check Monday thru Friday to en- computer training in abuse is completed S.Director of Field Clinical Services f Golden Living educated the Departin Managers on be 3/22/17(ED,DNS,M Coordinator ,BOM, Admissions Coordinator ,BOM, Admissions Coordinator ,Dietitian, Dietary Mana Housekeeping Supervisor, Rehab Director, Social Services, and Central Supply Coordinator) On identifying the signs symptoms of stress and burnout. Co 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 challengi behaviors and identification of strate work with these residents. 6.Other staff will receive the education 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 include strategies for working with residents that burnout EAP(employee assistance program) available for all staff for additional support. Education include strategies for working with residents	l ed by not e for nee sure eted. for nent DS ger, ger, s and ping e ng gies on by of	
	*Reporting: It is the re individual employee t reasonable suspicion	o immediately report any			can present with challenging behaving effectively. 6.Monitering for compliance Interim		

Facility ID: 922979

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TATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE S	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	<u> </u>	COMPL	
						;
		345010	B. WING		03/0	)3/2017
NAME OF PF	OVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
	IVINGCENTER - ASHE	/!!   E		500 BEAVERDAM ROAD		
GOLDEN	IVINGCENTER - AGHEN			ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 226	Continued From page	e 34	F 22	26		
		tment, neglect, abuse, injury		ED/DNS Designee and Act	ivity Director	
		d/or misappropriation of		will conduct Resident Cour	-	
		he designated supervisor in		weekly for 4 weeks then bi	-	
		or purposes of reporting		month they resume month		
	-	as soon as possible but not		abuse policies and see if re		
		the event of serious injury or		safe. The Interim ED will co		
	-	ved in a report or 24 hours		resident interviews of resid		
	for all other reports of			attend the Resident Counc	•	
		re a report within a shorter		weekly for 4 weeks then bi month. The Interim ED will	•	
timeframe. It is the responsibility of the designated supervisor to immediately communicate any report of an alleged vice			staff audits weekly for 4 we			
	-		Abuse and Neglect Policies			
		also notify immediate		Procedures to include what		
		D shall ensure that alleged		allegation or actual abuse	/neglect	
	violations are reporte	d promptly to the		situation is identified. The r	esults of the	
	regional/area Vice Pr	esident.		audits will be reviewed at C	•	
	<b>5</b> · · · ·			meetings to review and an	-	
	0	n 02/26/17 at 2:05 PM, the		patterns and trends. The A		
		ED #1 walked outside to the 4:00 PM and observed		President) and or the DFC Field Clinical Services) will		
	-	noking a cigarette. Resident		QAPI meeting either in per		
		ges had been revoked prior		EX. The QAPI team will ev		
	to this time. The DON			results and implement add		
		are you doing out here?		interventions as indicated		
	Why are you smoking	-		continued compliance. Cor		
		nere smoking one last time		substantial compliance is 4		
		ing to the other residents)		Interim ED/DNS/SW respo	nsible for	
		N stated that ED #1 then told		compliance.		
		eed to leave. I want you to DON reported that Resident				
	-	bke and said: "I'm going; I'm				
		hen ED #1 told Resident				
		ave before I hit you." The				
	DON stated she assu	ired the residents that no				
		any of them and asked				
		side and told ED #1 that he				
		hat no one was going to hit				
	anybody. The DON s		1			

