PRINTED: 08/02/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		345010	B. WING _			05/	/20/2016
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
001.0511	INVINOCENTED ACUE			5	500 BEAVERDAM ROAD		
GOLDEN LIVINGCENTER - ASHEVILLE			A	ASHEVILLE, NC 28804			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG			PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
					DEFICIENCY)		
F 000	INITIAL COMMENTS		E (	000			
F 000	INITIAL COMMENTS			JUU			
	An amended Stateme	ent of Deficiencies was					
	provided to the facility	y on 07/25/16 related to the					
	I .	I Dispute Resolution (IDR)					
		nel decision was as follows:					
	· •	ith a decreased scope and					
	, -	314 was upheld with a					
		I severity of level D. F329 as upheld with a decreased					
	scope and severity of						
		10101 2.					
		R decision. On 07/22/16 the					
	results of the CMS re	•					
F 224	decision as stated. E 483.13(c) PROHIBIT	vent iD #KBVVV II.	F 22				6/24/16
SS=D		GLECT/MISAPPROPRIATN	Γ 2	224			0/24/10
33-0	MICTALIAMENTIAL	SEED TAMIOTAL TROP RATIO					
	_	elop and implement written					
	policies and procedur	es that prohibit t, and abuse of residents					
	and misappropriation						
		o co.co p. opoy.					
		is not met as evidenced					
	by:						
		ns, record review, resident,			Preparation and/or execution of this pl	an	
	and staff interviews the incontinence care and	ne facility failed to provide			of correction does not constitute	or of	
		who required extensive			admission or agreement by the provide the truth of facts alleged or the	л ОГ	
	I .	o have a wound vacuum			conclusions set forth in the statement of	of	
		y acquired pressure sores			deficiencies. The plan of correction is		
	for 1 of 1 residents re				prepared and/or executed solely becau	ıse	
	(Resident #40).	-			it is required by provisions of federal ar		
	The findings in study a				state law.		
	The findings included						
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	1		TITLE		(X6) DATE

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.

**Electronically Signed** 

06/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345010	B. WING			C 05/20/2016	
NAME OF P	ROVIDER OR SUPPLIER	0.00.0	<del></del>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	05/	20/2016
NAME OF T	NOVIDER OR SOLT EIER						
GOLDEN	LIVINGCENTER - ASHE\	/ILLE			00 BEAVERDAM ROAD		
			Α	SHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 224	Continued From page	e 1	F 2	224			'
	Resident #40 was init	ially admitted to the facility re-admitted on 03/27/15 included paraplegia,			F 224 PROHIBIT MISTREATMENT/NEGLECT/MISAPPE PRIATE PROPERTY  Golden Living Center - Asheville	RO	
	Set (MDS) dated 04/0 was cognitively intact The MDS also indicate extensive physical as activities of daily living mobility, transfers, draws as the set of the set o				<ul> <li>(GLC-Asheville) has developed and implemented policies and procedures to prohibit mistreatment, neglect, and about of residents and misappropriation of resident property.</li> <li>The corrective action accomplisher for Resident #40 is the resident current has a subpubic catheter and colostomy therefore, does not require assistance</li> </ul>	ise d ily	
	personal hygiene, and was totally dependent on staff for bathing. Further review of the MDS indicated under Section E titled Behavior Resident #40 was coded to have no documented behaviors or rejection of care.				with toileting; however, he/she is check every shift and/or as needed for cathet and/or colostomy care. This was completed as of May 20,2016. Reside #40 and with his permission his family	er	
	A review of an update 04/04/16 indicated a for further breakdown present and the resid off-loading of the wou pressure sore would and the interventions			were asked about his care as it relates to the allegation he did not receive incontinence care and when it occurred. This was so the facility could do an appropriate investigation and grievance/concern according to facility policies and procedures. Completed as of			
	incontinent episodes, and position side to s observed not off-load reposition off sacral at On 05/16/16 at 11:05 interviewed and aske toileting and the resid got the colostomy I w and have even laid at	thorough skin care after apply barrier cream, turn ide, and should resident be ing sacrum remind him to rea.  AM Resident #40 was d if staff helped him with lent answered, "No, before I ould lay in feces for hours			June 17, 2016.  2. Residents who have been identified by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads, their assistants, and Unit Manager/Coordinator) to have the potential to be affected are those residents who required to be turned, repositioned, who require extensive assistance, and who also use a wound vacuum dressing (a wound dressing us		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			
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NAME OF D	ROVIDER OR SUPPLIER	0.100.10	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	05/20/2016
NAME OF FI	NOVIDER OR SUFFLIER				
GOLDEN	LIVINGCENTER - ASHEV	ILLE .		500 BEAVERDAM ROAD	
			ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 224	Continued From page	2	F 22	24	
	small area and having	g to lay for hours in feces is		negative pressure to promote heali	ng).
	_	worse. I know my wound is		Presently, the facility does not have	
	_	ut I believe the reason I had		residents who required to be turned	-
	•	is because they did not		repositioned, who require extensive	
	keep me clean." The			assistance, and who also use a wo	
	obtained the coloston	ny around 03/23/16. He		vacuum dressing. When the facility	
	further indicated the v	vound vacuum (a wound		resident, the facility will monitor the	ir
	dressing using negati	ve pressure to promote		bowel and bladder tracking for thre	e days
	healing) were not cha	nged 3 times a week as it		to determine when the resident is	
	was ordered by the wound physician. The resident also indicated he had an appointment			requiring incontinent care; wound v	acuum
				physician orders will be followed; a	
		morrow" 06/17/16 and that		nursing staff will monitor Nursing A	
		rse #1) had already removed		(NA) documentation to determine t	/pe of
		nd had placed a wet to dry		assistance required for turning and	
		sacral wound until after his		repositioning.	
	appointment on Tueso	day, 05/17/16.		3. The measures put in place or	
				systemic changes made are: Nursi	ng
	Resident #40 was see			Staff were educated on resident	
		ound physician on 05/17/16		incontinence care, turning and	
		he facility around 11:30 AM.		repositioning by the DNS and Assis	
		ng up in his bed at a 45		Director of Nursing Services (ADNS	
		ted he was waiting on his		various times from June 3, 2016 to	
		cuum was observed to not		9,2016. Nurses who care for resid	
	be in place or turned	on.		who have wound vacuum dressing	
	Decident #40 was ab	nominal on 05/17/16 of 12:20		re-inseviced on how to apply dress	-
		served on 05/17/16 at 12:30 ed at a 45 degree angle		and the operation of wound vacuur system by qualified staff such as W	
				Care Nurse Specialist on June 9, 2	
		stated his appointment had und physician had advised		All new nursing staff will be educate	
		place the wound vacuum		how to apply dressings and the ope	
		e had returned to the facility.		of wound vacuum system, turning a	
		vas observed to not be in		repositioning by WebEx, training se	
	place or turned on.			or one on one in-servicing. A moni	
	p.acc of tarriod off.			tool that includes turning, reposition	-
	On 05/17/16 at 2:00 F	PM NA #6 was interviewed.		and checking the wound vacuum d	
		vas unaware of Resident #40		is intact and operating properly. The	
		t he was always pleasant		monitoring tool will be completed every	
	_	are which was provided to		two hours for four weeks by the Ch	
		NAs did the best they could		Nurse and Nursing Assistants; che	9

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345010	B. WING		C <b>05/20/2016</b>	
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	1 03:20:20	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 224	resident care needs we stated Resident #40 we repositioned as he was resident's minimal cap himself off of his butto would rarely go into Fe he pushed his call light.  Resident #40 was obe PM lying on his right to The wound vacuum we place.  On 05/17/16 at 4:47 Fe NA #2 reported the resolution of the pushed his call light.  On 05/17/16 at 4:47 Fe NA #2 reported the resolution of the pushed his capable of himself off of his butto being short staffed she resident as she was sepushed his call light.  Resident #40 was obe PM sitting up in his bealert, and awake with stated he was waiting if the wound vacuum the resident stated "Nit to be put back on anyet." The wound vacuum the resident stated "Nit to be put back on anyet." The wound vacuum obs/17/16 read in part wound care as ordered cleanse wound and separate wound separate wound separate wound and separate wound separate wound and separate wound sep	being short staffed the vere not met. NA #6 further was not turned and as supposed to be due to the pability to turn and reposition ocks. NA #6 reported she desident #40's room unless and for assistance.  Served on 05/17/16 at 3:30 side with his eyes closed. Was observed to not be in a served on 05/17/16 at 3:30 side with his eyes closed. Was observed to not be in a served on 05/17/16 at 3:30 side with his eyes closed. Was observed to not be in a served on 05/17/16 at 3:30 side with his eyes closed. Was observed to not be in a served on 05/17/16 at 5:00 side of the supposed to unless he served on 05/17/16 at 5:00 served on 05/17/16 at 3:30 served on 05/17/16 at	F 22-	every shift for the following four wee and then daily the following four wee 4. GLC-Asheville will monitor the corrective plan to ensure the practic corrected and will not reoccur is The Manger/Coordinator and/or Manage the Day will check to ensure the monitoring tool is complete. This wi completed daily for four weeks, five a week for the next four weeks and days a week for the following four w The monitoring tools will be present the ED and/or DNS at Morning/Stand-Down Meetings. Th will report the findings of the reviews Quality Assurance Performance Improvement Committee (QAPIC). QAPIC will review and analyze for patterns and trends. The QAPIC wievaluate the results and implement additional interventions as needed the ensure continued compliance.  5. The correction date for substant compliance is June 24, 2016.	eks. ee was ee Unit er of  II be days three eeks. eed to ee ED s to  The  II	

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345010	B. WING		C <b>05/20/2016</b>		
	ROVIDER OR SUPPLIER	EVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	03/20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 224	125 mmHg (millime pressure 3 times a indicated "Please le and transport with v resident off of back  A review of the nurs had documented or which read in part rappointment today. vacuum therapy reciplace after appointr begin tomorrow for dressing change.  A review of the trea (TAR) dated for Ma Wound Care: One to GranuFoam with wo Mon/Wed/Fri dated discontinue date of by her initials that sorder as written.  A follow-up interview Resident #40 on 05 #40 stated the woulhim to have the stat on upon his arrival.	coam, and wound vacuum to ters of mercury) negative week. Further instructions eave wound vacuum in place wound vacuum and keep."  se's notes revealed Nurse #1 in 05/17/16 at 5:54 PM an entry esident went to wound care. Orders to continue wound seived. Wet to dry dressing in ment and vacuum therapy to Monday/Wednesday/Friday.  It went administration record by 2016 indicated the following: ime order to use silver bound vacuum therapy 05/17/16 at 11:59 PM and a 05/18/16. Nurse #5 indicated the had followed the one time.  It was conducted with was conducted with 1/18/16 at 9:20 AM. Resident and physician had instructed if put the wound vacuum back back to the facility. Resident	F 22				
	placed back on unti by the 7:00 PM to 7 indicated he had as wound vacuum beir was when the dress wound vacuum was #40 stated "I do not	ne wound vacuum was not I late Tuesday night 05/17/16 :00 AM nurse. Resident #40 ked Nurse #5 about the ng put back on and at that time sing was changed and the s placed back on. Resident think they would have put it of told them to do it and I had					

