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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DARTMOUTH	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

(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 246} SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to educate all staff on the use of a communication board and failed to utilize the care planned communication board for 1 of 1 sampled resident (Resident #80) reviewed for the use of a communication board. Findings included: Resident #80 was re-admitted to the facility on 01/17/15 with diagnoses which included cerebrovascular accident (stroke), diabetes, dementia, mood disorder, hypertension, and depression. Review of a care plan for Resident #80 dated 01/20/15 revealed the resident was non English speaking. The goal of making her needs known would be accomplished through a communication board that was kept in her bedside table. The care plan also indicated an interpreter would be used when needed. Review of the 4/14/15 Quarterly Minimum Data Set (MDS), revealed Resident #80 was usually understood and usually understands. Limited assistance was required with personal hygiene and extensive assistance was required with toilet use. Spanish was coded as the resident ' s preferred language.	{F 246}	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. This plan of correction is submitted as the facility's credible allegations of compliance. Criteria 1: Resident #80 was identified as a non-english speaking resident. As corrective action for this alleged deficient practice this resident has a communication board accessible to her and caregivers as of June 15, 2015. Criteria 2: An audit was conducted on June 15, 2015 of all facility residents by the Director of Nursing to determine if others may have the potential to be affected by this alleged deficient practice. All residents identified as non-english speaking have a communication board	7/9/15

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

Electronically Signed

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{F 246}	Continued From page 1 An observation was made on 6/15/15 at 4:00 PM. The resident was standing near the elevator. A staff member was trying to assist her back to the wheelchair. The staff member was using hand gestures to try to get the resident to sit in the wheelchair. The resident was staring at the staff member, but no response was given. There was no communication device observed. An observation was made on 6/16/15 at 9:10 AM. The resident was in bed asleep. A communication board with multiple pictures was seen on top of the resident ' s night stand. An interview was held with Nurse #1 on 6/16/15 at 9:12 AM. The nurse stated English was not the resident's primary language, but she could speak some English. She added along with some English spoken, the resident pointed to let staff know her needs. The nurse stated a communication board was used in the past, but was not currently being used. Nursing Assistant (NA) #1 was interviewed on 6/16/15 at 12:30 PM. NA #1 had been assigned to work with Resident #80 on the 7 to 3 shift. The NA stated Resident #80 spoke Spanish, but could understand English. She stated she did not use a communication board with the resident. The NA stated if Resident #80 was in pain, she could tell by looking at the resident's face. The NA stated she had received no recent training on using a communication board with Resident # 80. On 6/16/15 at 3:32 PM, NA #2 was interviewed. She had been assigned to care for Resident #80 on the 3-11 shift. NA #2 stated she communicated with Resident #80 using sign language which meant pointing at things she may need such as food, drink or use of the toilet. She stated sign language was used because NAs did not know how to speak the resident ' s language. The NA stated Resident #80 was able to	{F 246}	accessible to them and their caregivers as of June 15,2015. Criteria 3: An in-service training on the use of communication boards was completed on June 17, 2015 by the Director of Clinical Education. Caregivers were re-educated on the communication board and how to use it, proper times to use it and where it should be stored. Staff were required to return-demonstrate the retrieval and use of the communication board prior to being allowed to return to work. Care plans and care cards were updated to reflect communicating with these identified residents. Criteria 4: Random audits of at least 8 staff caregivers requiring return demonstration are conducted weekly for four weeks and reported to the QAPI Committee. The QAPI Committee will then determine required ongoing frequency of said monitoring.	

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{F 246}	Continued From page 2	{F 246}		

understand some English, but did not speak any English. The NA stated someone had told her there was a communication board, but she had not used the board. She added she had not been instructed on how to use the communication board for Resident 0.

Nurse #2 was interviewed at 3:36 PM on 6/16/15. The nurse stated she worked with Resident #80 during the 3 to 11 shift. The nurse added Resident #80 had papers in her dresser with pictures that described types of needs. She added she had recently been in-serviced by the Staff Development Coordinator (SDC) on use of the communication board. The nurse added the in-service had been provided to both nurses and NAs.