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		O. 0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	PLETED
			A. BOILDING			С
		345010	B. WING		03	03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				500 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHEV	VILLE		ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 226	inside the facility. The remained outside in t and the other resider facility's smoking poli safety concerns relat non-designated area ED #1 went back insi remained outside for staff. The DON stated Resident #59 to make heard the residents of talking about being u The DON stated ED smoking area, withou the residents he was Ombudsman about th	e DON stated ED #1 he smoking area with her its while she reviewed the icy and ED #1 talked about ed to residents smoking in s. The DON stated she and ide but the residents their smoke break with other d she went to look for e sure she was all right then butside in smoking area pset about what happened. #1 went back out to the it her knowledge, and told going to call the he incident. The DON stated	F 22	6		
	left a message then of President (AVP) from him of the incident. T immediately suspend investigation of the in An interview on 02/27 revealed she was out	ED #1's office and informed The DON stated the AVP led ED #1 pending further incident. 7/17 at 3:12 PM with PCA #1 tside supervising the				
	break. PCA #1 stated the other residents and allowed to smoke been been revoked. PCA # her she was just com residents. PCA #1 state resident's cigarette a #59 to "get out of her stated she didn't see	7 at the 4:00 PM smoke d Resident #59 came out with nd she told her she wasn't cause her privileges had #1 stated Resident #59 told ning out to talk to the other ated she was lighting another nd heard ED #1 tell Resident re before I hit you." PCA #1 Resident #59 smoking. PCA noved closer to ED #1 and ack in the building. PCA #1				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/29/2017 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345010	B. WING		_	03/0	03/2017
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ASHEV	ILLE		500 BEAVERDAM ROAD ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	DON reviewed the sm residents then she we stated about 5 minute outside for a split seco he was going to call the incident because what An interview with the PM about the facility's DON was familiar with she considered ED # #59 abuse, the DON verbal abuse. When the the facility's policy reg suspension of an emp accused of abusing a like she needed to ca involved was the adm the perpetrator had be and the administrator employee's statement suspension pending the immediately removed facility. The DON was explanation as to why the AVP and constant An interview with ED revealed he was outs 02/22/17 at 4:00 PM confirmed that he told get up and leave now acknowledged that he #1 stated he stepped area briefly to tell the notify the Ombudsmate ED #1 stated he thoug	facility. PCA #1 stated the hoking rules with the ent in the building. PCA #1 is later ED #1 came back ond and told the residents he Ombudsman about the t he said was wrong. DON on 02/28/17 at 3:07 is abuse policy revealed the in the policy. When asked if 1 threatening to hit Resident stated she considered it he DON was asked about parding immediate bloyee who was observed or resident, she stated she felt If the AVP because the staff inistrator. The DON stated if een any other employee she would have gotten the t and placed them on he investigation and the employee from the is unable to offer any further is she didn't immediately call ly observe ED #1.	F 226				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345010	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ASHEV	/ILLE			500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 226	facility after the incide have left immediately completing some doc that was why he didn' An interview on 03/01 revealed she received her orientation in Janu instructed to report ar abuse immediately to asked if she thought E Resident #59 on 02/2 PCA #1 stated she the When asked if she re- stated she didn't repo DON also witnessed f An interview on 03/01 AVP revealed his exp witnessed or alleged be reported immediately ar The AVP stated he sh immediately after the PM when ED #1 threat The AVP stated he was 6:16 PM of the incide at 4:00 PM when ED Resident #59. The AV on immediate suspen Another interview on DON about the incide when ED #1 threaten revealed she should h building and should h	he should have left the ent, he stated he should . He stated he was umentation in his office and it leave immediately. /17 at 1:51 PM with PCA #1 d training on abuse during uary 2017 and was by observed or alleged her supervisor. When ED #1's statement to 2/17 at 4:00 PM was abuse, ought it was verbal abuse. ported it to anyone, PCA #1 rt it to anyone because the the incident. /17 at 12:11 PM with the ectation was that any abuse of a resident should ely and the person accused should be removed from the nd the residents protected. would have been notified incident on 02/22/17 at 4:00 atened to hit Resident #59. as notified on 02/22/17 at nt that occurred on 02/22/17 #1 threatened to hit /P stated he placed ED #1	F	226			

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 03/29/2017 ORM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) I	DATE SURVEY COMPLETED
		345010	B. WING				C 03/03/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STI	REET ADDRESS, CITY, STATE, ZIP CODE	•	
		<i></i>	500 BEAVERDAM ROAD		0 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHE	/ILLE		AS	SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	Continued From page	<del>2</del> 38	F	226			
		following the incident.					
	Immediate Jeopardy. an acceptable allegat 03/03/17 at 2:45 PM. Allegation of Complia 3rd, 2017 F 226 For deficiencie development of and i and procedures: On 03/01/17 The Fiel and the Regional Are all the components of policy that was revise includes the 2 hour ti abuse allegations to a The Executive Direct Social Service Direct employees including	ance GLC Asheville March s concerning the facility's mplementation of policies d Service Clinical Director a Vice President reviewed f the abuse and neglect ed on 11/18/16 which me frame for reporting the appropriate agencies. or, Director of Nurses and or will review and educate all contract staff on policies and					
	abuse. The verbal ins abuse policy was give worked 3/1/17. All ab on policies and proce from any form of abus work.	t residents from any form of services with a copy of the en to all employees who sent staff will be educated edures to protect residents se prior to being allowed to					
	Director (ED) entered smoking area and ap smoking after her priv He then proceeded to resident #59 by statin the facility he would h by Director of Nurses resident #59 come to resident #59 and the	d 4 PM, the Executive I the facility's outside proached resident #59 for vileges had been revoked. b become verbally abusive to ing to her if she did not leave nit her. This was witnessed who immediately had her side and addressed other residents on the 472, #86, #10, #23, #79, #67,					

