STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to ensure 1 of 4 sampled residents was treated with dignity and respect (Resident #7). The findings included: Resident #7 was admitted to the facility on 05/06/14 with a diagnosis which included sepsis, pressure ulcer, diabetes and hypertension. . The annual Minimum Data Set (MDS) dated 08/11/14 indicated that Resident #7 was cognitively intact. The MDS further indicated Resident #7 required assistance from staff with transfers, bed mobility, toileting and bathing. The MDS also stated that personal preferences were very important to the resident. During an interview with Nurse Aide (NA) #1 on 09/11/14 at 2:36 pm she stated she had witnessed the social worker speaking harshly to Resident #7 and began packing up his belongings without asking his permission to do so. She further stated Resident #7 was crying and upset over the way the social worker had treated him. During an interview with Nurse #2 on 09/11/14 at	F 241	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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provision of federal/state laws require it. Criteria 1- Executive Director/ Director of Nursing Services/ Assistant Director of Nursing Services will monitor resident #7 to ensure residents respect of his individuality is honored weekly for the next 4 weeks and then monthly for 3 months. Executive Director/Director of Nursing/ Assistant Director of Nursing will ensure that resident #7 has a voice in subsequent cleaning and removal of personal items weekly for 4 weeks then monthly for 3 months. Criteria 2- 100% audit of alert	10/17/14

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

Electronically Signed | 10/03/2014

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F 241	Continued From page 1 2:48 PM he stated he entered Resident #7 ' s room to give him his medication and he was crying and upset. Resident #7 explained to him the social worker had been rude to him and had boxed up his belongings without his permission. Nurse #2 stated he did not hear the conversation but he saw the end result. During an interview with Resident #7 on 09/11/14 at 2:50 PM he stated the facility social worker made him feel " degraded " when she came into his room and began packing his belongings without his permission. He further stated that the social worker was rude and had a bad attitude when she came into the room. It upset him to the point of making him cry and he was not a person who cried. Resident #7 reported he did not say anything to the social worker at the time as he was sick and just wanted it to be over and have her out of his room. During an interview with the social worker on 09/12/14 at 9:30 AM reported she had spoke with Resident #7 regarding having to many belongings in his room prior to his hospitalization. After his return from the hospital the Social Worker reported she went to resident ' s room and told him she was going to clean out his belongings as it was unsanitary and unsafe. Social Worker further reported she had placed resident ' s belongings in a blue tote box and had called resident ' s family to come and pick it up. She further reported that she did throw some of Resident #7 ' s belongings away. The Social Worker revealed she went and apologized to Resident #7 the next day because a staff member told her Resident #7 had been upset. She further revealed she told Resident #7 she was not upset with him but was upset with staff	F 241	and oriented residents by Executive Director/Director of Nursing/Assistant Director of Nursing to ensure that no other resident has concerns regarding dignity and respect of individuality issues 1 time weekly for 4 weeks and then monthly for 3 months. In Addition, Executive Director/Director of Nursing/ Assistant Director of Nursing will ensure that residents have a voice in cleaning and removal of personal items weekly for 4 weeks then monthly for 3 months or as deemed necessary by QAPI Committe. Criteria 3- Executive Director/Director of Nursing or Assistant Director of Nursing to perform 100% employee in-service/education on dignity and respect of individuality to be completed by 10/17/14. Also, Executive Director/Director of Nursing Services or Assistant Director of Nursing Services will provide education to Social Worker on resident rights, dignity, and respect of individuality by 10/17/14 via Golden Living Learning Center and/or outside resources. Criteria 4- The data gathered from the monitoring systems mentioned above will be brought to the monthly QAPI meetings through December 2014 or until	

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F 241	Continued From page 2 for having not assisted him with cleaning up his room. During an interview with the Activities Director on 09/12/14 at 9:47 AM she stated she spoke to Resident #7 because he was crying and upset about the social worker being rude to him. The Activities Director explained Resident#7 informed her that the social worker had packed up his belongings without his permission there was too much clutter in his room. The Activities Director reported she spoke to Social Worker regarding Resident #7 being upset over her actions. During an interview with the Administrator on 09/12/14 at 10:01 AM revealed the social worker had given more of a directive to Resident #7 than a request and the situation with Resident #7 could have been handled better.	F 241	the QAPI Committee determines necessary. The QAPI Committee determines necessary. The QAPI Committee consists of: Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, Medical Director, MDS Director, Business Office Manager, Director of Social Service, Director of Activities, Director of Maintenance, Director of Dietary Services, Director of Admissions, and Director of Medical Records.	