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		345010	B. WING_			C <b>5/20/2016</b>	
	NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - ASHEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	•	5/20/2016	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 224	The resident further sme unless I push my when to change my deverything because to room." Resident #40 forget to stay off of his would begin to hurt of further stated he had and repositioning should be statention.  A telephone interview at 11:45 AM with Nur Resident #40 had as to have his wound variether stated she was physician orders so sorder to use the Grarplace the wound vacuum was not place the wound vacuum was not place the understanding the went out of the facility wound vacuum was supon his return. Nurse was short staffed and wound vacuum dress was the first opportuncenfirmed the wound from the beginning of 11:45 PM at which tird dressing was applied Resident #40 was wi	efore it was actually done." stated "they never check on call light. I have to tell them	F 2	24			

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		345010	B. WING			C <b>05/20/2016</b>		
NAME OF P	ROVIDER OR SUPPLIER	0.00.0		S	TREET ADDRESS, CITY, STATE, ZIP CODE	05/	120/2016	
TO UNE OF T	NOVIDEN ON OUT FIEN				00 BEAVERDAM ROAD			
GOLDEN	LIVINGCENTER - ASH	HEVILLE			SHEVILLE, NC 28804			
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(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 224	Continued From pa	age 6	F	224				
	On 05/19/19 at 8:4	5 AM a telephone interview						
		h the wound physician. He						
		ave expected the facility staff to						
		wound vacuum upon the						
		the facility. He confirmed his						
	order dated 05/17/	16 did not specifically indicate						
	when the wound va	acuum was to be re-started but						
		umption that the re-starting of						
		n would be an "automatic given						
		tant part of the wound healing						
		esident being able to advise the						
		sician and resident)						
		wound physician was unable						
	1	esident have been kept clean						
		s always complainant in						
		ack/buttock area that the r would not have been needed.						
	Colosionly would o	would not have been needed.						
	On 05/20/16 at 2:4	5 PM an interview was						
		rse #1. Nurse #1 confirmed						
		e the dressing or place the						
		essing for Resident #40 on						
		after he had returned to the						
	•	ound physician's appointment.						
	Nurse #1 stated "I	did not continue to wound						
	vacuum because t	he resident stayed up too						
	long." Nurse #1 fur	ther stated "I do not remember						
	why the resident's	wound vacuum was not put						
		e my days mixed up between						
		on Tuesday and Thursday."						
		d she had removed the wound						
		on Monday, 05/16/16 in order						
		go out of the facility on						
		for his wound physician						
		e #1 also confirmed that Nurse						
		wound vacuum dressing on						
		night. Nurse #1 reported she						
		or completed any treatments						
	according to the pl	nysician's orders from Monday						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	1 03.20.20.10	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 242 SS=E	she had not been into than on those 2 days. Resident #40's wound around 10:00 AM on not placed back on the area until Nurse #5 redressing on 05/17/16 had no wound vacuur approximately 38 hout 483.15(b) SELF-DET MAKE CHOICES  The resident has the schedules, and health her interests, assessinteract with members inside and outside the about aspects of his care significant to the interest of the series of the	obs/20/16. She further stated the resident's room other Nurse #1 confirmed divacuum was removed Monday, 05/16/16 and was e resident's sacral wound eplaced the wound vacuum at 11:45 PM, Resident #40 m dressing in place for rs.  ERMINATION - RIGHT TO right to choose activities, and care consistent with his or ments, and plans of care; so of the community both efacility; and make choices or her life in the facility that resident.  This not met as evidenced and, record review, resident, we facility failed to honor a the number of showers in a cents who were reviewed for 40, #34, #49, and #14).  Einitially admitted to the and was re-admitted on sees which included	F 24:		t to th ed eer	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION	\ , ,	(X3) DATE SURVEY COMPLETED	
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		345010 B. WIN				-	
NAME OF D	ROVIDER OR SUPPLIER	343010	5:	STREET ADDRESS, CITY, STATE, ZIP COD		20/2016	
NAME OF PI	ROVIDER OR SUPPLIER				, C		
GOLDEN	LIVINGCENTER - ASI	IEVILLE		500 BEAVERDAM ROAD			
				ASHEVILLE, NC 28804			
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F 242	Continued From page	age 8	F 2	242			
F 242	A review of a significate (MDS) dated 0 was cognitively into The MDS also indificate extensive assistant for bed mobility, trapersonal hygiene a staff for bathing. For revealed under Set #40 was coded to behaviors and under Customary Routhat the choice of simportant to Resid A review of a document also indicated Resident full bed bath at least also indicated Resident full bed bath at least shower on 12/21/105/09/16. The Direct they had a lot of a geometry and there was regarding having proposed and there was regarding having proposed and they have a review of a nurse of 5/14/16 for Residinformation was incompleted.	ficant change Minimum Data 14/01/16 indicated Resident #40 15 act for daily decision making. 16 cated Resident #40 required 17 cated Resident #40 required 18 ce of 2 person physical assist 18 cansfers, dressing, toileting, and 18 and was totally dependent on 18 curther review of the MDS 18 ction E titled Behavior Resident 18 chave no rejection of care type 18 er Section F titled Preferences 18 chowers and baths was coded 18 chowers and baths was very 18 ent #40. 18 ment titled "Bathing Type Detail 18 chowers and baths was very 18 ent #40 was receiving a partial to 18 ct 2 times a week. The report 18 ct 2 times a week. The report 19 ctor of Nursing (DON) clarified 18 cycles a general lack of education 19 casswords to document 10 elt confident residents were 10 east 2 times a week or anytime	F 2	completed to allow these resi obtain showers at their prefer was completed on May 25, 26.  Residents who have been by the Executive Director ((El Administrator), Director of Nu Services (DNS), and Leaders (comprised of Department Heatheir assistants, and Unit Manager/Coordinator) to have potential to be affected are the residents who are cognitive in decision making. The resident identified again asked by the Manager/Coordinator their sheat preferences and new shower was completed to allow these obtain showers at their preference rewidents will be asked at their shower schedule. This we completed on May 25, 2016. Schedules will be updated que the residents' assessment/cacycle.  The measures put in place systemic changes made are: Staff and Leadership Team has re-inserviced and new employed educated on the importance of having the opportunity right to activities, schedules, and heat consistent with his/her interest assessments, and plans of called the complete of the consistent with his/her interest assessments, and plans of called the called the consistent with his/her interest assessments, and plans of called the called the consistent with his/her interest assessments, and plans of called the called the consistent with his/her interest assessments, and plans of called the call	rence. This 2016. In identified D) Irsing Iship Team Is		
	asked about his pr been told he would	eference for showers but had I get 2 showers per week. If the nurse aides don't have		who are cognitive intact for damaking if they are receiving saccording to their preference.	aily decision howers		

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		345010	B. WING				20/2016
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOI DEN	LIVINGCENTER - ASHE	VILLE		50	00 BEAVERDAM ROAD		
COLDEIN	EN NOOENTER - AONE	VILLE		Α	SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242	enough time to get the there is not enough such there is not enough such at 8:45 AM with Resi wanted a shower 3 till Wednesday, and Frivacuum (a wound drivacuum (a w	was conducted on 05/20/16 dent #40. He indicated he mes a week on Monday, day before his wound essing using negative healing) and dressing to the sacral area. He stated or on Monday 05/09/16 and one since.  Inducted on 05/20/16 at 10:00 (NA) #5. NA #5 stated she number of showers or the not #40 was supposed to on his wound vacuum. NA #5 wen Resident #40 a shower in a while. NA #5 also times when the resident's wen due to there not being inducted on 05/20/16 at 11:10 he stated she expected the on be done on their assigned ers were not done they wednesday or Saturday insidered "shower free days." she was aware there were owers not being given 2 bey were in the process of osely.	F	242	monitoring will be completed five days week for four weeks, three times a wee the following four weeks and then one time a week for four weeks.  4. GLC-Asheville will monitor the corrective plan to ensure the practice was corrected and will not reoccur is the Leadership Team will bring the results the monitoring of the showers to the Eland/or DNS at Morning/Stand-Down Meetings. The ED will report the finding of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions as needed to ensure continued compliance.  5. The correction date for substantial compliance is June 24, 2016.	ek vas of O gs	
	accommodate every	ne stated sne tried to resident regarding their ference. She further stated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED		
		345010	B. WING _			C <b>05/20/2016</b>		
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	<u> </u>	03/20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PI		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 242	she had identified a getting their showers that she had been we ensure the resident's according to their prestated she expected	problem with resident's not so when she was hired and working on a process to so received their showers eference. The DON also showers to be given at least ore should the resident	F 2	42				
	O3/17/12 with diagnoral failure, diabetes mel A review of a quarter dated 05/04/16 indic cognitively intact for MDS also indicated extensive assistance dressing, toileting, a totally dependent on review of the MDS reserview of the MDS reserview of care type Section F titled Prefer Routine and Activities of showers and bath Resident #34.  A review of a docum Type Weekly Report 05/15/16 indicated From the week of 04/10/16/05/01/16, and one sign a total of 4 showers.	s admitted to the facility on obses which included heart litus, and respiratory failure.  If y Minimum Data Set (MDS) sated Resident #34 was daily decision making. The Resident #34 required of for bed mobility, transfers, and personal hygiene and was a staff for bathing. Further everaled under Section E titled was coded to have no expenses for Customary of the swas coded that the choice is was very important to the swas very important to the section #34 had received to 604/03/16, one shower for the week of the ower the week of 05/15/16, one sin 2 months.						
		aide care guide dated Resident #34 was to have "2						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	IPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED		
345010 B. WING				C 05/20/2046			
	NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - ASHEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	I	05/20/2016	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR  ( (EACH CORRECTIVE ACTION :	SHOULD BE	(X5) COMPLETION DATE	
F 242	showers" each week.  On 05/18/16 at 9:00 Aneed more help here, week and I want 3 sh #34 also stated she hand was told that ther give her any additional A follow-up interview Resident #34 on 05/2 she had been given a 05/19/16 and "Oh, it for much better." Resident had a shower since the An interview was con AM with Nurse Aide (Resident #34 receive when she worked and another shower earlied confirmed she had given 05/19/16. NA #5 anot asked her about 0 #5 further stated there resident's showers we not being enough state.  An interview was con AM with Nurse #7. Showers we not being enough state.  An interview was con AM with Nurse #7. Showers to days and if the showers should be done on W because that was cor Nurse #7 also stated problems with the showers with the	AM, Resident #34 stated "we I don't get but one shower a owers a week." Resident ad asked for more showers e was not enough staff to al showers.  Was conducted with 0/16 at 8:45 AM. She stated shower "yesterday" elt so good and I feel so not #34 indicated she had not be first week of 05/2016.  Iducted on 05/20/16 at 10:00 NA) #5. NA #5 stated do a shower every Thursday I was supposed to have in the week. NA #5 is stated do a shower every Thursday I was supposed to have in the week. NA #5 is stated Resident #34 had betting another shower. NA is evere times when the ere not given due to there if.  Iducted on 05/20/16 at 11:10 he stated she expected the be done on their assigned for were not done they endnesday or Saturday is sidered "shower free days." Is she was aware there were overs not being given 2 y were in the process of	F 2	242			

