

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

PRINTED: 12/30/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/12/2013
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - ASHEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 BEAVERDAM RD ASHEVILLE, NC 28804
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 312 SS=E	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide assistance for activities of daily living for 5 of 13 residents (Resident #13, #12, #1, #2, #7).</p> <p>The findings included:</p> <p>1. Resident #13 was admitted to the facility on 11/18/13 with diagnoses of Parkinson Disease, respiratory failure and Non-Alzheimer's Dementia. Review of the Minimum Data Set (MDS) dated 11/25/13 indicated Resident #13 was cognitively intact and was able to understand and make self understood. Resident #13 required extensive assistance with personal hygiene.</p> <p>Review of the care plan dated 11/25/13 revealed Resident #13 had a physical functioning deficit related to self care impairment with an intervention for staff to assist with activities of daily living.</p> <p>An observation was made on 12/11/13 at 9:00 AM of Resident #13. The resident was noted to have ¼ inch white chin hairs on bilateral jaw line and chin.</p> <p>An observation was made on 12/12/13 at 9:00</p>	F 312	<p><i>Preparation and or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because the provision of federal and state laws requires it.</i></p> <p>F 312 SS=E</p> <p>Criteria 1</p> <ol style="list-style-type: none"> <li>1. Resident 13's facial hair was removed immediately upon discovery and a plan per resident request for ongoing grooming initiated.</li> <li>2. Resident 12 was provided oral care upon discovery and will be added to dental consult for discoloration.</li> <li>3. Resident 1 was provided a shower and subsequent grooming per policy according to schedule on 12-11-13.</li> <li>4. Resident 2 was provided a shower and subsequent grooming per policy according to schedule on 12-12-13.</li> <li>5. Resident 7 was provided a shower and subsequent grooming per policy according to schedule on 12-16-13.</li> </ol>	1-9-14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Philo Burt</i>	TITLE Executive Director	(X6) DATE 1-13-14
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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.