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	S FOR MEDICARE &					IO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		· · /	E SURVEY
			A. BUILDING	3		
			5 11/11/0			С
		345010	B. WING			3/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	LIVINGCENTER - ASHE			500 BEAVERDAM ROAD		
GOLDEN				ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
E 226	Continued From non	- 20	E 00			
F 226			F 22	26		
		75. The Director of Nurses				
	-	e was going to hit anyone,				
		g policy and asked if they felt				
		they replied yes. The				
		nd Director of Nurses came				
	-	g and the ED went towards				
	his office.					
	The Director of Nurse					
		by not protecting the				
	residents by removin					
		ecutive Director then went to				
		r opened it and stated to				
	•	at he was going to report				
		Isman. When the Director of				
		tside smoking group talking				
		back to outside to smoking				
		sidents were ok and felt safe,				
		ector of Nurses that the				
		ad come back to doorway				
		porting himself. She asked				
	-	Il replied yes and she				
		t to worry as she was going				
	to report to all approp	Nurses came back into				
		was being discharged home				
		d and needed her belongings				
		ne Director of Nurses office.				
		Nurses was completing this				
		S Coordinator stay with the				
	Executive Director til	•				
		es then took Executive				
		and then she called the				
		udsman and left voice mail of				
		6 PM. She then called the				
		superior, Regional Vice				
		ons, and explained the				
		ended the Executive Director				
		pending investigation with				
						1

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		ND HUMAN SERVICES MEDICAID SERVICES					INTED: 03/29/20 FORM APPROVE IB NO. 0938-039
TATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		ONSTRUCTION	(X3	) DATE SURVEY COMPLETED
		345010	B. WING				C 03/03/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	STF	REET ADDRESS, CITY, STATE, ZIP COD	DE	
				500	BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHE	VILLE		AS	HEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 226	anywhere else in fac suspended and left th around 6:20 PM. He	ility. Executive Director was he building on 02/22/17 at or was officially terminated on	F	226			
	24 hour reportable a	cial Service Director began nd completed and sent to h and Human Services by 4					
	*The new Interim Exe 02/27/17 at or around on the Abuse and Ne	ecutive Director started on d 11 AM and was educated glect Policy and the the Field Service Clinical					
	staff on 02/23/17 incl	raining was initiated to all					
	Assistant Director of	nent managers, this icted by Social Worker and Nurses. Training continues rent employees who were					
	not present on 02/23 types of abuse, man	/17. Training includes the dated reporting requirements frame and immediate steps					
	24 hour reporting do Staff will not be allow	nts safety, and included the ne by Director of Nurses. ved to work until training on as been completed. The					
	Director of Nurses was by Fields Service Cli Living Center on the	as re-educated on 03/01/17 nical Director of Golden Abuse/Neglect policy					
	perpetrator from the chain of command an Superior if needed	ate removal of the alleged facility. This included proper nd her ability to remove her					
	03/02/17 at 3:16 PM process according to	es was re-educated on on 24 hour reportable Federal Regulations procedures with reporting					
	through established	-					