The SDC was interviewed on 6/16/15 at 4:15 PM. The SDC stated she had conducted a recent in-service for staff on use of a communication board. She stated the education included where to locate the communication board, how to use the board and which residents used a communication board. She stated communication boards were not just used for non-English speaking residents, but all residents with a communication problem. The in-service was provided for all staff, including nurses and NAs. She stated validation of competency was completed by asking staff if they knew how to use the board, asking residents that could speak a little English if the communication boards were used and making sure the boards were in resident ' s rooms. The SDC stated there had been no system in place to assure all staff were trained. Review of the sign in sheet for the in-service revealed all staff had not attended the communication board in-service.

On 6/16/15 at 5:11 PM, the Director of Nursing (DON) was interviewed. The DON stated the

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{F 246}	Continued From page 3 intent of communication board in-service was for 100% of the nursing staff to attend. Validation of competency in using the communication board included randomly asking staff if they were able to identify residents with a communication board and staff were able to show her the board. The DON stated there was no documentation of the random staff interviews. The DON stated she had seen staff using the communication board. She acknowledged she had not seen or interviewed Nurse #1, NA #1 or NA #2 about the use of the communication board.	{F 246}		
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	{F 279}		7/9/15

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{F 279}	Continued From page 4 by: 1. B Review of the May 2015 and June 2015 physician ' s orders indicated Resident #2 had an indwelling urinary catheter used to promote healing for a non-healing sacral pressure ulcer. Review of a 5/20/15 Significant Change in Status Minimum Data Set (MDS), indicated Resident #2 was cognitively intact. He was identified with an indwelling urinary catheter. The Care Area Assessment (CAA) indicated under the nature of the problem that the indwelling urinary catheter was used to promote wound healing. The CAA indicated urinary incontinence and the indwelling catheter would be addressed on the care plan. The overall objective would be to maintain current status and to minimize risks. Resident #2 ' s current care plan, which was reviewed in May 2015 did not include a problem of an indwelling urinary catheter, measurable goals that reflected the objective of the CAA or interventions to attain the goal. Nurse's notes for 6/10/15 at 8:17 AM indicated the MDS assessment was complete and the care plan had been updated to reflect the most recent issues. The MDS Coordinator was interviewed on 6/16/15 at 8:51 AM. She stated after the most recent recertification survey, there had been an audit of care plans using the last comprehensive MDS assessment as a guide. Anything that was checked " yes " for care plan on the CAA had been care planned. The MDS nurse produced and reviewed the CAA Audit worksheet for Resident #2. She had highlighted the area titled Catheter in pink which meant the area required addressing on the care plan. The MDS nurse stated if a resident had a catheter, then the catheter should be added to the care plan as a problem with goals and interventions. The MDS	{F 279}	Criteria 1: To accomplish corrective action for residents having been identified as affected by the alleged deficient practice, care plans for residents #2 and #60 were corrected immediately and updated to identify their needs based upon their clinical conditions. Criteria 2: To identify others who may have had the potential to be affected by the alleged deficient practice, an audit was conducted by the Regional Assessment Nurse and completed on June 26, 2015 of all resident care plans. The audit was tailored to the areas of catheters, palliative/hospice services, ostomies and wounds. Care plans were corrected to accurately reflect resident's individual care needs. Criteria 3: As a systemic change to assure the alleged deficient practice does not recur, a Continuing Education program of 1.5 hours was provided to both the Director of Resident Assessment and to the Resident Nurse Assessment Coordinator from "The Learning Center." This program covered the requirements contained in F279 and required a skills evaluation for completion. Criteria 4: To incorporate this corrective action into the facility's QAPI process, weekly random reviews of the residents care plans are presently conducted by the Regional Nurse Assessment Coordinator or the Director of Nursing Services. The results of such findings are communicated	