*Original Signature Date: 1-8-14*

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F 312	<p>Continued From page 1</p> <p>AM of Resident #13. The resident continued to have ¼ inch white chin hairs on bilateral jaw line and chin.</p> <p>During an interview on 12/12/13 at 9:08 AM Resident #13 stated she did not like to have any facial hair. Resident #13 reported she had requested for staff to shave her facial hair several times for the past week and a half. The resident stated staff said they would shave her as soon as they had time. Resident #13 further stated she thought staff was just too busy to worry about her facial hair.</p> <p>An interview with NA #1 on 12/12/13 at 2:22 PM revealed he had observed Resident #13's facial hair. He stated facial hair should be shaved on the resident's shower day or any time upon request of resident. NA #1 reported Resident #13's shower days were Tues. and Thurs. but she did not receive her shower on 12/11/13. NA#1 stated Resident #13 had asked for facial hair to be shaved but he had not had time to shave her today. NA #1 stated he had been pulled from the shower team to work on the 200 hall due to call outs. NA #1 further stated it was impossible to complete all resident care with 3 NAs and no shower team.</p> <p>During an interview on 12/22/13 at 4:30 PM the Director of Nursing (DON) stated it was her expectation for facial hair to be shaved on the resident's shower day or as needed. The DON stated if a resident asked to be shaved and staff did not have time it should be reported to the next shift and they should provide the care.</p> <p>2. Resident #12 was admitted to the facility on 08/04/13 with diagnoses of Alzheimer's disease,</p>	F 312	<p><b>Criteria 2</b></p> <p><i>All alert and oriented residents were interviewed by the Director of Social Services in reference to their needs being met by the nursing staff on 1/7/14. Education was provided to clinical staff in regards to facility expectations of the provision of oral care and showers by the Director of Clinical Education and Assistant Director of Nursing on or before 1/8/14.</i></p> <p><b>Criteria 3</b></p> <p><i>To monitor delivery of ADLs per facility policy and care plan, resident's shower sheets will be brought to clinical start-up meeting comprised of clinical management designees ongoing. At the change of each shift, licensed nurses will monitor provision of oral care, facial hair, and ADL care for residents that can and cannot be interviewed during mandatory shift-to-shift walking rounds ongoing.</i></p>	<p>1-9-14</p> <p>1-9-14</p>
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F 312	<p>Continued From page 2</p> <p>cerebral vascular accident, and Parkinson Disease. Review of the Minimum Data Set (MDS) dated 12/02/13 indicated Resident #12 was cognitively intact and was able to understand and make self understood. Resident # 12 required extensive assistance with personal hygiene.</p> <p>Review of the care plan dated 12/06/13 revealed Resident #12 had a physical functioning deficit related to self care impairment, mobility impairment with an intervention for staff to assist with activities of daily living (ADL) as needed. Resident #12 was also care planned for self-feeding difficulty as related to inability to coordinate hand to mouth movements.</p> <p>An observation of Resident #12 on 12/12/13 at 8:53 AM revealed resident's teeth were coated with a yellow/brownish film.</p> <p>During an interview on 12/12/13 at 8:54 AM Resident #12 stated staff did not provide oral care or set up for him to do oral care daily. Resident #12 stated he could brush his teeth if the staff set everything up for him but he preferred staff to brush his them because they did a better job. Resident #12 reported he had to ask staff to provide oral care or set things up for him to brush his teeth on a daily basis.</p> <p>An observation was made on 12/12/13 at 2:25 PM of Resident #12. The resident continued to have a yellow/brownish film coating teeth.</p> <p>An interview conducted with NA #2 on 12/12/13 at 2:50 PM revealed oral care was not provided for Resident #12. NA #2 stated oral care should be provided with AM care daily. NA #2 reported due to working short staffed he had not had time to</p>	F 312	<p><i>Criteria 4</i></p> <p><i>The data gathered from the monitoring tools will be brought to the monthly QAPI meetings for a minimum of 3 months or until QAPI committee determines necessary. The QAPI committee composed of the Executive Director, Director of Nursing Services, Medical Director, Assistant Director of Nursing Services, Director of Clinical Education, MDS Director, Business Office Manager, Director of Social Services, Director of Activities, Director of Maintenance, Director of Dining Services, and Director of Medical Records.</i></p>	12-14
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F 312	<p>Continued From page 3 provide Resident #12's oral care today.</p> <p>Interview with the DON on 12/12/13 at 4:28 PM revealed it was her expectation that oral care be provided daily for every resident.</p> <p>3. Resident #1 was admitted to the facility on 11/18/13 with diagnoses of Parkinson Disease, respiratory failure and Non-Alzheimer's Dementia. Review of the Minimum Data Set (MDS) dated 11/25/13 indicated Resident was cognitively intact and was able to understand and make self understood. Resident #1 required extensive assistance with bed mobility, transfers, toileting and bathing.</p> <p>Review of the care plan dated 11/21/13 revealed Resident #1 was at risk for falls and had a physical functioning deficit related to self care impairment with an intervention for staff to assist with activities of daily living.</p> <p>Review of the shower schedule revealed Resident #1 was scheduled to receive showers weekly on Tuesday and Friday. Review of ADL documentation revealed Resident # received one shower a week the week of 11/04/13 and 12/02/13. There was no documentation stating Resident #1 had refused showers.</p> <p>During an interview on 12/11/13 at 11:10 AM NA #2 stated with 3 NAs plus the shower team the work could be done but when the shower team was pulled to be the 3rd NA it was almost impossible to complete all care such as shaving, oral care and showers. NA #2 stated there were many days showers were not given and were passed on to the next shift.</p>	F 312		
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F 312	<p>Continued From page 4</p> <p>During an interview on 12/12/13 at 9:24 AM with Resident #1 revealed she was to have two showers per week but there were some weeks she only got one. Resident #1 stated the staff didn't have time to get to everyone.</p> <p>During an interview on 12/12/13 at 2:29 PM NA #1 stated he had been pulled from the shower team to work on the 200 hall due to call outs. NA #1 stated when there are only 3 NAs for the 200 hall it is impossible to get all of the care done. NA#1 stated he had been working 4 hours today and had made one round with his residents and he had 2 showers to give and rounds to start again for incontinence care. NA#2 further stated when he worked as a NA on the floor with no shower team cleaning nails, brushing teeth and showers did not get done.</p> <p>During an interview on 12/12/13 at 2:37 PM the Director of Nursing (DON) stated it was her expectation that all care should be provided to the resident and if certain areas were missed they should be reported for the next shift to do.</p> <p>During an interview on 12/12/13 at 3:39 PM Nurse #4 stated the NAs can barely keep the residents clean and dry and showers and activities of daily living (ADLS) were not getting done. Nurse #4 stated the residents were lucky to get one shower a week.</p> <p>4. Resident #2 was admitted to the facility on 03/09/10 with diagnoses of generalized muscle weakness, hypertension, cognitive impairment and depressive disorder. A review of the Minimum Data Set (MDS) dated 10/21/13 revealed Resident #2 was severely impaired for skills of daily decision making and had long and</p>	F 312			

