STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING ______ B. WING ______	C 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENDERSONVILLE	1510 HEBRON STREET HENDERSONVILLE, NC 28739

(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 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	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 provisions of federal and state law.	
		F225	Residents #1, #16, and #137's abuse investigations were reviewed by the Administrator. There were no negative outcomes related to the tardiness of reporting. The Administrator audited all remaining abuse investigations during the last 12 months. No other residents have been identified as having negative outcomes related to tardy reporting. The Administrator and Director of Nursing were educated by the Area Vice President of Golden Living on the state regulations of reporting and investigation of abuse allegations.	12/18/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Executive Director | TITLE | (X6) DATE 10/11/15

Received DEC 14 2015 by: PAM

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.

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of abuse investigations and staff interviews the facility failed to submit 3 of 3 abuse allegation investigations to the State agency in the required time frame. (Residents #1, #16 and #137) The findings included: The facility abuse policy dated 01/15/15 included the following: Any employee who suspects an alleged violation immediately notifies the Executive Director, or designee. The Executive Director notifies the appropriate state agency in accordance with state law. The results of all investigations are reported to the Executive Director or designee and to the appropriate state agency, as required by state law, within five working days of the alleged violation. 1. Review of a 24 hour abuse investigation for Resident #1 noted an investigation was initiated on 07/10/15. The 24 hour investigation initiated on 07/10/15 was transmitted to the State agency on 07/13/15. Documentation included with the investigation noted attempts had been made to transmit the investigation 4 times on 07/10/15 and 6 times on 07/11/15 but the transmission had failed. On 11/20/15 at 3:30 PM the administrator and Director of Nursing (DON) stated they coordinate abuse investigations to ensure they are complete and submitted within the required time frames. The DON stated she was unaware the 24 hour investigation had to be reported within 24 hours and that attempts had been made to submit the	F 225	The Regional Field Service Consultant or designee will audit all abuse allegations, 24 hour reports, and 5 day working reports for 3 months. The results of the audits will be presented at the monthly QAPI meeting by the Administrator or designee and reviewed by the QAPI committee monthly for 3 months.	12/18/15

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F 225	Continued From page 2 investigation on 07/10/15 and 07/11/15. The administrator stated she was on leave at the time of the investigation and was unaware the 24 hour report had not been submitted in the required time frame. 2. Review of 24 hour abuse investigation involving Resident #137 noted an investigation was initiated 09/19/15. The 24 hour investigation was transmitted to the State agency on 09/23/15 and the 5 day investigation was transmitted on 09/26/15. On 11/20/15 at 3:30 PM the administrator and Director of Nursing stated they coordinate abuse investigations to ensure they are complete and submitted within the required time frames. The administrator and Director of Nursing could not explain why the 24 hour investigation was not submitted by 09/20/15 and the 5 day investigation was not submitted by 09/25/15. 3. Review of a 24 hour abuse investigation involving Resident #16 noted an investigation was initiated on 05/17/15. The 24 hour investigation was transmitted to the State agency on 05/18/15 and the 5 day report was transmitted on 05/26/15. On 11/20/15 at 3:30 PM the administrator and Director of Nursing stated they coordinate abuse investigations to ensure they are complete and submitted within the required time frames. The administrator and Director of Nursing could not explain why the 5 working day investigation was not submitted by 05/25/15.	F 225		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	No residents in the Alzheimer's Care Unit came into contact or	12/18/15

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F 323	Continued From page 3 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to secure hazardous chemicals out of the reach of cognitively impaired residents on the Alzheimer's Care Unit and failed to apply a bed alarm to a resident with a history of falls and recent hip fracture (Resident # 131). Findings included: 1. An observation on 11/20/15 of the cupboards in the dining area of the Alzheimer's Care Unit at 9:15 AM revealed a spray bottle of disinfectant within reach of cognitively impaired residents. There were cognitively impaired residents in the dining area at the time of the observation. A Social Service staff had been present, and verified the bottle of disinfectant should not have been kept in an unlocked cupboard within reach of cognitively impaired residents. The Social Service staff member removed the bottle out of the cupboard, and went to find the Alzheimer's Care Unit Director. Further observation revealed a locked storage closet that had been left open, and contained 1 bottle of neutral spray cleaner, 1 bottle of bathroom disinfectant cleaner, 1 bottle of epi-clean alcohol hand sanitizer, and 1 aerosol can of spray disinfectant. An interview with the Alzheimer's Care Unit Director on 11/20/15 at 9:17 AM verified	F 323	were affected by containers of chemicals. All containers containing hazardous chemicals were removed from the Alzheimer's Care Unit. All staff will be re-educated on Golden Living Center's policy for storage of chemicals in the healthcare center. An audit of the presence of chemical containers in the Alzheimer's Care Unit will be performed by the Alzheimer's Care Director or designee 5 days a week for 1 month, then he/she will audit 1 day a week for 2 months. The results of the audits will be presented at the monthly QAPI meeting by the Alzheimer's Care Director or designee and reviewed by the QAPI committee monthly for 3 months. Resident #131 was given a bed alarm immediately upon identification of missing alarm. The resident was sent to the hospital for an evaluation and returned to (cont'd)	12/18/15