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345010	B. WING _			C <b>05/20/2016</b>	
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	I	03/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 242	An interview was con PM with the DON. S accommodate every personal shower preshe had identified a getting their showers that she had been wensure the resident's according to their prestated she expected 2 times a week or mercuest more.  3. Resident #49 was 07/22/14 with diagnorenal failure, arthritis significant change of (MDS) dated 09/09/1 was alert and oriente indicated Resident # assistance with dreshand required total as MDS also indicated locasionally incontin During an interview of Resident #49, she stabout her preference told she would get 2 Resident #49 also stabout her preference told she would get 2 Re	nducted on 05/20/16 at 4:30 ne stated she tried to resident regarding their ference. She further stated problem with resident's not sewhen she was hired and porking on a process to serceived their showers reference. The DON also showers to be given at least pore should the resident se admitted to the facility on reses which included diabetes, and chronic pain. The reference Minimum Data Set 5 indicated Resident #49 required extensive sing, toileting and hygiene, sistance with bathing. The Resident #49 was	F 2	42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345010	B. WING _		0	C <b>5/20/2016</b>	
	ROVIDER OR SUPPLIER	EVILLE	'	STREET ADDRESS, CITY, STATE, ZIP ( 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	•	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 242	have her showers of Saturday. Resident would get a bed bat days she did not re always. Resident there hair 3 times a word for an extra shower been told by a staff showers a week. Frecall who the staff thinks it was a nurs. Medical record revireport for 02/19/16 #49 was receiving a bath at least twice a exception between indicated Resident tub bath or bed bath a lot of agency staff there was a general having passwords to baths or bed baths but she felt confide showers, tub baths. Review of the care aides to guide resides to guide resides to guide resides howers" each weed one does not occur. During a staff interview on 05/20/2016 at 10 Resident #49 got a she worked and ha week. NA #1 also staff.	Friday, but she would rather on Tuesday, Thursday and the #49 also stated at times she the from the nurse aides on ceive her shower, but not easy stated she liked to wash week and she had never asked before because she had member she could only get 2 desident #49 was unable to member was, but stated she er aide.  Bew of the bathing type detail to 05/17/16 indicated Resident a shower, partial or full bed as week. There was one 03/11/16 and 03/21/16 that #49 did not receive a shower, in. The DON clarified they had for present in March 2016 and I lack of education regarding or document showers, tub given during that time period, intresidents were given or bed baths during that time.  I guide (used by the nurse lent care) on 05/19/16 at 3:57 ent #49 was to have "2 k and "inform nurse if either"	F2	242			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345010	B. WING		05/20/2016
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	1 03/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION
F 242	(DON) on 5/20/16 at tried to accommodate their personal showe further stated the act keeps up with this bu- currently have an Ac- stated if she knew so	vith the Director of Nursing 7:43 AM, she verbalized she e every person regarding or preference. The DON ivities department usually at the facility does not tivity Director. The DON also omeone wanted a shower 3 If of 2 she would make this	F 24	12	
	02/05/13 with diagnodementia, scoliosis, in osteoporosis, and de Minimum Data Set (Mindicated Resident # impaired. The MDS ff #14 required extension and personal hygiendon staff for bathing. The MDS for bathing and personal hygiendon staff for bathing. The moder Section E titled coded to have no rejuand under Section For Customary Routine as	respiratory disorder, repression. The most recent MDS) dated 02/19/16 14 was severely cognitively further indicated Resident re assistance with dressing and was totally dependent The MDS also revealed d Behavior Resident #14 was rection of care type behaviors titled Preferences for and Activities was coded that a sand baths was very			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345010	B. WING _			C 05/20/2016	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 242	A review of a docume Report" dated 02/19/indicated Resident #for 15 days between document revealed Fishower for 16 days b 05/10/16.  Review of a nurse aid Resident #14 was sureach week.  During an interview of Resident #14 was nowed. The RP further would come to the farm Resident #14 a bed be was Reside	ent titled "Bathing Type Detail 16 through 05/14/16 14 had received no shower 03/25/16 and 04/12/16. The Resident #14 had received 1 etween 04/22/16 and de care guide indicated pposed to have 2 showers on 05/18/16 at 9:00 AM with representative (RP), she is short staffed and that the being given 2 showers are stated a Hospice Aide cility each week and give path. The RP also stated it normal routine to get 2 "now she only gets one a "he RP indicated there were existed the resident and had be dirty, greasy, and not per stated and the dirty, greasy, and not per stated are get their showers 2 times a stated and sonly 1 time a week." NA #1 titles of daily living (ADL) care it was supposed to be due to the staffed. NA #1 indicated "it and change the residents as exicially when I have 31	F 2	42			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345010	B. WING		C	,
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  500 BEAVERDAM ROAD  ASHEVILLE, NC 28804	05/20/2016	)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE	TION
F 246 SS=D	On 05/17/16 at 4:47 F conducted with NA #2 not being provided to wanted them due to the staffed. NA #2 also st Resident #14 was supplied with the resident provided due to being indicated there was not all of the resident's carrow of the facility has had with saffected the resident's according to their prechoices for showers where working on and system so she would resident's showers to provided according to requested. The DON aware of the facility hespecially on 2nd and working on the staffin 483.15(e)(1) REASOLOF NEEDS/PREFER	PM an interview was 2. She stated showers were the residents when they ne facility being short ated she was aware oposed to have 2 showers a t's showers were not being short staffed. NA #2 ot having enough time to get are done in an 8 hour shift.  AM an interview was rector of Nursing (DON). ware of the issues the taffing and how it has se getting their showers ference. She also stated the was an issue that she had was trying to implement a be able to track the ensure that they were what the resident had further stated she was aving insufficient staffing I 3rd shifts and she was also g issues. NABLE ACCOMMODATION ENCES  That to reside and receive with reasonable advidual needs and when the health or safety of	F 24		6/24/16	5

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (A. BUILDING		(X3) DATE SURVEY COMPLETED					
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		345010	B. WING _				20/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
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GOLDEN	LIVINGCENTER - ASH	EVILLE		ASHEVILLE, NC 28804			
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F 246	This REQUIREMENT by: Based on observat staff and resident in place a call light wit reviewed for accome #48). The findings include Resident #48 was a 02/02/16 with diagn quadriplegia, anxiet pain. The admission dated 02/11/16 indictotal assistance for hygiene, toileting, be assistance with eati Resident #48 was a During an observati 05/18/16 at 9:28 AM lying in bed with her black and pink strip sheet. Resident #48 arms or legs and of call light to request demonstrated by tunher neck toward the to reach it. Residen needed help she would a use her call light to During an observati 05/19/16 at 9:22 AM bed with her call light to During an observati 05/19/16 at 9:22 AM bed with her call light was of under her pillow and of her bed sheet. Reway she can use her pillow within reach staff and the pillow within reach staff and the pillow within reach staff and reach it.	ions, medical record review, aterviews, the facility failed to thin reach for 1 of 1 resident amodation of needs (Resident ed: admitted to the facility on loses which included by, asthma, heartburn, and an Minimum Data Set (MDS) cated Resident #48 required bathing, transfers, dressing, athing and extensive ing. The MDS also indicated	F 2	F 246 REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  Golden Living Center - Ashe (GLC-Asheville) honors resi resident and receive service reasonable accommodation needs & preferences.  1. The corrective action at for Residents #48 is immedi notification the call light was of Resident #48 it was place position according to reside care.  2. Residents who have be by the Executive Director ((I Administrator), Director of N Services (DNS), and Leade (comprised of Department I their assistants, and Unit Manager/Coordinator) to ha potential to be affected are if residents who have been as planned to need the use of a call light. These residents w by the Unit Manager/coordin the call light was in the corre 3. The measures put in pl systemic changes made are Staff and Leadership Team re-inserviced and new empl educated on the importance who have been assessed/ca need the use of a Flat panca are in correct place. The Un Manager/Coordinator and/o	ident's right es with as of individu ccomplished iately after s not in react ed correct ent's plan of een identified ED) Jursing ership Team deads and ave the those ssessed/care a Flat panca vere checked nator to ensu ect position. lace or e: Nursing have been loyees will be e of residents are planned ake call light nit	e e se to t	