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F 312	<p>Continued From page 5</p> <p>short term memory impairment. Resident #2 required extensive assistance with personal hygiene, bathing and toileting.</p> <p>Review of the care plan dated 11/04/13 revealed Resident #2 was at risk for falls and had a physical functioning deficit related to self care impairment with an intervention for staff to assist with activities of daily living.</p> <p>Review of the shower schedule revealed Resident #2 was scheduled to receive showers weekly on Tuesday and Thursday. Review of ADL documentation revealed Resident #2 received one shower a week the weeks of 10/12/13, 10/19/13, 10/30, 11/09/13 and 12/05/13. There was no documentation stating Resident #2 had refused showers.</p> <p>During an interview on 12/11/13 at 11:10 AM NA #2 stated with 3 NAs plus the shower team the work could be done but when the shower team was pulled to be the 3rd NA it was almost impossible to complete all care such as shaving, oral care and showers. NA #2 stated there were many days showers were not given and were passed on to the next shift.</p> <p>During an interview on 12/12/13 at 2:29 PM NA #1 stated he had been pulled from the shower team to work on the 200 hall due to call outs. NA #1 stated when there are only 3 NAs for the 200 hall it is impossible to get all of the care done. NA#1 stated he had been working 4 hours today and had made one round with his residents and he had 2 showers to give and rounds to start again for incontinence care. NA #1 stated he did not think he would have time to give Resident #2 ' s shower today. NA#2 further stated when he</p>	F 312		
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F 312	<p>Continued From page 6</p> <p>worked as a NA on the floor with no shower team cleaning nails, brushing teeth and showers did not get done.</p> <p>During an interview on 12/22/13 at 2:37 PM the Director of Nursing (DON) stated it was her expectation that all care should be provided to the resident and if certain areas were missed they should be reported for the next shift to do.</p> <p>During an interview on 12/12/13 at 3:39 PM Nurse #4 stated the NAs could barely keep the residents clean and dry and showers and activities of daily living (ADLS) were not getting done. Nurse #4 stated the residents were lucky to get one shower a week.</p> <p>5. Resident #7 was admitted to the facility on 01/17/09 with diagnoses of Alzheimer's disease, dementia, mood disorder and hypertension. The MDS dated 07/18/13 revealed Resident #7 was severely impaired for skills of daily decision making and had long and short term memory impairment. Resident #7 required extensive assistance for personal hygiene, toileting and bathing.</p> <p>Review of the care plan dated 07/29/13 revealed Resident #7 was at risk for falls and had a physical functioning deficit related to self care impairment with an intervention for staff to assist with activities of daily living.</p> <p>Review of the shower schedule revealed Resident #7 was scheduled to receive showers weekly on Tuesday and Thursday. Review of ADL documentation revealed Resident #2 received one shower a week the weeks of 11/7/13, 11/12/13, 11/18/13, 11/25/13, 12/05/13,</p>	F 312			

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F 312	Continued From page 7 and 12/09/13. There was no documentation stating Resident #2 had refused showers.  During an interview on 12/11/13 at 11:10 AM NA #2 stated with 3 NAs plus the shower team the work could be done but when the shower team was pulled to be the 3rd NA it was almost impossible to complete all care such as shaving, oral care and showers. NA #2 stated there were many days showers were not given and were passed on to the next shift.  During an interview on 12/12/13 at 2:29 PM NA #1 stated he had been pulled from the shower team to work on the 200 hall due to call outs. NA #1 stated when there are only 3 NAs for the 200 hall it is impossible to get all of the care done. NA#1 stated he had been working 4 hours today and had made one round with his residents and he had 2 showers to give and rounds to start again for incontinence care. NA#2 further stated when he works as a NA on the floor with no shower team cleaning nails, brushing teeth and showers did not get done.  During an interview on 12/22/13 at 2:37 PM the Director of Nursing (DON) stated it was her expectation that all care should be provided to the resident and if certain areas were missed they should be reported for the next shift to do.  During an interview on 12/12/13 at 3:39 PM Nurse #4 stated the NAs can barely keep the residents clean and dry and showers and activities of daily living (ADLS) were not getting done. Nurse #4 stated the residents were lucky to get one shower a week.	F 312			
F 353	483.30(a) SUFFICIENT 24-HR NURSING STAFF	F 353			



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F 353 SS=E	Continued From page 8 PER CARE PLANS  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.  The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:  Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.  Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.  This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide assistance with activities of daily living due to insufficient nursing staff for 5 of 14 residents (Resident #1, #2, #7, #12, #13).  The findings are:  1. Resident #13 was admitted to the facility on 11/18/13 with diagnoses of Parkinson Disease, respiratory failure and Non-Alzheimer's Dementia. Review of the Minimum Data Set (MDS) dated	F 353	<i>F 353</i> <i>SS =E</i>  <i>Criteria 1</i>  <i>1. Resident 13's facial hair was removed immediately upon discovery and a plan per resident request for ongoing grooming initiated.</i> <i>2. Resident 12 was provided oral care upon discovery and will be added to dental consult for discoloration.</i> <i>3. Resident 1 was provided a shower and subsequent grooming per policy according to schedule on 12-11-13.</i> <i>4. Resident 2 was provided a shower and subsequent grooming per policy according to schedule on 12-12-13.</i> <i>5. Resident 7 was provided a shower and subsequent grooming per policy according to schedule on 12-16-13.</i>  <i>Criteria 2</i>  <i>The staff were reeducated on the facility's attendance policy and the proportional comparison of staff attendance to patient care on 12/18/13 and 12/19/13 by the Executive Director and Director of Nursing Services. Staff were reeducated on proper procedure if shower team is placed on an assignment by the Executive Director and Director of Nursing Services on 12/18/13 and 12/19/13. All alert and oriented residents were interviewed by the Director of Social Services in reference to their needs being met by the nursing staff on 1/7/14.</i>	1-9-14  1-9-14	