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 03/29/2017 FORM APPROVED //B NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED
		345010	B. WING				C 03/03/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	LIVINGCENTER - ASHE	//   =		50	0 BEAVERDAM ROAD		
GOLDEN				AS	SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 226	made if the events the involve abuse or result Staff will receive educt Neglect Policy upon h Services, Assistant D Social Service Director Specialist. In addition it will be a person to p abuse and neglect all opportunity to have a the policy. The abuse quarterly. This will be Nursing Services, As Services and Busines computer orientation employee will be allow monitored by Assistan effective 03/03/17. Th will run compliance re- verify all new employ computer training. A Resident Council M to review resident righ neglect. Resident Co conducted by Activity Executive Director. A were in attendance. Council Meeting Minu Quality Assurance Pee The residents voiced and were very happy was gone. The Interim Executive 02/27/17 was educate Policy, the Grievance command for reportin by the Field Service ( On 03/01/17 an audit	at cause the allegation It in serious bodily injury. cation on the Abuse and hire by Director of Nursing irector of Nursing Services, or and Business Office to the computer orientation berson in service concerning lowing employees the n adequate understanding of e policy will be reviewed e conducted by Director of sistant Director of Nursing as Office Specialist. All will be completed before wed to work and will be nt Director of Nursing he Business Office Manager eport Monday thru Friday to ees have completed leeting was held on 03/01/17 hts, reporting of abuse and uncil meeting was Director and interim Approximately 12 residents The results of the Resident utes will be reviewed at erformance Improvement. no complaints or concerns that the Executive Director e Director who started on ed on the Abuse and Neglect	F	226			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) D/ CO         MAME OF PROVIDER OR SUPPLIER       345010       B. WING       (X3) D/ CO         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       (X3) D/ CO	0MB NO. 0938-0391 X3) DATE SURVEY COMPLETED C 03/03/2017					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD	-	CONSTRUCTION (X3) DAT		(X1) PROVIDER/SUPPLIER/CLIA	OF DEFICIENCIES	STATEMENT C
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         500 BEAVERDAM ROAD	00,00,2011		WING	345010		
		•	5		ROVIDER OR SUPPLIER	NAME OF PF
GOLDEN LIVINGCENTER - ASHEVILLE				ILLE	LIVINGCENTER - ASHEV	GOLDEN I
ASHEVILLE, NC 28804		SHEVILLE, NC 28804				
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTION           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         PREFIX         (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E (X5) COMPLETION DATE	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	PREFIX	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC)	PREFIX
F 226       Continued From page 42       F 226         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.       F 226         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.       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.         The 5 day reportable Investigation was completed 03/01/17 and was sent to North Carolina Department of Health and Human Services.       This incident was reported to Adult Protective Service on 03/01/17 at 7:30 PM.         The incident was reported to North Carolina Board of Administrative staff and non-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 perpertator was the ED it should be reported immediately to the ED or DON and if the perpertator may the ED it should be reported immediately to the facility's abuse policy and the chain of command.			F 226	r of any abuse or have the ents. Did they know how to o to report it too? This was managers. incidence occurred on e Director verbalized to the ad MDS Coordinator that he esident #59 and her liant behavior to rules and g over and over had evel. orted to ombudsman on at or around 6pm was completed on 02/23/17 olina Department of Health Investigation was completed at to North Carolina and Human Services. orted to Adult Protective it 7:30 PM. orted to North Carolina rs via voice mail on was removed on 03/03/17 at ews with nursing staff, id non-nursing staff, id non-nursing staff ceived in-service training t types of abuse and the observed or alleged abuse e reported immediately to the perpetrator was the ED to the AVP. Staff confirmed ith a copy of the facility's chain of command. DN, ED #2 and Field Service	they felt unsafe, knew desire to abuse reside report abuse and who conducted by Nursing Immediately after the 02/22/17 the Executiv Director of Nursing an was frustrated with Re continuous non-comp regulations happening increased his stress le This incident was repo 2/22/17 via voice mail A 24 hour reportable 03/01/17 and was ser Department of Health This incident was repo Service on 03/01/17 a The incident was repo Board of Administrato 03/01/17. Immediate Jeopardy of 5:09 PM when intervie administrative staff an confirmed they had re and knew the differen requirement that any of a resident should b the ED or DON and if it should be reported to they were provided wi abuse policy and the of Interviews with the DO	F 226

Facility ID: 922979

If continuation sheet Page 43 of 56

	OF DEFICIENCIES	MEDICAID SERVICES			(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
					С
		345010	B. WING		03/03/2017
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	
	LIVINGCENTER - ASHE			500 BEAVERDAM ROAD	
GOLDEN				ASHEVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETIC
F 226	Continued From page	e 43	F 22	6	
		on the requirement that any			
	observed or alleged a	abuse by the ED should be			
		to the AVP and the accused			
	perpetrator should in the facility.	nmediately be removed from			
F 325	-	ITAIN NUTRITION STATUS	F 32	5	4/4/17
SS=D	UNLESS UNAVOIDA		1 02	č	
	(g) Assisted nutrition				
		ic and gastrostomy tubes, ndoscopic gastrostomy and			
		copic jejunostomy, and			
	enteral fluids). Based				
		ssment, the facility must			
	ensure that a residen	nt-			
		able parameters of nutritional			
		body weight or desirable			
		nd electrolyte balance, unless condition demonstrates that			
		resident preferences			
	indicate otherwise;				
	(3) Is offered a thera	peutic diet when there is a			
		nd the health care provider			
	orders a therapeutic				
		Γ is not met as evidenced			
	by: Based on observatio	ons, record review and		1. The facility was contacted by the	
		ent and staff, the facility failed		Dialysis Center RD (registered dietitian	n)
	to implement the ther	-		regarding resident #90 diet. The Dialys	
	recommended for a r	esident receiving dialysis for		RD's recommendations were sent to the	he
		ved for nutrition (Resident		primary MD for approval. Resident #90	Dis
	#90).			receiving the diet recommended by Dialysis Center RD.	
	The findings included	1:		2. There are no other residents in the	
				facility that are receiving dialysis at this	s
	Resident #90 was ad	lmitted to the facility on		time. If a current resident were identified	