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{F 279}	Continued From page 5 nurse reviewed the care plan for Resident #2 and acknowledged there was no care plan for the catheter. She added there were so many assessments reviewed and opened for revision of the care plan, she thought Resident #2 ' s care plan was just missed. An interview was held with the Director of Nursing (DON) on 6/16/15 at 5:31 PM. She stated type of problems she expected to be care planned included indwelling urinary catheters. The DON stated the facility did have a corporate MDS nurse, but she was unsure if the corporate nurse had reviewed the MDS Coordinators audits and verified accuracy of the audits and assured all areas had been care planned as needed. 2. Resident #60 was admitted on 1/27/15 with diagnoses that included chronic pain, diabetes and chronic kidney disease. The resident's most recent Minimum Data Set (MDS), a quarterly dated 5/30/15, indicated the resident was severely cognitively impaired. He was identified as having 1-Stage III pressure ulcer measuring 0.5 centimeter (cm) x 0.9 cm x 0.3 cm with granulation tissue. Skin and Ulcer treatment included pressure reducing device for chair, bed, nutrition/hydration interventions to manage skin problems, pressure ulcer care and application of dressings. Review of Resident #60 ' s current care plan, reviewed in May 2015, indicated Resident #60 ' s pressure ulcer had not been addressed as a problem with measurable goals and interventions to attain the goal. The MDS Coordinator was interviewed on 6/16/15 at 8:51 AM. She stated after the most recent recertification survey, there had been an audit of care plans using the last comprehensive MDS assessment as a guide. Anything that was checked " yes " for care plan on the CAA had	{F 279}	to the Director of Resident Assessment with accompanying suggestions for correction whenever appropriate via e-mail, and reported to the QAPI committee at regular monthly meetings.	

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{F 279}	Continued From page 6 been care planned. The MDS nurse produced and reviewed the CAA Audit worksheet for Resident #60. The MDS nurse had highlighted the area titled Pressure Ulcer in pink which meant the area required addressing on the care plan. The MDS nurse stated if a resident had a pressure ulcer, then the pressure ulcer should be added to the care plan as a problem with goals and interventions. The MDS nurse reviewed the care plan for Resident #60 and acknowledged there was no care plan for his pressure ulcer. She added there were so many assessments reviewed and opened for revision of the care plan, she thought Resident #60 ' s care plan was just missed. An interview was held with the Director of Nursing (DON) on 6/16/15 at 5:31 PM. She stated type of problems she expected to be care planned included pressure ulcers. The DON stated the facility did have a corporate MDS nurse, but she was unsure if the corporate nurse had reviewed the MDS Coordinators audits and verified accuracy of the audits and assured all areas had been care planned as needed. Based on record reviews and staff interviews the facility failed to develop care plans that included measurable goals and individualized interventions for 2 of 3 residents (Residents # 2 and #60) reviewed for pressure ulcers and 1 of 1 resident reviewed with indwelling urinary catheters (Residents #2). The findings included: 1. A. Resident #2 was originally admitted to the facility on 04/29/03 and was readmitted to the facility on 05/13/15 with diagnoses of diabetes, hemiplegia, renal disease and peripheral vascular	{F 279}		

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{F 279}	Continued From page 7 disease. The most recent Minimum Data Set (MDS) dated 06/10/15 revealed Resident #32 was cognitively intact and had two stage 3 pressure ulcers to his sacrum. The MDS further stated Mr. Carter required extensive assistance for bed mobility and was totally dependent for transfers. The Care Area Assessment (CAA) dated 06/01/15 identified pressure ulcers would be care planned with the overall objective for wound improvement and to maintain the current functioning for Resident #2. Review of the care plan revealed an actual pressure ulcer with appropriate goals and interventions was not care planned but the potential for a pressure ulcer was care planned. An interview was conducted on 06/16/15 at 8:51 AM with the MDS Coordinator. She stated she developed Resident #2's care plan. The MDS Coordinator stated Resident #2's CAA triggered for pressure ulcers and pressure ulcers should have been care planned as an actual problem with goals for healing and resident centered interventions. An interview was conducted on 06/16/15 at 5:31 PM with the Director of Nursing (DON). She stated pressure wounds should be care planned with appropriated goals and interventions.	{F 279}		
{F 520} SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	{F 520}		7/9/15