	OF DEFICIENCIES CORRECTION			(X3) DATE SURVEY COMPLETED			
			A. BOILDI	_		، ا	c
		345010	B. WING				20/2016
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OO! DEN	WWW.COENTED ACUE	w =		50	00 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHE\	/ILLE		Α	SHEVILLE, NC 28804		
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F 246	Continued From page	e 18	F:	246			
	been on her pillow thi				the Day will check call light placement	on	
		3			residents who have been assessed/ca		
	During an observation	n of Resident #48 on			planned to need the use of a Flat panc	ake	
		l, she was observed to be			call light for four weeks, the once a day	/ for	
	, , ,	call light completely under			four weeks, and five times a week for f	our	
		oped to the bed sheet or her			weeks. Leadership Team will check		
	-	stated she was unable to			during Leadership Room Rounds for ca		
		ugh through her pillow to			light placement on residents who have been assessed/care planned to need t		
	activate her call light.				use of a Flat pancake call light. This	IE	
	During an observation	n of Resident #48 on			monitoring will be completed five days	а	
		the call light was observed			week for four weeks, three times a week		
		et attached by a clip in a			the following four weeks and then one		
		d sock. Resident #48 stated			time a week for four weeks.		
	she should not have t	to remind the staff to place			GLC-Asheville will monitor the		
	_	ach. Resident #48 further			corrective plan to ensure the practice v	vas	
		ot remember to do it for her			corrected and will not reoccur is the	_	
		k them and that she was			Leadership Team will bring the results		
		y did not put it beside her			the monitoring of the call light placeme to the ED and/or DNS at	nt	
	head on the pillow.				Morning/Stand-Down Meetings. The E	D	
	Medical record review	v indicated Resident #48 had			will report the findings of the reviews to		
		all dated 02/17/16, listing an			Quality Assurance Performance	'	
		ner goals as call bell or call			Improvement Committee (QAPIC). Th	e	
	light within reach.	3			QAPIC will review and analyze for		
	-				patterns and trends. The QAPIC will		
	During an interview w	vith the Director of Nursing			evaluate the results and implement		
	· ,	t 7:43 AM, she stated her			additional interventions as needed to		
		dents to have call lights			ensure continued compliance.		
	_	can use them when they			5. The correction date for substantial		
	need assistance.				compliance is June 24, 2016.		
	During an interview w	vith Nurse #4 on 05/20/16 at					
	_	ated Resident #48 could					
	·	e her call light. Nurse #4					
		ght was kept on her pillow					
	_	plack and pink sock. Nurse					
		had never been in the room					
	for Resident #48 whe	n her call light was off her					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		C	(X3) DATE SURVEY COMPLETED	
		345010	B. WING _			C <b>05/20/2016</b>	
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	E .	0.00000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 248 F 248 SS=D	not the bed sheet. 483.15(f)(1) ACTIVIT INTERESTS/NEEDS  The facility must provof activities designed the comprehensive a	ays clipped to the pillow and	F 2			6/24/16	
	by: Based on observation staff and family intervals physical, mental, and 1 of 1 resident (Resident #14 was accepted with a diagnoses which depression, and high also indicated she rewith bed mobility, tra MDS further indicate significantly cognitive indicated Resident # the last assessment 12/02/15). Review of the significated Resident, staff thad responded to the personal preferences	l psychosocial well-being for dent #14).		F 248 ACTIVITIES MEET INTEREST/NEEDS OF EACH Golden Living Center - Ashevi (GLC-Asheville) activities progdirected by a qualified profess a qualified therapeutic recreat specialist or an activities profe 1. The corrective action acc for Residents #14 is a new Reservices Assessment will be oby June 23, 2016 with input from #14's family member. The asswill include resident's leisure particularly activities of the resident will be invited to atter related to his/her preferences. In documented which activities attended and quarterly according resident's care plan schedule plan will be updated. This will completed by June 24, 2016.	ille gram ins sional who tion essional. complished ecreation completed rom Reside sessment preferences ill be erences an nd activities . It will be Resident #1 ding to the care I be	nt s. d	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE COMP	SURVEY LETED
			A. BOILDI	_		(	2
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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F 248	Continued From page	e 20	F	248			
	· -	important to listen to music,			by the Executive Director ((ED)		
		to do things with groups of			Administrator), Director of Nursing		
	,	at important to do favorite			Services (DNS), and to have the poten	tial	
	activities.	P			to be affected are those residents who		
	Medical record reviev	w indicated a care plan for			have been assessed/care planned that	t	
		d on 03/03/16. The care plan			activities such as going outside when t	he	
	indicated Resident #1	14 required assistance in			weather is good, listen to music, do thi	ngs	
	participating in activit	ies of her choice including			with groups of people and do their favo	rite	
	devotions, coffee bre	ak, music and spiritual			activities. Also those residents who ne	ed	
	activities. The care p	lan also indicated she			assistance to and from activities requir	ing	
		and from activities of her			them to be reminded and encouraged	to	
		needed to be reminded of			attend. These residents' Plan of Care	will	
	. •	The interventions were for			be reviewed by June 24, 2016; an		
		articipate in activities and			updated list will be prepared to the Acti	-	
	giving compliments fo	or her attempts to			Assistant to have available to invite the		
	participate.	ith a family was and an an			to scheduled activities. A new Recreati		
	_	vith a family member on			Services Assessment will be completed		
	· ·	the family member indicated tend activities as often as			quarterly according to resident's care p schedule. The assessment will include		
		family member stated, "They			resident's leisure preferences. The		
		lude her as often as they			residents' Plan of Care will be updated	to	
		hink they have enough staff."			include these preferences and residen		
	_	vith the Administrator on			will be invited to attend activities relate		
		1, he acknowledged the			his/her preferences.	u to	
		no longer worked there and			The measures put in place or		
		tivity program is not what it			systemic changes made are: Staff and		
		e working on that." He			Activity Assistant been re-inserviced a		
		ey are in the process of			new employees will be educated on the		
	"looking for a new Ac				importance of residents attending		
	_	M, piano playing and singing			activities of their choice; assisting and		
		activity area of 100 hall.			encouraging those resident to activities	S.	
	Resident #14 was ob	served in her room, awake			Activity attendance records will be kep	t for	
	and lying in bed.				residents attending activities. These		
		M, the music activity is			records will be reviewed weekly in the	-	
	_	vity area of the 100 hall.			ED and/or DNS at Morning/Stand-Dow	n	
		rved lying in bed with her			Meetings. This monitoring will be		
	eyes open and holdin	-			completed ever week for four weeks,		
	_	vith Nurse Aide (NA) #2 on			every other week the following four we	eks	
	05/17/16 at 4:47 PM,	NA #2 stated they didn't			and then one time a month for four		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
			7 56.25		<del></del>	(	
		345010	B. WING_			1	20/2016
NAME OF P	ROVIDER OR SUPPLIER		<b>'</b>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
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GOLDEN	LIVINGCENTER - ASHE\	/ILLE		A	SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 248	ready for activities or During a second intermember of Resident: the family member st and evenings in the fathat staff did not offer activities. The family on 05/17/16 was a prher mother would have member also stated to staffed, no one had ti residents to activities in her mother's room activity of any kind. During a third interview member of Resident: the family member stoken out of bed and copportunities for activistated her mother had (sluggish or drowsy) interacted with her to to do or not do. During a fourth interview member of Resident: the family member stoken out of bed and copportunities for activistated her mother had (sluggish or drowsy) interacted with her to to do or not do. During a fourth interview member of Resident: the family member stoken with activities a group setting. She know why her mother type of activity prograher mother spent her lying in bed. During an interview wo 05/19/16 at 8:20 AM, in the facility and that activities and making activities.	assist in getting residents in taking them to activities. Eview with the same family #14 on 05/18/16 at 9:00 AM, ated she spent many days acility with her mother and to take her mother to member stated the singing ime example of an activity we enjoyed. The family he facility was so short me to take dependent and she never saw anyone providing a one on one we with the same family #14 on 05/18/16 at 4:10 PM, ated her mother had not no one had offered her any vities. The family member do been more lethargic today, but staff had not know what she would want liew with the same family #14 on 05/19/16 at 8:15 AM, ated no one assisted her on a one on one basis or in also stated she did not was not involved in some arm. She further stated that days sitting in her room or with the Unit Manager on she stated there was no AD a staff take turns leading sure residents attend the	F	248	weeks.  4. GLC-Asheville will monitor the corrective plan to ensure the practice we corrected and will not reoccur is the ED and/or DNS at Morning/Stand-Down Meetings will monitor activity attendance records and ensure Recreation Service Assessments are completed timely according to care plan schedule. The Ewill report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions as needed to ensure continued compliance.  5. The correction date for substantial compliance is June 24, 2016.	ce es ED	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345010	B. WING			C 05/20/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804		33/20/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 248	Resident #14 was ob out of her room and parea with other resident Resident #14 had be participating in an action 05/15/16.  During an interview worked part-time, and AD in the facility. AA one at the facility who further stated with the maintain the activities depended on staff to residents to the activities any one to one activities any one to one activities dependent #14 at that about the activities for she had seen her plant.	ctivity area of 100 hall. served up in her wheelchair, blaying bingo in the activity ents. This was the first time en observed out of her room tivity since the survey started with the Activity Assistant 1:00 PM, she stated she only d there was not a full-time also stated there was no to was a certified AD. AA the help of staff, they tried to se program and she encourage and bring titles when they were being tated she was not aware of titles being done with time. When AA was asked or Resident #14, she stated ying bingo today but she had	F 2	·		
	AA reviewed the active for the month of May resident had been to prior to today. AA also on one activities for Jof 2016, and Resider one on one activities further stated she had documentation record During an interview w (DON) on 05/20/16 at acknowledged the activities for the facility of AD. She also stated residents would also observations of the residents for the facility of the residents would also observations of the residents when the residents would also observations of the residents when the residents wh	<u>-</u>				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3 AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING		(X3) DATE SURVEY COMPLETED			
		345010	B. WING		C <b>05/20/2016</b>
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	1 03/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRING DEFICIENCY)	BE COMPLETION
F 248	intervention is needed facility had a manage and care plans are up that needed an imme Nurse #6 reviewed th and stated her care p add interventions for observations and acti acknowledged the ca was inadequate and of activities she would e activities when she wevents.	stated care plans are rterly and whenever an d. She also stated the r meeting every morning odated then for any resident diate intervention added. e care plan for Resident #14 lan had not been updated to falls such as increased	F 24		6/24/16
SS=D	PROFESSIONAL  The activities program qualified professional therapeutic recreation professional who is lie applicable, by the State eligible for certification specialist or as an act recognized accreditin 1, 1990; or has 2 year or recreational program of which was full-time program in a health coccupational therapis assistant; or has com approved by the State This REQUIREMENT by:	n must be directed by a who is a qualified a specialist or an activities censed or registered, if the in which practicing; and is a a therapeutic recreation tivities professional by a g body on or after October are of experience in a social am within the last 5 years, 1 in a patient activities are setting; or is a qualified to or occupational therapy pleted a training course experience.			
	Based on observatio	ns, staff and family		F 249 QUALIFICATIONS OF ACTIVIT	ГҮ