Event ID: KHTF11

Facility ID: 922979

If continuation sheet Page 44 of 56

		MEDICAID SERVICES				<u>VO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			TE SURVEY MPLETED
			A. BUILDING	3		
		345010	B. WING			С
		345010	B. WING		0	3/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ASHE	VILLE		500 BEAVERDAM ROAD		
	1			ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 325	Continued From page	e 44	F 32	25		
		ses that included Diabetes	1 02	as needing dialysis, or admitted	to facility	
		n (HTN) and End Stage		on dialysis, the Dialysis RD wou		
		D). Review of Resident #90's		contacted for diet recommendat		
	physician's orders rev			3.Other residents could be affect		
		led (Con CHO) diet which		dining tray card does not match		
	was ordered on 02/1			current diet order in Point Click		
				4. Monitoring for compliance an	audit was	
		90's dialysis communication		conducted by		
	book revealed a note			Dietary Manager, MDS, DNS, R		
	Dietician (RD) at the	-		Dietician and ADNS and will be		
		ated his diet was to be		by 3/28/17 on all residents diet,	-	
	changed to high prote	ein and low potassium.		tray cards to make sure match t		
		m Data Cat (MDC)		Point Click Care order from MD		
	An admission Minimu	2/20/17 indicated Resident		be conducted by Department M		
		ntact for daily decision		residents at meal time in dining on the hall for those that chose		
	making and had no d	-		room to ensure they are receiving		
	•	s or rejection of care. The		correct diet order after initial au	-	
		lent #90 required limited		3/29/17. The audit will be done	•	
		tivities of daily living except		week for 4 weeks then 3 times	week for 4	
		equired supervision. The		weeks then weekly. The audit w		
	MDS coded Resident			joint effort between Department		
	therapeutic diet and o	-		Managers, Dietary Manager and		
				Dietary Manager Assistant. All a		
		e plan dated 02/22/17		be reviewed in the QAPI month		
		#90's diet alteration related		The whole house audit will be d		
	-	D and HTN with fluctuating		stated above until cleared by Q		
		is, alteration in kidney		committee. Audits will be then d		
		nfection at fistula site. The		quarterly by CDM(Certified Diet	-	
	•	t #90 to maintain nutritional		Manager)and reviewed at QAPI		
		ht. Interventions included:		Correction date for substantial of is 4/4/17 Person responsible for	•	
	-	utrient restriction in relation diagnoses, communication		is 4/4/17.Person responsible for compliance is Interim ED/ADNS		
		D as needed, diet as		5.Licenesed staff will be educat		
	ordered, educate pat			DNS, Nursing Managers and Di	-	
		tor meal consumption daily.		Manager by 4/4/17 on correctly		
		to mean consumption daily.		dietary communication slip to th		
	Review of a dietary n	ote dated 02/22/17 revealed		department each time there is c	-	
		receives a Con CHO End		residents diet. Review of new of	-	

Facility ID: 922979

If continuation sheet Page 45 of 56

			()(0)			IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · · ·	E SURVEY
			A. BOILDING			С
		345010	B. WING		0	3/03/2017
NAME OF P	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE	1	
		<i></i>		500 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHE\			ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 325	Continued From page	e 45	F 32	5		
		es to dialysis 3 times a		be reviewed in Clinical Start Up 3/29/17 after audit completed or residents by Nursing Managers	n all	
	PM eating lunch in hi	served on 03/01/17 at 12:22 s room which consisted of sprouts and dessert. The e was on a renal diet.		Dietary Supervisor.	anu	
	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. 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. 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 restated she also talks center if there are cha asked about the mea	esident is served. The DM to the RD at the dialysis anges recommended. When I that Resident #90 was t dinner which appeared to				

Facility ID: 922979

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		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	E SURVEY IPLETED
					С	
		345010	B. WING		03	3/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ASHE\	/ILLE		500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 325	roommate received, t may have looked the had turkey and rice in roommate's casserold An interview with Nur PM about the facility's with the dialysis center receiving dialysis had was sent to and from communication betwee dialysis center staff. about the note from th 02/14/17 which recom #90's diet to a high pr Nurse #1 stated it sho physician's order on f record. Nurse #1 che in the computer and s change wasn't in the he should have writte physician's order but communication book from dialysis. When a for checking the book #1 stated the nurse w resident returned from for checking the dialy Nurse #1 confirmed t	he DM stated the entree same but Resident #90 only n the casserole and his	F 325			
	5:32 PM about the dir CHO diet and a renal renal diet had sodium and some protein res	with the DM on 03/02/17 at fference between a Con diet, the DM stated the n, potassium, phosphorous trictions. When asked if she ommendation for a diet vsis center RD dated				