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{F 520}	Continued From page 8 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in January 2014 and May 2015. This was for three recited deficiencies which were originally cited in May 2015 on a recertification and complaint investigation and again on the current recertification revisit survey. The deficiencies were in the areas of accommodation of needs, development of care plans and quality assessment and assurance. The facility's continued failure to implement and maintain procedures from a Quality Assessment and Assurance Committee, during two federal surveys of record, show a pattern of the facility's inability to sustain an effective Quality Assurance	{F 520}	Criteria 1: In order to accomplish corrective action for those residents found to be affected by the alleged deficient practice, specific plans of action and monitoring tools were created and will be monitored by the QAPI Committee according to the frequency and time frames set forth in those plans. As with previous alleged deficient practice, any monitoring and data will be reported to the QAPI Committee, continued according to their instruction until said committee deems it no longer necessary and reflected in the minutes of said meeting. Criteria 2: Due to its global systemic nature, an alleged ineffective QAPI program has the potential to affect all	

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{F 520}	Continued From page 9 Program. Findings included: This tag is cross referred to: 1 a. F246 Accommodation of Needs: Based on observations, staff interviews and record review, the facility failed to educate staff on the use of a communication board and failed to utilize the care planned communication board for 1 of 1 sampled resident (Resident #80) reviewed for the use of a communication board. During the May 2015 recertification survey and complaint investigation, the facility was cited for failure to accommodate a resident (Resident #80) whose primary language was not English in her ability to communicate needs. The facility was recited during the current recertification and complaint survey re-visit investigation for failing to utilize the communication board for a non-English speaking resident and failing to train the staff working with the resident on how to use the communication board (Resident #80). b. F 279: Development of Care Plans: Based on observations, staff interviews and review of facility records, the facility failed to development care plans for pressure ulcers for 2 residents (Resident #2 and Resident #60) and failed to develop a care plan for an indwelling urinary catheter for 1 resident (Resident #2). During the May 2015 recertification survey and complaint investigation, the facility was cited for develop care plans for act ivies of daily living, behavioral symptoms, falls, positioning to promote wound healing and urinary incontinence. On the current recertification and complaint investigation re-visit survey, the facility failed to develop care plans for 2 residents with pressure ulcers (Resident #2 and #60) and one resident requiring the use of an indwelling urinary catheter (Resident #2).	{F 520}	residents, thus corrective action is also directed at all residents by design. Criteria 3: As a systemic change to assure that the alleged deficient practice does not recur, the facility has restructured its QAPI program, assigned new "councils" to monitor and address key indicators of quality and adopted the use of a standardized monitoring grid as a guide for the meeting. Additionally, training on the QAPI process using guidance materials from Centers for Medicare and Medicaid Services was conducted for all members of the committee. Finally, the committee will meet monthly as opposed to the minimally required quarterly meeting. The first meeting post-training and following the new process was conducted on June 24, 2015. A special part of the meeting was dedicated to monitoring key issues identified during the survey process and said reporting is reflected in the minutes of the QAPI meeting. A special meeting of the QAPI Committee will be held on July 8 to review initial monitoring that was created specifically for the revisit plan of correction and assure compliance with F246 and F279. Criteria IV: To monitor its performance, the monthly minutes of the QAPI committee will be forwarded to the Field Services Clinical Director for critical review and comment.	

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{F 520}	Continued From page 10 c. F 520: Quality Assurance (QA): Based on observations, record reviews and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May 2015. This was for four recited deficiencies which were originally cited in May 2015 on a recertification and complaint investigation and again on the current recertification re-visit survey. The deficiencies were in accommodation of needs, supervision to prevent accidents, development of care plans and quality assessment and assurance. The facility's continued failure to implement and maintain procedures from a Quality Assessment and Assurance Committee, during two federal surveys of record, show a pattern of the facility's inability to sustain an effective Quality Assurance Program. During the May 2015 recertification survey and complaint investigation, the facility was cited for failure to have an effective QA program to for failure to implement and maintain an effective QA program regarding 4 repeat deficiencies in the areas of accommodation of needs, accidents, development of care plans and QA during two federal surveys of record. During an interview with the Administrator on 6/16/15 at 6:27 PM, he stated the facility ' s QA committee met on 5/27/15. He stated the development of care plans, accommodation of needs and the QA process were not discussed. The Administrator stated the deficiencies from the May 2015 recertification and complaint investigation survey were not discussed because the care plan had not been finalized and monitoring tools had not been placed. The plan, he stated, was to discuss the issues at the QA	{F 520}		

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{F 520}	Continued From page 11 meeting slated for 6/24/15. At that time, monitoring tools and audits will be discussed.	{F 520}		