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F 353	<p>Continued From page 9</p> <p>11/25/13 indicated Resident #13 was cognitively intact and was able to understand and make self understood. Resident #13 required extensive assistance with personal hygiene.</p> <p>Review of the care plan dated 11/25/13 revealed Resident #13 had a physical functioning deficit related to self care impairment with an intervention for staff to assist with activities of daily living.</p> <p>An observation was made on 12/11/13 at 9:00 AM of Resident #13. The resident was noted to have ¼ inch white chin hairs on bilateral jaw line and chin.</p> <p>During an interview with Resident #13 on 12/12/13 at 9:08 AM stated she did not like to have any facial hair. Resident #13 reported she had requested for staff to shave her facial hair several times for the past week and a half. The resident stated staff said they would shave her as soon as they had time. Resident #13 further stated she thought staff was just too busy to worry about her facial hair.</p> <p>A review of staffing assignments for 11/01/13 to 12/12/13 revealed 20 out of 42 days on 1st shift the shower team nurse aides (NAs) were pulled to work the floor to give each hall 3 NAs.</p> <p>A review of the Resident Council Meeting minutes dated 11/26/13 revealed a complaint had been made by 11 out of 11 residents present at the meeting for more NAs being needed because their needs were not being met. The action taken was Nursing Administration was actively recruiting for NAs. Three NAs were presently in orientation to be completed the week of 12/09/13.</p>	F 353	<p><b>Criteria 3</b></p> <p><i>A weekly audit of the alert and oriented residents will be completed for 4 weeks or until deemed compliant by IDT members to ensure the staffing meets the resident's needs. This audit will be completed by the Director of Social Services or designee. All new admissions will be interviewed in the patient care meeting following admission to the facility for 4 weeks or until deemed compliant by the IDT members. This meeting will be completed by the Director of Social Services and/or designees. Admission director completes admission audits for all new admissions within 7 days of admission per facility policy. Provision of ADL care will be discussed in the weekly Resident Council meetings for 4 weeks directed by the Executive Director and/or Director of Nursing Services. Provision of ADL care will be discussed in the monthly Resident Council meetings monthly for three months. All facility residents will either be interviewed and/or observed weekly in regards to their ADL care received. To ensure adequate staffing for day shift to provide the needed care, the facility will continue to recruit for new staff. If needed, the facility will reach out to agency staffing in order to provide the adequate staffing. Implementation of an on-call procedure for CNAs to ensure adequate staffing</i></p>	1-9-14	

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F 353	<p>Continued From page 10</p> <p>They were awaiting background checks on two other candidates.</p> <p>During an interview with NA #2 on 12/11/13 at 11:10 AM stated the NAs worked short staffed most days. NA #2 stated with 3 NAs plus the shower team the work could be done but when the shower team was pulled to be the 3rd NA it was almost impossible to complete all care such as shaving, oral care, making and changing beds plus showers.</p> <p>An interview with Nurse #1 on 12/12/13 at 10:08 AM revealed oral care was rarely done for residents and some residents had to wait long periods of time to be changed when wet due to the facility being short staffed. Nurse #1 further stated lunch trays are passed out late on many days due to lack of staffing on the halls.</p> <p>An interview with NA #6 (shower team) on 12/12/13 at 11:38 AM revealed she was scheduled to work Monday through Friday from 8:00 AM to 4:00 PM and was pulled to work a resident assignment approximately twice a week due to call outs and no shows. NA #6 stated she typically shaved residents and provided oral care with showers. The interview further revealed the east wing was supposed to have 4 NAs on 1st shift (7:00 AM to 3:00 PM) and the west wing was supposed to have 3 NAs plus a shower team aide on each wing. NA # 6 further stated there were days when there were only 2 NAs per wing and it was difficult to complete showers and provide residents with assistance with ADL.</p> <p>An interview with NA #1 on 12/12/13 at 2:22 PM revealed he had observed Resident #13's facial hair. He stated facial hair should be shaved on</p>	F 353	<p><i>will be initiated ongoing and monitored by the Director of Nursing Services and Scheduler.</i></p> <p><i>Criteria 4</i></p> <p><i>The data gathered from the monitoring tools will be brought to the monthly QAPI meetings for a minimum of 3 months or until QAPI committee determines necessary. The QAPI committee composed of the Executive Director, Director of Nursing Services, Medical Director, Assistant Director of Nursing Services, Director of Clinical Education, MDS Director, Business Office Manager, Director of Social Services, Director of Activities, Director of Maintenance, Director of Dining Services, and Director of Medical Records.</i></p>	1-9-14	