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345010	B. WING			1	20/2016
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
001.5511				50	00 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHE	VILLE		Α	SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 249	with an activity prograprofessional. The findings included During an interview v 05/16/16 at 2:20 PM, her mother (Resident activities as often as member stated "They her as often as they they have enough state During an interview v 05/17/16 at 12:13 PM Activity Director (AD) the facility a few weethe activity program if further stated they (the process of "looking for 0.5/17/16 at 2:00 P was observed in the During an interview v 0.5/17/16 at 4:47 PM, have enough staff to ready for activities or During an interview v 0.5/18/16 at 9:00 AM, she spent many days with her mother (Resoffer to take her mother member also stated take dependent residuever saw anyone in a one on one activity During an interview v 0.5/19/16 at 8:20 AM, in the facility and that	refailed to provide residents am directed by a qualified d:  with a family member on the family member indicated to #14) did not attend she would like. The family rejust don't seem to include used to. I just don't think aff."  with the Administrator on the family member with the Administrator on the family member with the had left employment with the bear and stated "I know is not what it should be." He for a new Activity Director."  M, piano playing and singing activity area of 100 hall. with Nurse Aide (NA) #2 on NA #2 stated they didn't assist in getting residents in taking them to activities. with a family member on the family member on the family member stated is and evenings in the facility dident #14) and staff did not her to activities. The family the staff did not have time to dents to activities and she her mother's room providing	F	249	PROFESSIONAL  Golden Living Center - Asheville (GLC-Asheville) provides an ongoing program of activities to meet the interest and the physical, mental, and psychosocial well-being of each resident. The corrective action accomplisher for Residents #14 is a new Recreation Services Assessment will be completed by June 23, 2016 with input from Reside #14's family member. The assessment will include resident's leisure preference. The residents Plan of Care will be updated to include these preferences a resident will be invited to attend activitic related to his/her preferences. It will be documented which activities Resident attended and quarterly according to resident's care plan schedule the care plan will be updated. This will be completed by June 24, 2016. The currexecutive Director ((ED) Administrator) who was a former Activities Director assisted the Activities Assistant to construct a calendar for the months Ma June which included special activities residents had requested during a reside group meeting and also input from the resident's calendar committee. The Leadership Team (comprised of Department Heads and their assistants and Unit Manager/Coordinator) and/or Manager of the Day assist the Activities Assistant with all activities and ensure activity calendar is followed. The facility in the process of finding a qualified activities professional.	nt. d d dent es. ind es f 144 ent ent f 195 ent	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345010	B. WING _			05/	20/2016
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GOLDEN	LIVINGCENTER - ASHE	VILLE		Α	SHEVILLE, NC 28804		
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F 249	(AA) on 05/19/16 at a she was not a certified classes to become of in classes to be an A During a 2nd interview 4:00 PM, she stated the AD had left over not a full-time AD in there was no one at a certified AD and she director was certified help of staff, they tried program and she depand bring residents to were being provided aware of any one to residents at that time During an interview with the companion of	on hall.  with the Activity Assistant 10:20 AM, she stated that ad AD, was not enrolled in ne, nor did she plan to enroll D.  ww with the AA on 05/19/16 at she only worked part-time, 3 weeks ago and there was the facility. AA also stated the facility who was a was not sure if the prior . AA further stated with the ad to maintain the activities bended on staff to encourage to the activities when they . AA also stated she was not one activities being done with	F2	249	by the ED, Director of Nursing Services (DNS), and Leadership Team (compris of Department Heads and their assistar and Unit Manager/Coordinator) to have the potential to be affected are those residents who have been assessed/car planned that activities such as going outside when the weather is good, liste to music, do things with groups of peopand do their favorite activities. Also tho residents who need assistance to and from activities requiring them to be reminded and encouraged to attend. These residents' Plan of Care will be reviewed; an updated list will be prepart to the Activity Assistant to have availabt to invite them to scheduled activities. A new Recreation Services Assessment be completed quarterly according to resident's care plan schedule. The assessment will include resident's leisu preferences. The residents' Plan of Cawill be updated to include these preferences and resident will be invited attend activities related to his/her preferences.  3. The measures put in place or systemic changes made are: Staff and Activity Assistant been re-inserviced are new employees will be educated on the importance of residents attending activities of their choice; assisting and encouraging those resident to activities Activity attendance records will be kept residents attending activities. These records will be reviewed weekly in the ED and/or DNS at Morning/Stand-Dow Meetings. This monitoring will be completed ever week for four weeks,	ed ints, en en e ed en e ed en e ed en e ed en	

PRINTED: 08/02/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345010	B. WING _		C <b>05/20/2016</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/2	20/2010
				500 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHEV	/ILLE		ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 249 F 278 SS=D	resident's status.  A registered nurse mueach assessment with participation of health A registered nurse muassessment is completed in the complete and the comp	SSMENT DINATION/CERTIFIED  It accurately reflect the  ust conduct or coordinate in the appropriate in professionals.  ust sign and certify that the	F 2	every other week the following four we and then one time a month for four weeks.  4. GLC-Asheville will monitor the corrective plan to ensure the practice of corrected and will not reoccur is the Eliand/or DNS at Morning/Stand-Down Meetings will monitor activity attendance records and ensure Recreation Service Assessments are completed timely according to care plan schedule. The Elimiliar report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The ED will keep QAPIC informed of the status of finding qualified activities director. The QAPIC evaluate the results and implement additional interventions as needed to ensure continued compliance.  5. The correction date for substantia compliance is June 24, 2016.	was Ce es ED Ch e the g a c will	6/24/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345010	B. WING_				20/2016
	ROVIDER OR SUPPLIER	/ILLE		50	TREET ADDRESS, CITY, STATE, ZIP CODE 00 BEAVERDAM ROAD SHEVILLE, NC 28804		
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F 278	willfully and knowingl false statement in a r subject to a civil mon \$1,000 for each asse willfully and knowingl to certify a material a resident assessment penalty of not more thassessment.  Clinical disagreemen material and false statement and false statement assessment.  This REQUIREMENT by:  Based on observation resident, and staff intaccurately assess resannual Minimum Data 2 of 4 residents (Resident #10 was 11/03/03 with diagnost anxiety, hypertension	Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual and false statement in a is subject to a civil money man \$5,000 for each to does not constitute a stement.  The is not met as evidenced as the medical record review, erviews, the facility failed to sidents' dental status on the a Set (MDS) assessment for ident #10 and #74).	F2	278	F 278 ASSESSMENT ACCURACY/COORDINATION/CERTIFD  Golden Living Center - Asheville (GLC-Asheville) provides resident assessment that are accurately reflect resident's current status.  1. The corrective action accomplisher for Resident #10 and #74 is their annual	the d	
	required supervision dental/oral concerns assessment. Resident #10 was ob AM. Resident #10 was her upper or lower jan During an interview w 05/18/16 at 9:13 AM,	served on 05/16/16 at 9:36 as noted to have no teeth in w.			Minimum Data Set (MDS) assessment was modified to reflect resident's currer dental status. This was completed on M 18, 2016  2. Residents who have been identifie by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads and their assistants, and Unit Managers) to	<b>l</b> ay	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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		ASHEVILLE, NC 28804		
NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
age 28	F 278	3		
view with the Minimum Data (IDSC) on 05/18/16 at 3:29 PM, and the annual MDS dated (IDSC) on 05/18/16 at 3:29 PM, and the annual MDS dated (IDSC) on 05/18/16 at 3:29 PM, and the annual MDS dated (IDSC) on 05/20/16 at 7:43 AM, the DON (IDSC) was new to the position. The expectation was for the MDS (IDSC) was new to the position. The expectation was for the MDS (IDSC) was new to the position. The expectation was for the MDS (IDSC) was new to the position. The expectation was for the MDS (IDSC) was new to the position. The expectation was for the MDS (IDSC) was new to the position. The expectation was for the MDS (IDSC) was new to the position. The expectation was for the MDS (IDSC) with expectation was for the MDS (IDSC) with expectation was allert the cognitive impairment and (IDSC) with expectation was allert the expectation with eating. There were no man to the with expectation with expectatio	F 278	have the potential to be affected a current residents. The DNS, Assis Director of Nursing Services (ADN Manager/Coordinator and/or DNS designee will review current reside dental assessment for accuracy. In necessary the MDS will be update reflect current dental status.  3. The measures put in place or systemic changes made are: The Minimum Data Set Coordinator (M was re-educated on how to assess code a resident's dental status on 2018 by the Clinical Assessment Reimbursement Specialist. Licens Nurses were re-educated on June by DNS; new nursing staff during orientation will be educated on how complete a dental assessment at admission and quarterly for accurate The MDSC and other Interdiscipling Team Members will be attending a education session with the North Coordinator related to MDS accurate Resident's Dental Assessment and as completed according to the residessessment/care plan schedule with brought to the Morning/Stand-Down Meetings to be reviewed. These rewill be reviewed weekly by ED and DNS at Morning/Stand-Down Meet This monitoring will be completed week for four weeks, every other value for the content of the morning four weeks and then one month for four weeks.	stant S), Unit ents' When d to  DSC) s and May 18, sed 9, 2016 w to acy. hary n Carolina acy. d MDS ident ill be vn ecords d/or tings. ever veek the time a	
THE TARKS THE SAME TO SEE THE		A. BUILDING  345010  B. WING  HEVILLE  (STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)  age 28  per dental plate on weekends able to wear her lower dental view with the Minimum Data (MDSC) on 05/18/16 at 3:29 PM, ed the annual MDS dated nowledged she had miscoded for Resident #10. view with the Director of 05/20/16 at 7:43 AM, the DON e had limited experience with MDSC was new to the position. Her expectation was for the MDS correct.  as admitted to the facility on proses which included diabetes Review of the admission MDS vealed Resident #74 was alert no cognitive impairment and on with eating. There were no ns noted on this admission  W with Resident #74 on the MM, Resident #74 stated she entures that she used daily and to have both an upper and in her mouth. View with the MDSC on PM, the MDSC reviewed the lated 04/12/16 and stated a full set of dentures because she had previously commented boout how attractive her teeth acknowledged she had tal section for Resident #74. View with the Director of 05/20/16 at 7:43 AM, the DON	HEVILLE    STATEMENT OF DEFICIENCIES   SOURCE   SOURCE	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER	L		50	REET ADDRESS, CITY, STATE, ZIP CODE  10 BEAVERDAM ROAD  SHEVILLE, NC 28804	<u>  03/</u>	20/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278		SC was new to the position. expectation was for the MDS	F 2	278	will report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions and needed to ensure continued compliance.  5. The correction date for substantial compliance is June 24, 2016.	e	
F 279 SS=E	to develop, review an comprehensive plan of the facility must develop plan for each resident objectives and timeta medical, nursing, and needs that are identificant assessment.  The care plan must do to be furnished to attain highest practicable plan psychosocial well-bei §483.25; and any serbe required under §44	e results of the assessment d revise the resident's of care.  elop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial fied in the comprehensive escribe the services that are ain or maintain the resident's nysical, mental, and ng as required under vices that would otherwise 83.25 but are not provided	F 2	279			6/24/16
	§483.10, including the under §483.10(b)(4).  This REQUIREMENT by:	exercise of rights under e right to refuse treatment is not met as evidenced ins, record reviews and staff			F 279 DEVELOP COMPRENSIVE CA	RE	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ ND PLAN OF CORRECTION IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345010	B. WING _			05/2	: :0/2016
NAME OF P	ROVIDER OR SUPPLIER	1	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	ODE		.0.2010
				500 BEAVERDAM ROAD			
GOLDEN	LIVINGCENTER - ASHE\	/ILLE		ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 279	F 279 Continued From page 30		F 2	279			
		•		PLANS  Golden Living Center - Ash (GLC-Asheville) uses the re	esults of the		
	The findings included	l:		assessment to develop, rev the resident's comprehensiv care.		rise	
	1. Resident #14 was admitted to the facility on 02/05/13 with diagnoses which included dementia, osteoporosis, and respiratory disorder. The quarterly Minimum Data Set (MDS) dated 02/19/16 indicated the resident had severely impaired cognition and had trouble falling or staying asleep. Resident #14 required extensive assistance with 1 to 2 person assist for bed mobility, transfers, personal hygiene, and dressing. The MDS also indicated the resident was not steady and was only able to transfer with staff assistance. The MDS further revealed Resident #14 had 2 or more falls since her last MDS assessment.  A care plan dated 03/03/16 was reviewed and was noted to be incomplete with goals and interventions of falls for Resident #14. The care plan had no interventions added after the resident's fall of 04/14/16 which caused an injury to the resident's face and head. Further review of the care plan did not indicate interventions to increase staff observations or resident involvement in activities.  The falls were noted to have occurred from the resident's bed or attempting to transfer. Review of			1. The corrective action a for Resident #14, #34 and # care plans were including m goals and individualized into were updated to reflect their and shower preferences. To completed before June 16, 2. Residents who have be by the Executive Director ((Administrator), Director of N Services (DNS), and Leade (comprised of Department Herical their assistants, and Unit M have the potential to be affect residents who have had a farm 18, 2016 and those residents cognitive intact for daily decomprised of Department Herical to the affect residents who have had a farm 18, 2016 and those residents who were again asked by the Ur Manager/Coordinator their spreferences and new shower was completed to allow the obtain showers at their preferences will be identified residents in the saked at a shower preferences and ad	#40 is their neasureable erventions r falls status falls ince fall since f	ed rch	
	assessed the resident the time and descript notified the physician	ndicated the facility had nt post a fall, had provided ion of the falls, and had and the resident's legal Interventions to prevent		shower schedule and their particles in the shower schedules/plan updated quarterly during the assessment/care plan cycle completed on May 25, 2016	of care will e residents' e. This was		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY IPLETED
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		345010	B. WING _			05	5/20/2016
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				5	00 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASH	EVILLE		Δ	ASHEVILLE, NC 28804		
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F 279	Continued From pa	ge 31	F 2	279			
		nces were not always indicated			resident has a potential for a fall and/o	r	
		I the summary or outcome of			had a fall the resident will be reviewed	at	
	the fall was not alw	ays documented.			the Morning/Stand-Down Meetings an	d/or	
					Weekly Risk meeting where new		
	•	ort dated 04/04/16 indicated			interventions will be added to the care		
		revent a fall occurrence was			plan and/or Care Area Assessment (C	AA).	
		se staff observation with better			3. The measures put in place or		
		intervention was not added to the nurse aide care guides.			systemic changes made are: The Minimum Data Set Coordinator (MDS)	2)	
	life care plan or to	ille fluise alue care guides.			was re-educated on how to assess,	<i>-)</i>	
	Δ review of the nur	se's notes dated 04/14/16 at			complete interventions and care plans	to	
		Resident #14 had another fall			include Activities of Daily Living (ADL's		
		cated on the fall report.			and shower preferences by Clinical	•)	
		noted to be lying on the edge			Assessment Reimbursement Specialis	st.	
		down on her right side with			Licensed Nurses were re-educated by		
		er forehead and a bump			DNS on June 9, 2016; new nursing sta		
	developing, the phy	sician and RP were notified.			during orientation will be educated on	how	
					to complete shower preferences and		
		onducted on 05/20/16 at 10:00			document falls and/or potential for falls	<b>3</b> .	
		or of Nursing (DON). She			The MDSC and other Interdisciplinary		
		are of the issues with			Team Members will be attending an		
		falls/accidents and that she			education session with the North Caro	lina	
		e in-services for the staff to			Resident Assessment Instrument		
		vork and follow-up on			Coordinator related to MDS accuracy,	and	
		DON stated she expected the their observations of residents			care plans to include interventions to prevent falls and shower preferences.		
		he expected the care plans to			Resident's CAAs and MDS will be		
	·	e appropriate interventions			updated/completed according to the		
	after a fall investiga				resident assessment/care plan schedu	ıle	
	anton a ram mroongo				and/or as new interventions are added		
	An interview was co	onducted on 05/20/16 at 10:30			be brought to the Morning/Stand-Down		
	AM with the MDS N	lurse. She stated the care			Meetings to be reviewed. These recor		
		updated quarterly and when			will be reviewed weekly by ED and/or		
	an intervention was	needed such as after a fall.			DNS at Morning/Stand-Down Meeting		
		facility had a managers			This monitoring will be completed even		
		ning and care plans were			week for four weeks, every other week		
		e for any resident that needed			following four weeks and then one time	э а	
		vention. The MDS nurse			month for four weeks.		
	confirmed Resident	t #14's care plan was			4. The GLC-Asheville will monitor th	е	1