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F 323	Continued From page 4 chemicals should not have been stored in an unlocked cupboard or closet within reach of cognitively impaired residents. An interview with the Housekeeping Director on 11/20/15 at 11:40 AM revealed chemicals were not to be stored in the Alzheimer's Care Unit. He stated the chemicals are to be stored on the housekeeping carts and locked up, off the Alzheimer's Care Unit. An interview with the Administrator on 11/20/15 at 11:45 AM revealed her expectations of chemical storage on the Alzheimer's Care Unit would be: If there were any chemicals, they would be locked and free from the ability of Alzheimer's Care Unit residents to get a hold of chemicals. 2. Resident #131 was admitted to the facility 10/12/15 with diagnoses which included dementia, acute pain, hypertension and adjustment disorder with anxiety. The admission care plan dated 10/13/15 for Resident #131 included the problem area, At risk for falls related to wandering, use of medication and new environment. The care plan included approaches which included: -call light or personal items available and in easy reach -chair alarm -footwear to prevent slipping when out of bed -observe for side effects of medications every shift -orientation to new room as needed -therapy referral -staff to ensure resident is appropriately positioned in bed (added 11/02/15)	F 323	the facility with no injuries. An audit was performed by the Director of Nursing for all residents in the healthcare center who require bed and chair alarms. No other residents were identified without alarms in place. The nursing staff will be re-educated on ensuring that appropriate fall interventions are in place, including bed alarms. The Director of Nursing or Designee will audit 5 residents who have bed alarms to ensure they are in place 3 times per week for 1 month, then 5 residents weekly for 2 months. The results of the audits will be presented at the monthly QAPI meeting by the Director of Nursing or designee and reviewed by the QAPI committee monthly for 3 months.	12/18/15

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F 323	Continued From page 5 -medication review by nurse practitioner, continue working with therapy notification, labs as ordered (added 11/03/15) -bed alarm, falls mat (added 11/11/15) -room change made off the dementia unit (added 11/11/15) -during periods of increased alertness, keep resident in areas of increased supervision (added 11/14/15) The nursing assistant care guide for Resident #131 included the need for a bed and chair alarm. Review of nurses notes in the medical record of Resident #131 included the following: 10/15/15-Resident moved to dementia unit due to wandering behaviors. 10/19/15-Resident assessed with severe cognitive impairment. 11/07/15-Resident refused to get out of bed and complained of right hip pain. Sent to the hospital for treatment and evaluation. Call from hospital noting resident had a right hip fracture and would be admitted for surgical repair. Resident #131 was readmitted to the facility 11/11/15. Review of the medical record noted Resident #131 had multiple falls after admission which included: 11/02/15-fall out of bed without injury 11/03/15-2 falls without injury. One fall was out of bed and the other fall while ambulating. 11/11/15-fall out of bed without injury 11/14/15-2 falls out of bed without injury Resident #131 was observed during the five days of the recertification survey. These observations included: 11/18/15 9:30 AM Resident #131 was observed	F 323		

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F 323	Continued From page 6	F 323		

in her bed which was in a low position. A bed was in place and an alarm was in place on the bed.
11/18/15 11:30 AM Resident #131 was in a wheelchair. An alarm pad was in place in the wheelchair.
11/18/15 12:00 PM-1:00 PM Resident #131 ate lunch in the main dining room seated in her wheelchair with an alarm pad in place.
11/18/15 1:45 PM Resident #131 was seated in the wheelchair, at the nurses station, with an alarm pad in place in the seat of the wheelchair.
11/18/15 3:20 PM Resident #131 was in her room, in a low bed, with a mat beside the bed. The bed alarm was not in place. The alarm was observed in the seat of the wheelchair.
11/18/15 3:40 PM Resident #131 was laying on the floor, in the room, with her body off the mat, beside the bed. An alarm was not sounding because it had not been put in place. Staff was immediately informed and responded to the room of Resident #131.

On 11/18/15 at 3:45 PM the nurse responsible for Resident #131 stated she and a therapist assisted Resident #131 to bed around 3:00 PM. The nurse stated she was not aware an alarm was supposed to be in place when Resident #131 was in bed. On 11/18/15 at 4:00 PM the therapist that assisted to transfer Resident #131 to bed stated he was asked to provide assistance with the transfer by the nurse of Resident #131 and assumed the nurse knew individual care needs, including the alarm. On 11/18/15 at 4:15 PM the Director of Nursing verified the alarm should have been in place on the bed of Resident #131. The Director of Nursing stated she expected nursing staff to be aware of individual resident needs; including the use of alarms. On 11/19/15 at 8:50