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F 353	<p>Continued From page 11</p> <p>the resident's shower day or any time upon request of resident. NA#1 stated Resident #13 had asked for facial hair to be shaved but he had not had time to shave her today. NA #1 stated he had been pulled from the shower team to work on the 200 hall due to call outs. NA #1 further stated it was impossible to complete all resident care with 3 NAs and no shower team.</p> <p>During an interview with the Director of Nursing (DON) on 12/22/13 at 2:37 PM stated it was her expectation that all care should be provided to the resident and if certain areas were missed they should be reported for the next shift to do. The DON stated if there were call outs they did what they had to do to take care of the residents. The DON stated 6 NAs, 2 shower team NAs and 1 restorative NA should be the staffing for each hall on 1st shift 7 days a week. She reported staff was asked to work over or come in early and on 1st shift the shower team was pulled to work the floor if there were call outs.</p> <p>A follow up interview with the DON on 12/22/13 at 4:56 PM revealed she was aware of the staffing complaint at the Resident Council meeting on 11/26/13 but she did not know what needs were not being met for residents due to staffing. The DON further stated she had not spoken to the residents about what needs were not being met by staff.</p> <p>2. Resident #12 was admitted to the facility on 08/04/13 with diagnoses of Alzheimer's disease, cerebral vascular accident, and Parkinson Disease. Review of the Minimum Data Set (MDS) dated 12/02/13 indicated Resident #12 was cognitively intact and was able to understand and make self understood. Resident # 12 required</p>	F 353			

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F 353	<p>Continued From page 12</p> <p>extensive assistance with personal hygiene.</p> <p>Review of the care plan dated 12/06/13 revealed Resident #12 had a physical functioning deficit related to self care impairment, mobility impairment with an intervention for staff to assist with activities of daily living (ADL) as needed. Resident #12 was also care planned for self-feeding difficulty as related to inability to coordinate hand to mouth movements.</p> <p>An observation of Resident #12 on 12/12/13 at 8:53 AM revealed resident's teeth were coated with a yellow/brownish film.</p> <p>During an interview with Resident #12 on 12/12/13 at 8:54 AM stated staff did not provide oral care or set up for him to do oral care daily. Resident #12 stated he could brush his teeth if the staff set everything up for him but he preferred staff to brush his them because they did a better job. Resident #12 reported he had to ask staff to provide oral care or set things up for him to brush his teeth on a daily basis.</p> <p>An observation was made on 12/12/13 at 2:25 PM of Resident #12. The resident continued to have a yellow/brownish film coating teeth.</p> <p>An interview conducted with NA #2 on 12/12/13 at 2:50 PM revealed oral care was not provided for Resident #12. NA #2 stated oral care should be provided with AM care daily. NA #2 reported due to working short staffed he had not had time to provide Resident #12's oral care today.</p> <p>Interview with the DON on 12/12/13 at 4:28 PM revealed it was her expectation that oral care be provided daily for every resident.</p>	F 353			

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F 353	<p>Continued From page 13</p> <p>A review of staffing assignments for 11/01/13 to 12/12/13 revealed 20 out of 42 days on 1st shift the shower team nurse aides (NAs) were pulled to work the floor to give each hall 3 NAs.</p> <p>A review of the Resident Council Meeting minutes dated 11/26/13 revealed a complaint had been made by 11 out of 11 residents present at the meeting for more NAs being needed because their needs were not being met. The action taken was Nursing Administration was actively recruiting for NAs. Three NAs were presently in orientation to be completed the week of 12/09/13. They were awaiting background checks on two other candidates.</p> <p>During an interview with NA #2 on 12/11/13 at 11:10 AM stated the NAs worked short staffed most days. NA #2 stated with 3 NAs plus the shower team the work could be done but when the shower team was pulled to be the 3rd NA it was almost impossible to complete all care such as shaving, oral care, making and changing beds plus showers.</p> <p>An interview with Nurse #1 on 12/12/13 at 10:08 AM revealed oral care was rarely done for residents.</p> <p>An interview with NA #6 (shower team) on 12/12/13 at 11:38 AM revealed she was scheduled to work Monday through Friday from 8:00 AM to 4:00 PM and was pulled to work a resident assignment approximately twice a week due to call outs and no shows. NA #6 stated she typically shaved residents and provided oral care with showers. The interview further revealed the east wing was supposed to have 4 NAs on 1st</p>	F 353		