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345010	B. WING _			1	C <b>20/2016</b>	
	ROVIDER OR SUPPLIER	VILLE		50	REET ADDRESS, CITY, STATE, ZIP CODE  BEAVERDAM ROAD  SHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 279	03/17/12 with diagnor failure, Diabetes Mel A review of a quarter dated 05/04/16 indicated for the cognitively intact for MDS also indicated from the extensive assistance (ADL) and was totally bathing and had no crefusal of care.  A review of an update functioning deficit dainterventions related (ADL) for Resident # with measurable goal interventions initiated to her ADL.  An interview was corally and with the MDS Nuresponsible for development of the information sherologically and the comporated into the checked the interventions interventions.	admitted to the facility on ses which included heart litus, and respiratory failure. Ity Minimum Data Set (MDS) ated Resident #34 was daily decision making. The Resident #34 required for activities of daily living y dependent on staff for documented behaviors or led care plan for physical ted 05/05/16 revealed no to activities of daily living 34. There was no care plan	F2	279	corrective plan to ensure the practice vector and will not reoccur is the Elewill report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions and needed to ensure continued compliance.  5. The correction date for substantial compliance is June 24, 2016.	e		
	individualized as muc nurse stated she sho care plan for Resider	ch as possible. The MDS ould have developed an ADL						