Facility ID: 922979

If continuation sheet Page 47 of 56

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 03/29/201 MAPPROVEI D. 0938-039
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		PLETED
		345010	B. WING			C / <b>03/2017</b>
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
		<i></i>		500 BEAVERDAM ROAD		
GOLDEN L	IVINGCENTER - ASHEV	/ILLE		ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 325	she had received from 02/13/17 which order diet. When asked how potassium diet would CHO diet, the DM state extra meat and limited potassium such as gr An interview on 03/02 Director of Nursing (D system for communic center, revealed each dialysis has their own sent with the resident DON explained that a which contains a sect the facility to record in section for dialysis state nurses are trained in asked what her expect nurses checking the of order changes, the D nurse who was on du returned from dialysis new orders and to pur resident's electronic in An interview on 03/03 facility RD revealed s RD at the dialysis cer Resident #90 needed of the low protein diet since admission to the An interview on 03/03 Resident #90's physic	ted the only diet order slip in nursing was dated ed a carbohydrate controlled w a high protein, low be different from the Con ited he would have gotten d foods that were high in een, leafy vegetables. 2/17 at 6:23 PM with the DON) about the facility's ating with the dialysis in resident who receives communication book that is to and from dialysis. The is standardized form is used tion for the nursing staff at notes to dialysis and a aff to record notes to the cility. The DON stated all the the use of the form. When ctation was in regard to communication book for ON stated she expected the ty when the resident is to check the book for any t any new orders in the ecord. 2/17 at 9:30 AM with the he had conferred with the her and confirmed that a high protein diet instead the had been receiving e facility on 02/13/17.	F 3	25		

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STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETED		
				С			
		345010	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	03/03/2017		
NAME OF PI	ROVIDER OR SUPPLIER						
GOLDEN LIVINGCENTER - ASHEVILLE				500 BEAVERDAM ROAD ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 325	Continued From page	e 48	F 32	5			
	When asked about his	s expectation for					
	recommendations from	m the dialysis center being					
		sician stated he expected					
		to be followed and they tten on Resident #90's					
	medical record.	tien on Resident #90 S					
F 490	483.70 EFFECTIVE		F 490	o	4/4/17		
SS=J		ESIDENT WELL-BEING		-			
	483.70 Administration						
		ninistered in a manner that					
	enables it to use its resources effectively and efficiently to attain or maintain the highest						
	-	mental, and psychosocial					
	well-being of each res						
	This REQUIREMENT	is not met as evidenced					
	•	nd staff interviews and		Golden Living Center Asheville is a fa	acility		
	record reviews, the ad	dministration failed to protect		that is administered in a manner that	-		
	a resident from abuse			enables it to use its resources effectiv			
		maintain an abuse free		and efficiently to attain or maintain the			
		e verbally abused a resident; g (DON), who was next in		highest practicable physical, mental a psychosocial wellbeing of each reside			
	charge in the chain of			1. The interim ED and DNS have bee			
	immediately remove an alleged perpetrator from			in-serviced and educated on the Gold			
		nd failed to follow the policy		Living Abuse and Neglect policies and			
		ea Vice President (AVP)		Procedures including what to do if an			
	immediately a witness of a resident.	sed incident of verbal abuse		actual or allegation of abuse or negled are identified regardless of who the			
				alleged perpetrator is, who to notify a	nd		
	Immediate Jeopardy	began on 02/22/17 at 4:00		reporting requirements on 2/27/17 and			
		59 was verbally abused by		3/1/17 by Field Service Clinical Direct	or.		
	ED #1. The Director of			2. Staff have been educated by the	the last		
		t (PCA) #1 witnessed ED #1 ident #59. The DON allowed		DNS,SW,ADNS,BOM and BOMA on t Golden Living Abuse and Neglect Pol			
	-	nain in the building without		and Procedures, this training is include			
		tional hours. Neither the		on new hire orientation and reviewed			
	-	ed the AVP immediately of		annually.			

Facility ID: 922979

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 03/29/2017 RM APPROVED NO. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		345010	B. WING			C 03/03/2017		
NAME OF F	NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ASHEVILLE			SI	TREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN					00 BEAVERDAM ROAD SHEVILLE, NC 28804			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 490	the incident. Immedia on 03/01/17 at 5:09 F and implemented an allegation of compliant of compliance at a low (isolated with no actur more than minimal ha jeopardy) to complete monitoring systems p related to protecting r notifying the AVP and policy and procedure. The findings included Cross refer to F 223: interviews, record rev facility failed to mainta- right to be free from v when Executive Direct Resident #59 causing witnessed the incider anxious (Residents # Cross refer to F 225: interviews, record rev facility failed to immed of a resident by Exect Area Vice President ( notify the North Carol Investigations (NCHC) incident. This affected for abuse (Resident # Cross refer to F 226: interviews and record implement its abuse p protection of the resident	the Jeopardy was removed PM when the facility provided acceptable credible nce. The facility remains out wer scope and severity of D al harm with potential for arm, that is not immediate a education and ensure out into place are effective residents from being abuse, I following the facility's abuse Based on resident view and staff interviews, the ain 1 of 3 sampled residents' rerbal abuse (Resident #59) ctor (ED) #1 threatened to hit g 4 of 7 residents who at to be afraid, nervous and 22, #59, #72 and #86). Based on resident view and staff interviews, the diately report verbal abuse utive Director (ED) to the (AVP) and also failed to ina Health Care Personnel CPI) within 2 hours of the d 1 of 3 residents sampled #59). Based on resident and staff I review, the facility failed to	F	490	<ol> <li>On March 21st,2017, the Psychologithe 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.</li> <li>The Psychologist will meet with residents on 4/4/17 to make them av of the services that are available for dealing with stress, life style changes coping strategies.</li> <li>The Psychologist will be meeting with stress, life style changes coping strategies.</li> <li>The Psychologist will be meeting with stress, bu and working with residents that pose challenges with their behavior.</li> <li>ED/DNS inninated an Employee Engagement Program with the goal create a cultural atmosphere that is cohesive to residents and employees prevent the risk of abuse and decreas stress of residents and staff. The first meeting will be held on 3/29/17 and meet weekly x4 weeks then monthly This program will include one staff member from each department and vinvite President and Vice President of Resident Council plus 2-3 other long residents to be on program. The prowill meet weekly for 4 weeks then monthly This program will neets to include residents and employees together, to make more of cohesive working environment. With any findings of bu committee for EAP will work to try to reduce and prevent any type of abust from occurring.</li> <li>All employees will complete "Carin"</li> </ol>	t vare s and vith irrnout e to s to ise t will of term gram onthly g o rnout se		