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F 353	<p>Continued From page 14</p> <p>shift (7:00 AM to 3:00 PM) and the west wing was supposed to have 3 NAs plus a shower team aide on each wing. NA # 6 further stated there were days when there were only 2 NAs per wing and it was difficult to complete showers and provide residents with assistance with ADL.</p> <p>During an interview on 12/12/13 at 2:29 PM NA #1 stated he had been pulled from the shower team to work on the 200 hall due to call outs. NA #1 stated when there were only 3 NAs for the 200 hall it was impossible to get all of the care done. NA#1 stated he had been working 4 hours today and had made one round with his residents and he had 2 showers to give and rounds to start again for incontinence care. NA#1 further stated when he worked as a NA on the floor with no shower team cleaning nails, brushing teeth and showers did not get done.</p> <p>During an interview with the Director of Nursing (DON) on 12/22/13 at 2:37 PM stated it was her expectation that all care should be provided to the resident and if certain areas were missed they should be reported for the next shift to do. The DON stated if there were call outs they did what they had to do to take care of the residents. The DON stated 6 NAs, 2 shower team NAs and 1 restorative NA should be the staffing for each hall on 1st shift 7 days a week. She reported staff was asked to work over or come in early and on 1st shift the shower team was pulled to work the floor if there were call outs.</p> <p>During an interview with Nurse #4 on 12/12/13 at 3:39 PM stated the NAs could not keep the residents clean and dry and showers and activities of daily living (ADLS) were not getting done due to lack of staffing.</p>	F 353			

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F 353	Continued From page 15  A follow up interview with the DON on 12/22/13 at 4:56 PM revealed she was aware of the staffing complaint at the Resident Council meeting on 11/26/13 but she did not know what needs were not being met for residents due to staffing. The DON further stated she had not spoken to the residents about what needs were not being met by staff.  3. Resident #1 was admitted to the facility on 11/18/13 with diagnoses of Parkinson Disease, respiratory failure and Non-Alzheimer's Dementia. Review of the Minimum Data Set (MDS) dated 11/25/13 indicated Resident was cognitively intact and was able to understand and make self understood. Resident #1 required extensive assistance with bed mobility, transfers, toileting and bathing.  Review of the care plan dated 11/21/13 revealed Resident #1 was at risk for falls and had a physical functioning deficit related to self care impairment with an intervention for staff to assist with activities of daily living.  Review of the shower schedule revealed Resident #1 was scheduled to receive showers weekly on Tuesday and Friday. Review of ADL documentation revealed Resident #1 received one shower a week the weeks of 11/04/13 and 12/02/13. There was no documentation stating Resident #1 had refused showers.  A review of staffing assignments for 11/01/13 to 12/12/13 revealed 20 out of 42 days on 1st shift the shower team nurse aides (NAs) were pulled to work the floor to give each hall 3 NAs.	F 353			



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F 353	<p>Continued From page 16</p> <p>A review of the Resident Council Meeting minutes dated 11/26/13 revealed a complaint had been made by 11 out of 11 residents present at the meeting for more NAs being needed because their needs were not being met. The action taken was Nursing Administration was actively recruiting for NAs. Three NAs were presently in orientation to be completed the week of 12/09/13. They were awaiting background checks on two other candidates.</p> <p>During an interview with NA #2 on 12/11/13 at 11:10 AM stated the NAs worked short staffed most days. NA #2 stated with 3 NAs plus the shower team the work could be done but when the shower team was pulled to be the 3rd NA it was almost impossible to complete all care such as shaving, oral care, making and changing beds plus showers.</p> <p>An interview with NA #6 (shower team) on 12/12/13 at 11:38 AM revealed she was scheduled to work Monday through Friday from 8:00 AM to 4:00 PM and was pulled to work a resident assignment approximately twice a week due to call outs and no shows. NA #6 stated she typically shaved residents and provided oral care with showers. The interview further revealed the east wing was supposed to have 4 NAs on 1st shift (7:00 AM to 3:00 PM) and the west wing was supposed to have 3 NAs plus a shower team aide on each wing. NA # 6 further stated there were days when there were only 2 NAs per wing and it was difficult to complete showers and provide residents with assistance with ADL.</p> <p>During an interview on 12/12/13 at 2:29 PM NA #1 stated he had been pulled from the shower team to work on the 200 hall due to call outs. NA</p>	F 353			