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - ASHEVILLE  ASHEVILLE, IV. 28804    Continued From page 33   PM with the Director of Nursing. She stated she was aware of the issues with documentation and preferences of showers and ADL care and that she was putting in place systems to be initiated and updated as appropriate with interventions in regards to ADL.    3) Resident ##40 was initially admitted to the facility on 02/15/11 and was re-admitted on 03/27/15/11 with diagnoses which included paraplegia, seizure disorder, and Diabetes Mellitus. A review of an appearance of the properties of showers of the state of the diagnoses which included paraplegia, seizure disorder, and Diabetes Mellitus. A review of minimum Data Set (MIDS) dated 04/01/16 indicated Resident #40 was cognitively intent for daily decision making. The MDS also indicated Resident #40 was cognitively intent for every of the MDS indicated under Section E titled Behavior Resident #40 was cognitively of the MDS indicated under Section E titled Behavior Resident #40 was cognitively of the MDS indicated under Section E titled Behavior Resident #40 was cognitively of the MDS indicated under Section E titled Behavior Resident #40 was cognitively of the MDS indicated under Section E titled Behavior Resident #40 was cognitively of the MDS indicated under Section E titled Behavior Resident #40 was cognitive of daily living (ADL) for Resident #40 was cognitive of daily living (ADL) for Resident #40. There was no care plan with measurable goals or individualized interventions initiated for Resident #40. There was no care plan with measurable goals or individualized interventions individualized interventions in the provision of the MDS indicated under the was no care plan with measurable goals or individualized interventions intiated for Resident #40 in regards	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - ASHEVILLE  STREET ADDRESS, CITY, STATE, 2IP CODE 509 BEAVERDAM ROAD  ASHEVILLE, NC 28804  PRICE  (EACH IDENCINENCY NUST BE RECIDED BY YILL REGULATORY OR LISC IDENTIFYING INFORMATION)  F 279  Continued From page 33  PM with the Director of Nursing. She stated she was aware of the issues with documentation and preferences of showers and ADL care and that she was putting in place systems to ensure preferences of showers and ADL care was followed and maintained. The DON also stated she expected the care plans to be initiated and updated as appropriate with interventions in regards to ADL.  3) Resident #40 was initially admitted to the facility on 02/15/11 and was re-admitted on 03/27/15 with diagnoses which included paraplegia, seizure disorder, and Diabetes Mellitus. A review of a significant change Minimum Data Set (MDS) dated 04/01/16 indicated Resident #40 was complixly intact for daily decision making. The MDS also indicated Resident #40 required extensive physical assistance of 2 persons for activities of daily living (ADL) which included bed mobility, transfers, dressing, tolleting, and personal hygiene, and was totally dependent on staff for bathing. Further review of the MDS indicated under Section E titled Behavior Resident #40 was completed no interventions initiated for Resident #40 in regards  The proportion of the			345010	B. WING				
FREETIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  FROM STAGE REGULATORY OR LSC IDENTIFYING INFORMATION)  F 279  Continued From page 33  PM with the Director of Nursing. She stated she was aware of the issues with documentation and preferences of showers and ADL care and that she was putting in place systems to ensure preferences of showers and ADL care and that she expected the care plans to be initiated and updated as appropriate with interventions in regards to ADL.  3) Resident #40 was initially admitted to the facility on 02/15/11 and was re-admitted on 03/27/15 with diagnoses which included paraplegia, seizure disorder, and Diabetes Mellitus. A review of a significant change Minimum Data Set (MDS) dated 04/01/16 indicated Resident #40 was compitively intact for daily decision making. The MDS also indicated Resident #40 required extensive physical assistance of 2 persons for activities of daily living (ADL), which included bed mobility, transfers, dressing, tolleting, and personal hygiene, and was totally dependent on staff for batting. Further review of the MDS indicated under Section E titled Behavior Resident #40 was condet to have no documented behaviors or rejection of care.  A review of an updated care plan for physical functioning deficit dated 04/04/16 revealed no interventions related to activities of daily living (ADL) for Resident #40. There was no care plan with measurable goals or individualized interventions in interaction for individualized interventions in related for Resident #40 in regards					500 BEAVERDAM ROAD		312012010	
PM with the Director of Nursing. She stated she was aware of the issues with documentation and preferences of showers and ADL care and that she was putting in place systems to ensure preferences of showers and ADL care was followed and maintained. The DON also stated she expected the care plans to be initiated and updated as appropriate with interventions in regards to ADL.  3) Resident #40 was initially admitted to the facility on 02/15/11 and was re-admitted on 03/27/15 with diagnoses which included paraplegia, seizure disorder, and Diabetes Mellitus. A review of a significant change Minimum Data Set (MDS) dated 04/01/16 indicated Resident #40 was cognitively intact for daily decision making. The MDS also indicated Resident #40 required extensive physical assistance of 2 persons for activities of daily living (ADL) which included bed mobility, transfers, dressing, toileting, and personal hygiene, and was totally dependent on staff for bathing. Further review of the MDS indicated under Section E titled Behavior Resident #40 was coded to have no documented behaviors or rejection of care.  A review of an updated care plan for physical functioning deficit dated 04/04/16 revealed no interventions related to activities of daily living (ADL) for Resident #40. There was no care plan with measurable goals or individualized interventions related to activities of daily living (ADL) for Resident #40. There was no care plan with measurable goals or individualized interventions ribitated for Resident #40 in regards	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	COMPLETION	
to his ADL care.  An interview was conducted on 05/20/16 at 10:30  AM with the MDS Nurse. She stated she was	F 279	PM with the Director was aware of the iss preferences of show she was putting in place preferences of show followed and maintal she expected the caupdated as appropriate as a possible of the property of the	of Nursing. She stated she bues with documentation and ers and ADL care and that face systems to ensure ers and ADL care was ined. The DON also stated re plans to be initiated and atte with interventions in a sinitially admitted to the and was re-admitted on oneses which included disorder, and Diabetes a significant change MDS) dated 04/01/16 and was cognitively intact for a significant change MDS also indicated and extensive physical ons for activities of daily living and bed mobility, transfers, and personal hygiene, and and not on staff for bathing. Further adicated under Section Elent #40 was coded to have aviors or rejection of care.  The ded care plan for physical and of the day	F 2	79			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345010	B. WING		C	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	05/20/2016	
GOLDEN	LIVINGCENTER - ASHEV	ILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	D.4TE	
F 279	the information she of review, other documed direct care staff. She incorporated into the checked the intervent further stated the resi individualized as much nurse stated she should care plan for Resident An interview was comply with the Director of was aware of the issuppreferences of shower she was putting in play preferences of shower followed and maintain she expected the care updated as appropriate regards to ADL.  483.20(k)(3)(i) SERV PROFESSIONAL STATE The services provided must meet profession that the provide services that for 2 of 2 residents references and the services that for 2 of 2 residents references that 2 references that	ortained from the record intation and interviews with stated the care plans were computer system and she ion she wanted to use. She dent's care plans were h as possible. The MDS ald have developed an ADL it #40.  Iducted on 05/20/16 at 4:30 of Nursing. She stated she les with documentation and irs and ADL care and that lice systems to ensure irs and ADL care was led. The DON also stated be plans to be initiated and ite with interventions in  ICES PROVIDED MEET ANDARDS  If or arranged by the facility al standards of quality.  It is not met as evidenced his, medical record review, perview, the facility failed to met professional standards viewed (Resident #10 and	F 2		d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345010	B. WING			C <b>05/20/2016</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	)E	00/20/2010	
				500 BEAVERDAM ROAD			
GOLDEN	LIVINGCENTER - ASHE	VILLE		ASHEVILLE, NC 28804			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE	
F 281	Continued From pag	e 35	F 28	31			
	, `	d vessels that restricts blood		medicine cup was discarded			
		diabetes. The annual		2016. Resident # 49 was pro			
		MDS) dated for 02/29/16		cups of ice water and her pre-			
		10 had mild cognitive		was updated to include three	•		
	impairment.			water each shift. This was co	ompleted on		
		n on 05/16/16 at 9:41AM, a		May 20, 2016.			
	I .	cup with a white cream		2. Residents who have bee			
	I .	itting on the bed of Resident cout the contents of the		by the Executive Director ((El Administrator), Director of Nu			
		ent #10 stated a nurse gave		Services (DNS), and Leaders			
	•	put on her legs because of		(comprised of Department He	•		
		although she was unsure		their assistants, and Unit	aus and		
	1	Resident #10 stated she had		Manager/Coordinator) to have	e the		
		was keeping it to use again.		potential to be affected are cu			
	I .	vith Nurse #2 on 05/16/16 at		residents. Unit Manager/Coor			
		isualized the contents of the		checked resident rooms for m			
		ated she was unsure what		cups with contents in them ar	nd/or any		
	the medication was.			medications at residents' bed			
	treatment cart and wa	as looking to see if she could		ice water. This was completed	d on May		
	figure out what it was	s. Nurse #2 stated that the		20,2016 no medications were	noted at		
	medication was a me	edicated cream,		bedside.			
		lent #10 was to receive twice		The measures put in place.			
		her lower legs. Nurse #2		systemic changes made are:	•		
		given Resident #10 the		Staff and Leadership Team ha			
	medication this morn			re-inserviced on June 3rd and			
	During an interview v			and new employees will be ed			
	,	rse #1) on 05/16/16 at 10:02		the importance of not leaving			
	l '	she had not yet seen		cups at bed side and ensure have ice water. Leadership Te			
		and did not give her the put on her legs. Nurse #1		· 1	•		
		esident #10 the medicated		Room Rounds will be checkin medications and ice water. T	-		
		nt #10 accepted it she would		monitoring will be completed			
		Resident #10 to apply it		week for four weeks, three tin	-		
	' ' '	ated she didn't know whether		the following four weeks and			
		assessment to determine if		time a week for four weeks.			
		ister medications. Nurse #1		4. GLC-Asheville will monitor	or the		
		ysician's order was still		corrective plan to ensure the			
	active and had not be	-		corrected and will not reoccur	-		
		eview indicated a physician's		Leadership Team will bring th			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345010	B. WING _			1	20/2016
NAME OF P	ROVIDER OR SUPPLIER	5.55.5	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	20/2016
					0 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHEV	/ILLE			SHEVILLE, NC 28804		
					<u>`</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	Continued From page	e 36	F 2	281			
F 201	order initially started of date for Triamcinolonskin) to both lower leg administered routinely physician's order further cream was to be applishift.  Review of the Medica (MAR) for May 2016 is signatures for administratives was by Nurse #3 on OAA phone interview was on 05/20/16 at 3:50 Pishe had worked from and 7AM - 4PM on OBC clearly remembered profer Resident #10 did not container of medicate transfer the cream into the room. Nurse her hands, put on glo Resident #10's legs at gloves, washed her houp back out of the room without an order viso.  During a staff interviee Nursing (DON) on 05.	on 12/18/12 with no stop e cream topically (on the gs and was scheduled to be y, twice a day. The ner stated the medicated ied every day and evening  Ition Administration Record indicated the most recent istration of the medication ion of the medication ion of the medication ion of the medication ion of the medicine cup to take it if and indicated that she washed ives, applied the cream to ind then removed her indicated that she washed ives, applied the cream to ind then removed her indicated that she medicine ion with her when she left. Indicated the resident to put ion indicated the resident to put ion indicated the resident could do  Itin 12/18/12 with a resident to put ion indicated the resident could do  Itin 12/18/12 with a resident to leave		281	the audits and Leadership Room Roun to the ED and/or DNS at Morning/Stand-Down Meetings. The El will report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions as needed to ensure continued compliance.  5. The correction date for substantial compliance is June 24, 2016.	D e	
	2. Resident #49 was	admitted to the facility on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345010	B. WING _			C <b>05/20/2016</b>	
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CO 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	DDE	1 03/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA		
F 281	high cholesterol, chroand chronic pain. The correction Minimum I 09/09/15 indicated R extensive assistance transfers. The MDS f #49 had pain that lim During an interview v 05/16/16 at 11:44AM did not get the fluids Resident #49 also strice in the morning version for water or ice she serview of a grievand 03/15/16 indicated sh The resolution to the Administration Recorshift."  Review of the TAR for "Unscheduled Other styrofoam cups of ice was not an area on the designated to docum done.  An order summary reactive for the resident 2016. The report not styrofoam cups of ice signed by the physici During an interview v 05/18/16 at 4:06 PM, had received ice and twice today.  During an interview v 05/19/16 at 3:26 PM, knew she was supported to the summary reactive today.	ses which included diabetes, onic lung disease, arthritis e significant change Data Set (MDS) dated esident #49 required with bed mobility and further indicated Resident ited her day to day activities.  With Resident #49 on , Resident #49 stated she she wanted between meals. ated she did not get water or rry often and when she asked till often did not get any. We filed by Resident #49 on the was receiving "no water.: grievance was "Treatment and (TAR) - extra water per correct was listed "3 to water at each shift." There the TAR specifically then or if this was being the port (all orders currently the was reviewed for May the dan order listed as "3 to water each shift" and was an on 05/03/16. With Resident #49 on Resident #49 on Resident #49 stated she water in her styrofoam cup	F2	281			