Facility ID: 922979

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STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		PLETED
		345010	B. WING			C
	ROVIDER OR SUPPLIER	545010		STREET ADDRESS, CITY, STATE, ZIP CO		/03/2017
				500 BEAVERDAM ROAD		
GOLDEN LIVINGCENTER - ASHEVILLE				ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORREC           REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCE		PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 490	Continued From page 50 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). 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. Allegation of Compliance GLC Asheville March 3rd, 2017 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 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 of Nurses failed to follow facility abuse policy and did not have him removed from facility immediately. The Executive Director then went to		F 49	<ul> <li>90</li> <li>the Caregiver" in-service by in-service goal is to inform to challenges that they can face caregiver, and ways to cope stress and foster teamwork provided by DNS,BOM and employee who has not com 3/31/17 will not be eligible for completed.</li> <li>8. Monitoring for compliance of the EEP(Employee Enga Program) will be reviewed r QAPI meeting. The AVP(Are President) and or the DFCS Field Clinical Services) will QAPI meeting either in pers EX. The QAPI team will eva results and implement additi interventions as indicated to continued compliance. Corr substantial compliance is 4/ Interim ED/DNS responsible compliance.</li> </ul>	the staff of the ce as a e and reduce . In-service BOMA. Any pleted by or work till e, the results gement nonthly at the ea Vice S(Director of attend the son or via Web aluate the tional o ensure rection date for '4/17. The	