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F 353	<p>Continued From page 17</p> <p>#1 stated when there are only 3 NAs for the 200 hall it is impossible to get all of the care done. NA#1 stated he had been working 4 hours today and had made one round with his residents and he had 2 showers to give and rounds to start again for incontinence care. NA#1 further stated when he works as a NA on the floor with no shower team cleaning nails, brushing teeth and showers did not get done.</p> <p>During an interview with the Director of Nursing (DON) on 12/22/13 at 2:37 PM stated it was her expectation that all care should be provided to the resident and if certain areas were missed they should be reported for the next shift to do. The DON stated if there were call outs they did what they had to do to take care of the residents. The DON stated 6 NAs, 2 shower team NAs and 1 restorative NA should be the staffing for each hall on 1st shift 7 days a week. She reported staff was asked to work over or come in early and on 1st shift the shower team was pulled to work the floor if there were call outs.</p> <p>During an interview with Nurse #4 on 12/12/13 at 3:39 PM stated the NAs could not keep the residents clean and dry and showers and activities of daily living (ADLS) were not getting done due to lack of staffing.</p> <p>A follow up interview with the DON on 12/22/13 at 4:56 PM revealed she was aware of the staffing complaint at the Resident Council meeting on 11/26/13 but she did not know what needs were not being met for residents due to staffing. The DON further stated she had not spoken to the residents about what needs were not being met by staff.</p>	F 353			

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F 353	<p>Continued From page 18</p> <p>4. Resident #2 was admitted to the facility on 03/09/10 with diagnoses of generalized muscle weakness, hypertension, cognitive impairment and depressive disorder. A review of the Minimum Data Set (MDS) dated 10/21/13 revealed Resident #2 was severely impaired for skills of daily decision making and had long and short term memory impairment. Resident #2 required extensive assistance with personal hygiene, bathing and toileting.</p> <p>Review of the care plan dated 11/04/13 revealed Resident #2 was at risk for falls and had a physical functioning deficit related to self care impairment with an intervention for staff to assist with activities of daily living.</p> <p>Review of the shower schedule revealed Resident #2 was scheduled to receive showers weekly on Tuesday and Thursday. Review of ADL documentation revealed Resident #2 received one shower a week the weeks of 10/12/13, 10/19/13, 10/30, 11/09/13 and 12/05/13. There was no documentation stating Resident #2 had refused showers.</p> <p>A review of staffing assignments for 11/01/13 to 12/12/13 revealed 20 out of 42 days on 1st shift the shower team nurse aides (NAs) were pulled to work the floor to give each hall 3 NAs.</p> <p>A review of the Resident Council Meeting minutes dated 11/26/13 revealed a complaint had been made by 11 out of 11 residents present at the meeting for more NAs being needed because their needs were not being met. The action taken was Nursing Administration was actively recruiting for NAs. Three NAs were presently in orientation to be completed the week of 12/09/13.</p>	F 353			

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F 353	<p>Continued From page 19</p> <p>They were awaiting background checks on two other candidates.</p> <p>During an interview with NA #2 on 12/11/13 at 11:10 AM stated the NAs worked short staffed most days. NA #2 stated with 3 NAs plus the shower team the work could be done but when the shower team was pulled to be the 3rd NA it was almost impossible to complete all care such as shaving, oral care, making and changing beds plus showers.</p> <p>An interview with NA #6 (shower team) on 12/12/13 at 11:38 AM revealed she was scheduled to work Monday through Friday from 8:00 AM to 4:00 PM and was pulled to work a resident assignment approximately twice a week due to call outs and no shows. NA #6 stated she typically shaved residents and provided oral care with showers. The interview further revealed the east wing was supposed to have 4 NAs on 1st shift (7:00 AM to 3:00 PM) and the west wing was supposed to have 3 NAs plus a shower team aide on each wing. NA # 6 further stated there were days when there were only 2 NAs per wing and it was difficult to complete showers and provide residents with assistance with ADL.</p> <p>During an interview on 12/12/13 at 2:29 PM NA #1 stated he had been pulled from the shower team to work on the 200 hall due to call outs. NA #1 stated when there are only 3 NAs for the 200 hall it is impossible to get all of the care done. NA#1 stated he had been working 4 hours today and had made one round with his residents and he had 2 showers to give and rounds to start again for incontinence care. NA #1 stated he did not think he would have time to give Resident #2's shower today. NA#1 further stated when he</p>	F 353		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - ASHEVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 BEAVERDAM RD</b> <b>ASHEVILLE, NC 28804</b>		
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F 353	<p>Continued From page 20</p> <p>works as a NA on the floor with no shower team cleaning nails, brushing teeth and showers did not get done.</p> <p>During an interview with the Director of Nursing (DON) on 12/22/13 at 2:37 PM stated it was her expectation that all care should be provided to the resident and if certain areas were missed they should be reported for the next shift to do. The DON stated if there were call outs they did what they had to do to take care of the residents. The DON stated 6 NAs, 2 shower team NAs and 1 restorative NA should be the staffing for each hall on 1st shift 7 days a week. She reported staff was asked to work over or come in early and on 1st shift the shower team was pulled to work the floor if there were call outs.</p> <p>During an interview with Nurse #4 on 12/12/13 at 3:39 PM stated the NAs can barely keep the residents clean and dry and showers and activities of daily living (ADLS) were not getting done due to lack of staffing.</p> <p>A follow up interview with the DON on 12/22/13 at 4:56 PM revealed she was aware of the staffing complaint at the Resident Council meeting on 11/26/13 but she did not know what needs were not being met for residents due to staffing. The DON further stated she had not spoken to the residents about what needs were not being met by staff.</p> <p>5. Resident #7 was admitted to the facility on 01/17/09 with diagnoses of Alzheimer's disease, dementia, mood disorder and hypertension. The MDS dated 07/18/13 revealed Resident #7 was severely impaired for skills of daily decision making and had long and short term memory</p>	F 353			