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F 323	Continued From page 7 AM the administrator stated she expected nurses to be aware of resident care needs, which included the use of alarms. The administrator stated the nurse should have been aware of the need of the alarm for Resident #131 since she routinely worked with the resident. The administrator stated Resident #131 was sent to the hospital for an evaluation after the fall 11/18/15 and returned to the facility with no injuries.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431	Resident # 47's Haldol was disposed of upon identification of no opened date. The expired Lidocaine and liquid Tylenol were disposed of immediately. All medication carts were audited by the Director of Nursing. No additional expired, undated, or unlabeled medications or were identified. Licensed nurses and medication aides will be re-educated on Golden Living Center's policy of destruction/ removal of expired medications and the labeling of multi-dose injectable medications by the Director of Nursing or designee. All medication carts will be audited by the Director of Nursing or (cont'd)	12/18/15

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F 431	Continued From page 8 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review the facility failed to remove expired over the counter (OTC) medications from 1 of 5 medication carts (East Wing Medication Cart # 2) and failed to remove 2 opened, multi-dose vials of injectable medications by the "use by date" from 1 of 5 medication carts (East Wing Medication Cart # 3). The findings included: Review of the facility's medication storage guidelines titled "Recommended Minimum Medication Storage Parameters: Injectable Medications" read in part: "Multiple-Dose Vials for Injection - Date when opened and discard unused portion after 28 days or in accordance with manufacturer's recommendations." 1. Inspection of the East Wing Medication Cart #1 on 11/20/15 at 11:45 AM revealed an opened 16 ounce bottle of acetaminophen liquid 160 milligrams/5 milliliters that was almost full with an expiration date of July 2015. An interview with Medication Aide #1 on 11/20/15 at 11:54 AM revealed any nurse or medication aide who administered medications from the	F 431	designee once a week for 1 month, then once a month x 2 months. The results of the audits will be presented by the Director of Nursing or designee at the monthly QAPI meeting and reviewed by the QAPI committee monthly for 3 months.	12/18/15

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F 431	Continued From page 9	F 431		

medication cart was responsible for checking the cart for expired medications and for discarding any expired medications.

An interview on 11/20/15 at 2:38 PM with the Director of Nursing (DON) revealed she expected any nurse or medication aide giving medications out of a medication cart to check for expired medications and to dispose of them.

An interview on 11/20/15 at 3:03 PM with the Administrator revealed she expected expired medications to be removed from the medication cart. The Administrator stated it was the responsibility of any nurse or medication aide giving medications out of a medication cart to check for expired medications and to dispose of them.

2. Inspection of the East Wing Medication Cart #3 revealed an opened 20 milliliter(ml) bottle of 1% Injectable Lidocaine with approximately 8 ml solution remaining in the bottle with a date opened label of 10/02/15. Also, in the same medication cart was an opened 10 ml bottle of injectabl Haldol labeled for Resident # 47. The bottle was not labeled with the date it was opened; the pharmacy label indicated it was dispensed on 08/12/15.

An interview on 11/20/15 at 2:30 PM with Medication Aide #2 revealed she thought the facility policy was to discard any unused solution from a multi-dose vial 30 days after opening.

An interview on 11/20/15 at 2:38 PM with the Director of Nursing (DON) revealed the facility policy for multi-dose vials of injectable medication was to label the medication when it was opened

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F 431	Continued From page 10 and to discard any unused portion 28 days after opening. The DON stated she expected any nurse or medication aide giving medications out of a medication cart to check for expired medications and to dispose of them. An interview on 11/20/15 at 3:03 PM with the Administrator revealed she expected multi-dose vials of medications to be dated when opened and for any unused portion to be discarded according to facility policy. The Administrator stated expired medications should be removed from the medication cart. The Administrator stated it was the responsibility of any nurse or medication aide giving medications out of a medication cart to check for expired medications and to dispose of them.	F 431		
F 520 SS=E	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. 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	F 520	Refer to F431 for compliance, monitoring, and auditing and the QAPI process for resident #47. The Regional Field Services Clinical Consultant or designee will re-educate the QAPI committee on Golden Living's QAPI policies and on identifying issues, systems, root cause analysis, and the implementation of the plan of correction. The Regional Field Services Clinical Consultant or designee will audit all QAPI meeting minutes for 6 months.	12/18/15

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F 520	Continued From page 11	F 520		

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 interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place October 2014. This was for one recited deficiency which was originally cited in October 2014 on the recertification investigation. The deficiency was in the area of medication storage. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program.
(Residents #40)

The findings included:

This tag is cross referred to:

F431: Medication Storage: Based on observations, staff interview and record review the facility failed to remove expired over the counter (OTC) medications from 1 of 5 medication carts (East Wing Medication Cart # 2) and failed to remove 2 opened, multi-dose vials of injectable medications by the "use by date" from 1 of 5 medication carts (East Wing Medication Cart # 3).

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENDERSONVILLE	1510 HEBRON STREET HENDERSONVILLE, NC 28739

(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 520	Continued From page 12 During the recertification survey of October 2014 the facility was cited for failure to remove expired medications from 4 of 5 medication carts. On 11/20/15 at 5:25 PM the Administrator stated the facility had been auditing medication storage with the expectation nurses and medication techs were checking every shift for outdated medications. The administrator stated nurse managers had been doing random monthly audits and they felt the issue had been resolved and, for that reason, it was no longer a part of the quality assurance program.	F 520		