If continuation sheet Page 51 of 56

			~~~~~			10. 0938-03		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	· · · ·	TE SURVEY MPLETED		
			A. BUILDIN	G				
		345010	B. WING			C		
		545010				3/03/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1			
GOLDEN LIVINGCENTER - ASHEVILLE				500 BEAVERDAM ROAD				
				ASHEVILLE, NC 28804				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES       ID         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE			
F 490	Continued From page	<del>-</del> 51	F 4	90				
1 100		r opened it and stated to	1 4	50				
		at he was going to report						
	-	sman. When the Director of						
		Nurses heard the outside smoking group talking loudly she then went back to outside to smoking						
		idents were ok and felt safe.						
	They told the Directo							
	•	ad come back to doorway						
		porting himself. She asked						
		Il replied yes and she						
	-	t to worry as she was going						
		priate agencies. When she						
	came back into facilit	-						
		previously planned and						
		gs that were locked in the						
		fice she completed this task.						
	While she was compl	leting this task the MDS so						
	-	vith the Executive Director till						
		e Director of Nurses then						
	took Executive Direct	tor to his office and called						
	the North Carolina O	mbudsman and left voice						
	mail of incident. She	then called the Executive						
		egional Vice President of						
		ained the incident and he						
	suspended the Exect	utive Director effective						
		investigation and he left						
	building at or around	6:20 PM with Director of						
		nat he didn't go anywhere						
	else in facility. He wa	s officially terminated on						
	02/27/17 at 7:45 AM.							
		cutive Director started on						
		11 AM and was educated						
	on the Abuse and Ne							
		the Field Service Clinical						
		The Director of Nurses was						
		/17 by Field Service Clinical						
	Director of Golden Li							
	Abuse/Neglect policy	including the immediate						
		d perpetrator from the						

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/29/2017 MAPPROVED D. 0938-0391		
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					SURVEY PLETED		
		345010	B. WING			_	C 03/03/2017			
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE				
			500 BEAVERDAM ROAD							
GOLDEN	GOLDEN LIVINGCENTER - ASHEVILLE			Α	SHEVILLE, NC 28804					
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)				(X5) COMPLETION DATE		
F 490	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL G REGULATORY OR LSC IDENTIFYING INFORMATION)		F	490		EFICIENCY)				
	First meeting was 02/ next scheduled Resid 03/20/17. The Area Vice Presid Clinical Director will e and staff on the chain and neglect protocol, the remedies for failin and/or mistreatment of the Area Vice Preside Director reviewed abu procedures on visit to Asheville and checke information and will co	being treated respectfully. 28/17, then 03/01/17 and ent Council meeting will be ent and Field Service ducate the facility leadership of command and the abuse including but not limited to, g to report abuse, neglect of a resident. On 03/01/17 int and Field Service Clinical use and neglect policies and Golden Living Center of d the regulations for new portinue to do so on monthly 3/01/17 to begin training with								

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CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					OMB NO. 0938-03				
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION	· · /	(X3) DATE SURVEY COMPLETED		
			A. BUILDIN	A. BUILDING			C 03/03/2017		
		345010	B. WING						
	ROVIDER OR SUPPLIER	040010			T ADDRESS, CITY, STATE, ZIP CODE	0	3/03/2017		
					EAVERDAM ROAD				
GOLDEN LIVINGCENTER - ASHEVILLE					VILLE, NC 28804				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORF	RECTION	(X5)		
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETIO		
F 490	Continued From pag	e 53	F4	90					
		the above. A Graph of chain							
		ntact numbers and their							
	responsibilities is pos	sted at time clock that is							
	accessible to all emp	accessible to all employees.							
	*All other residents have the right to be free from								
	verbal, sexual, physi								
	corporal punishment								
	On 03/01/17 the dep								
	interviewed all other								
	any signs of abuse, u know how to report a								
	abuse they would like								
	03/01/17 department								
	monitor with daily roo								
		anything to report and any							
	abuse that they want								
	03/01/17 during their	care plans Social Worker							
	will ask residents if the	ney feel safe, if they know							
		/ know who to report to and if							
		to report. Any staff that has							
	•	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							
	•	aff on policies and t residents from any form of							
		services with a copy of the							
		en to all employees who							
		absent staff will be educated							
		d to work in facility. To ensure							
	the quality of care is								
		nd free of harm, any staff							
	that has not completed abuse and neglect								
		able to work until training is							
	completed.								
		t of current Golden Living							
	Center employees w managers and asked out, if they felt unsafe	as conducted by department I if they felt stressed or burnt e, knew of any abuse or lents. Did they know how to							

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	MENT OF HEALTH AN	ID HUMAN SERVICES					FORM	): 03/29/2017 / APPROVED ). 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					SURVEY LETED	
		345010	B. WING			C 03/03/2017			
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP (	CODE			
			500 BEAVERDAM ROAD						
GOLDEN LIVINGCENTER - ASHEVILLE				4	ASHEVILLE, NC 28804				
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)			TION SHOULD B		(X5) COMPLETION DATE	
F 490	report abuse and who responses were posit overly stressed. The f staff meetings and dis population of our resid mechanisms to deal w A Psychologist for Ge agreed to come to fac residents and employ burnout, dealing with mechanisms. She is s of March 6, 2017. As changes take plac standpoint as far as th out Golden Living Center Executive Director will Regional Vice Preside monthly. Golden Living of Ashe Engagement Program cultural atmosphere th and decrease stress. member from each de and will invite the Res Vice President, along Residents to be a par program will meet mo stressors, upcoming e include residents and make for a more cohe All employees will cor Caregiver in-service t challenges they are fa one of the most challe	to report it to? All ive and no one felt unsafe or facility will have monthly all scuss stressors, the dents and coping with challenging residents. olden Living of Asheville has cility to meet with the ees separately to discuss stress and coping setting up schedule for week e from the corporate ne progression of leasing net the staff will be kept basis at in-services to keep ry to prevent any stressors. of Asheville's Interim I be kept up to date by ent and will speak to staff eville will form an Employee n with a goal to create a hat is cohesive to residents p prevent the risk of abuse We will have one staff epartment on the committee sident Council President and with 2-3 Long Term Care t of the program. The inthly and discuss any events and plan events to employees together to esive working environment. mplete a Caring For the	F	490					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/29/2017 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345010	B. WING _		C 03/03/2017			
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
GOLDEN	LIVINGCENTER - ASHEV	/ILLE		50	00 BEAVERDAM ROAD			
				A	SHEVILLE, NC 28804			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 490			F 4	490				
	ED #2 and the DON of observed or alleged a immediately reported	aled training was provided to on the requirement that any abuse by the ED should be to the AVP and the accused mediately be removed from						

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