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F 353	<p>Continued From page 21</p> <p>impairment. Resident #7 required extensive assistance for personal hygiene, toileting and bathing.</p> <p>Review of the care plan dated 07/29/13 revealed Resident #7 was at risk for falls and had a physical functioning deficit related to self care impairment with an intervention for staff to assist with activities of daily living.</p> <p>Review of the shower schedule revealed Resident #7 was scheduled to receive showers weekly on Tuesday and Thursday. Review of ADL documentation revealed Resident #2 received one shower a week the weeks of 11/7/13, 11/12/13, 11/18/13, 11/25/13, 12/05/13, and 12/09/13. There was no documentation stating Resident #2 had refused showers.</p> <p>A review of staffing assignments for 11/01/13 to 12/12/13 revealed 20 out of 42 days on 1st shift the shower team nurse aides (NAs) were pulled to work the floor to give each hall 3 NAs.</p> <p>A review of the Resident Council Meeting minutes dated 11/26/13 revealed a complaint had been made by 11 out of 11 residents present at the meeting for more NAs being needed because their needs were not being met. The action taken was Nursing Administration was actively recruiting for NAs. Three NAs were presently in orientation to be completed the week of 12/09/13. They were awaiting background checks on two other candidates.</p> <p>During an interview with NA #2 on 12/11/13 at 11:10 AM stated the NAs worked short staffed most days. NA #2 stated with 3 NAs plus the shower team the work could be done but when</p>	F 353			

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F 353	<p>Continued From page 22</p> <p>the shower team was pulled to be the 3rd NA it was almost impossible to complete all care such as shaving, oral care, making and changing beds plus showers.</p> <p>An interview with NA #6 (shower team) on 12/12/13 at 11:38 AM revealed she was scheduled to work Monday through Friday from 8:00 AM to 4:00 PM and was pulled to work a resident assignment approximately twice a week due to call outs and no shows. NA #6 stated she typically shaved residents and provided oral care with showers. The interview further revealed the east wing was supposed to have 4 NAs on 1st shift (7:00 AM to 3:00 PM) and the west wing was supposed to have 3 NAs plus a shower team aide on each wing. NA # 6 further stated there were days when there were only 2 NAs per wing and it was difficult to complete showers and provide residents with assistance with ADL.</p> <p>During an interview on 12/12/13 at 2:29 PM NA #1 stated he had been pulled from the shower team to work on the 200 hall due to call outs. NA #1 stated when there are only 3 NAs for the 200 hall it is impossible to get all of the care done. NA#1 stated he had been working 4 hours today and had made one round with his residents and he had 2 showers to give and rounds to start again for incontinence care. NA#1 further stated when he works as a NA on the floor with no shower team cleaning nails, brushing teeth and showers did not get done.</p> <p>During an interview with the Director of Nursing (DON) on 12/22/13 at 2:37 PM stated it was her expectation that all care should be provided to the resident and if certain areas were missed they should be reported for the next shift to do. The</p>	F 353			

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F 353	<p>Continued From page 23</p> <p>DON stated if there were call outs they did what they had to do to take care of the residents. The DON stated 6 NAs, 2 shower team NAs and 1 restorative NA should be the staffing for each hall on 1st shift 7 days a week. She reported staff was asked to work over or come in early and on 1st shift the shower team was pulled to work the floor if there were call outs.</p> <p>During an interview with Nurse #4 on 12/12/13 at 3:39 PM stated the NAs could not keep the residents clean and dry and showers and activities of daily living (ADLS) were not getting done due to lack of staffing.</p> <p>A follow up interview with the DON on 12/22/13 at 4:56 PM revealed she was aware of the staffing complaint at the Resident Council meeting on 11/26/13 but she did not know what needs were not being met for residents due to staffing. The DON further stated she had not spoken to the residents about what needs were not being met by staff.</p>	F 353			