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		COMPLETED	
		345010	B. WING _			C 05/20/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	<u> </u>	J3/20/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 281	her pills and then sipiday. Resident #49 alvery dry and she like. She stated that she histyrofoam cups of ice. During an interview w 05/19/16 at 3:40 PM, Resident #49 only 2 son first shift because supposed to have 3 distated she had a care be done for her and to Review of the care grown directions for 3 cuper shift. During an interview w (DON) on 05/20/16 a she had recently had about ice water. The expectation was for the sure the resident has cups each time they make sure the orders During an interview w Manager (UM) on 05 stated Resident #49 each shift. UM further preference of Reside During an interview work.	rinks what they give her with so out of her cups during the so stated her mouth gets at to have her water with her. and only been given 2 water today.  With Nurse Aide (NA) #4 on NA #4 stated she had given styrofoam cups of ice water she didn't know she was cups each shift. NA #4 also a guide for what needed to his was not listed.  With the Director of Nursing to 7:43 AM, the DON stated an in-service with the NA's DON also stated her he nurses and aides to make ice water in her styrofoam come in to the room and are followed.  With the 100 hall Unit 1/20/16 at 10:05 AM, UM received 3 cups of water in indicated this was a not #49 and not an order.  With NA #1 on 05/20/16 at leed Resident #49 got 2 cups	F 2	81			
F 282 SS=D	483.20(k)(3)(ii) SERN PERSONS/PER CAF  The services provide must be provided by	/ICES BY QUALIFIED RE PLAN d or arranged by the facility	F 2	82		6/24/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345010	B. WING			C 05/20/2046	
NAME OF D	ROVIDER OR SUPPLIER	0-100 10	1	STREET ADDRESS, CITY, STATE, ZIP CODE		05/20/2016	
NAME OF T	NOVIDEN ON 3011 EIEN						
GOLDEN	LIVINGCENTER - ASH	EVILLE		500 BEAVERDAM ROAD			
				ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PRESENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 282	Continued From pa	nge 39	F 28	2			
	by: Based on observa resident, and staff i follow the care plar 2 of 2 residents wh transfers (Resident The findings includ A document titled " a creation date of 0 01/22/16, and an e "Place the Manufac Facility Mechanical and had no other w facility provided do Information: Policy Required for Patier designed for safe u There are circumst combativeness, ob individual that may two-person transfer facility to determine transfer is more ap  1) Resident #26 wa 03/30/12 with diagr palsy, Alzheimer's and chronic pain.  Review of an annual	Mechanical Lift, Hydraulic" with 1/08/15, a last review date of ffective date of 01/26/15 read cturer's Instructions for the Lift Here" the page was 1 of 1 writing on the paper. Another cument titled "General on Number of Staff Members at Transfer" read in part lifts are isage with one caregiver. ances, such as esity, contractures, etc. of the dictate the need for a r. It is the responsibility of each as admitted to the facility on propriate.  The sadmitted to the facility on proses which included cerebral disease, psychotic disorder,		F 282 SERVICES BY QUALIFIE PERSONS/PER CARE PLAN  Golden Living Center - Asheville (GLC-Asheville) provides or arra services by a qualified person in accordance with each resident's plan of care.  1. The corrective action accomfor Resident #26 & #40 is review updated their lift assessments at care on May 31, 2016.  2. Residents who have been in by the Executive Director ((ED) Administrator), Director of Nursin Services (DNS), and Leadership (comprised of Department Head their assistants, and Unit Managhave the potential to be affected residents who use a mechanical These residents lift assessments of care were reviewed and upda June 1, 2016. Residents lift ass and plan of care will be updated during the residents' assessment plan cycle.  3. The measures put in place of systemic changes made are: Nur will be re-inserviced on how comassessment and carry out care wusing a mechanical lift on June 2016 by representative from the	anges anges awritten applished and plan of dentified ang a Team as and are those lift. and plan ted on essments quarterly at/care or arsing staff aplete a lift when 15 & 16,		
	cognitively intact ar	icated Resident #26 was nd capable of making his MDS specified Resident #26		2016 by representative from the mechanical lift manufacturer. No employees will be trained during	ew		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		345010	B. WING			C <b>05/20/2016</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	<b></b> DE	03/20/2010	
001.551				500 BEAVERDAM ROAD			
GOLDEN	LIVINGCENTER - ASHE	EVILLE		ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 282	Continued From pag	ge 40 assistance of 2 persons for	F 2	82 orientation. Weekly during the	ne		
	bed mobility, transfer personal hygiene, a staff with 2 persons indicated Resident # bowel and bladder.	ers, dressing, toileting, and nd was totally dependent on assist for bathing. The MDS #26 was always incontinent of		Morning/Stand-down Meeting Meetings (meets weekly) lift will review for completeness weekly for one month, every month and then monthly for t 4. GLC-Asheville will monit	gs and RISK assessments and accuracy other week a three months.		
revealed Reside to not steady du resident would he care plan indica part to assist recall light and pe		ed care plan dated 03/29/16 e26 was at risk for falls related transfers with a goal that the eno fall related injury. The interventions which read in the back to bed as requested, all items in easy reach, and a mechanical lift and assist of s.		corrective plan to ensure the corrected and will not reoccu will report the findings from the lift assessments to Quality Asserting Performance Improvement C (QAPIC). The QAPIC will reparallyze for patterns and tren QAPIC will evaluate the resu implement additional interver needed to ensure continued	r is the ED ne review of ssurance committee view and ds. The Its and ntions and		
	nurse aides) dated (read in part lift with a back to bed per required On 05/16/16 at 2:25 observed to transfer	ident information used by 05/14/16 for Resident #26 assist of 2 for transfer, assist uest.  PM Nurse Aide (NA) #5 was Resident #26 using a Hoyer		5. The correction date for s compliance is June 24, 2016			
	There was no other with NA #5 and the with NA #5 and the An interview was co 05/16/16 at 3:05 PM responsible for the chired through an agnot an employee of she had transferred using the mechanica been trained when uthere were suppose	n his wheelchair to his bed. staff observed in the room resident.  nducted with NA #5 on 1. NA #5 stated she was care of Resident #26 and was ency as a nurse aide and was the facility. NA #5 confirmed Resident #26 by herself al lift. She stated she had using a mechanical lift that d to be 2 people. NA #5 med that according to the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345010	B. WING _			C <b>05/20/2016</b>
	ROVIDER OR SUPPLIER  LIVINGCENTER - ASHE	/ILLE		STREET ADDRESS, CITY, STATE, ZIP COI 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	DE	00.20.20.0
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 282	care guide Resident a supposed to be trans lift with 2 persons assher normal routine an occasionally have a swhen using a mechan additional staff. She funable to find anothe transfer of Resident ashe transferred the resident and the resident she transferred the resident she transferred the resident she transferred the resident she transferred the resident she transfer as stated thand the NAs worked provide the residents was needed.  An interview was con 05/17/16 at 4:47 PM. unusual to be respon residents on 2nd or 3 stated "there are a lot transfer a resident us ourselves because thanyone to help assist had transferred reside by herself.  An interview was con 05/19/16 at 10:37 AM expected 2 NAs to transfer and residents were not prin a timely manner.	#26 was a total lift and was ferred using a mechanical sist. NA #5 stated this was id that she would second person to assist her inical lift when there were urther stated she was in NA or nurse to assist in the fe26 transfer that was why esident by herself.  ducted with Resident #26 on Resident #26 stated there en only 1 NA would transfer the facility was short staffed thard but was unable to the care sometimes that  ducted with NA #2 on NA #2 stated it was not sible for 30 or more ind shifts. NA #2 further it of times we have to ing a mechanical lift by ere is not enough staff for us." NA #2 indicated she ents using a mechanical lift  ducted with Nurse #8 on	F	282		

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP IDENTIFICATION NUMBER: A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345010	B. WING		C 05/20/2016
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	1 33/23/2010
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 282	trained to have 2 permechanical lift and the would transfer a reside facility being short state. An interview was con 05/19/16 at 11:10AM there to be 2 staff methad to be transferred lift. Nurse #7 further sexpected Resident #2 with 2 person assist.  An interview was con Nursing (DON) on 05 stated the manufacture one or two persons a mechanical lift. The E would have expected	A. NA #7 stated she was son assist when using a here were times when she dent by herself due to the affed.  Aducted with Nurse #7 on . She stated she expected embers every time a resident by the use of a mechanical stated she would have 26 to have been transferred aducted with the Director of 6/19/16 at 2:30 PM. The DON over of the lift indicated that the sist with transfers using a 200N further stated that she is the NAs to transfer a that resident's plan of care	F 282		
	03/27/15 with diagno	re-admitted to the facility on ses which included isorder, and psychotic			
	(MDS) dated 04/01/1 was cognitively intact his needs known. The #40 required extensive assist for bed mobility toileting, and persons persons assist for bar	al hygiene, and required 2 thing.			
	Review of an updated	d care plan dated 04/04/16			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345010	B. WING _			05/20/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 500 BEAVERDAM ROAD ASHEVILLE, NC 28804		3/20/2016	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	to the need for assist activities of daily living resident would have care plan indicated in part to use the maxilift and assist of staff transfers.  Review of a nurse ai 05/14/16 for Resident mechanical lift with a An interview was corn AM with Resident #4 times when there wo transfer him from his from his wheelchair the facility was short staff another NA or nurse wait a long time. Resident was transferred from his "yesterday" due to be transferred from his wheelchair to be tween 9:30 PM and asked the staff 2 to bed and was told to soon as they could. It was transferred to be room at the time using An interview was corn 05/17/16 at 4:47 PM unusual to be respondents on 2nd or 3 stated "there are a lot transfer a resident us ourselves because the staff and the staff and the time using the staff and the staff are staff at the staff and the staff and the staff are staff at the staff and the staff are staff at the staff at the staff and the staff at th	ance with mobility and g (ADL) with a goal that the no fall related injuries. The noterventions which read in lift for transfers, mechanical times 2 persons for  de (NA) care guide dated the 440 read in part saist of 2 for transfers.  Inducted on 05/20/16 at 8:45 or the stated there were uld only be one NA to bed to his wheelchair or to the bed because the fed and there was not to assist without having to indent #40 also stated when doctor's appointment the end short staffed he was not wheelchair back to his bed do 9:45 PM. He indicated he to 3 times to be transferred that they would get to him as the further indicated when he and that only 1 NA was in his to get the mechanical lift.	F 2	82			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
345010		B. WING _		C <b>05/20/2016</b>				
	ROVIDER OR SUPPLIER	'ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	, 33			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 282	by herself.  An interview was con 05/19/16 at 10:37 AM expected 2 NAs to tra mechanical lift. Nurse shortage of staff and residents were not proin a timely manner.  An interview was con 05/19/16 at 11:00 AM trained to have 2 persemechanical lift and the would transfer a resid facility being short staff and the condition of the	ducted with Nurse #8 on . Nurse #8 stated he unsfer Resident #40 using a #8 indicated there was a there were times when ovided the care they needed  ducted with NA #7 on . NA #7 stated she was son assist when using a ere were times when she ent by herself due to the	F 2	82				
F 312 SS=D	would have expected resident according to to ensure the safety of 483.25(a)(3) ADL CA DEPENDENT RESID	that resident's plan of care if the resident. RE PROVIDED FOR	F 3	12		6/24/16		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  A. BUILDII  345010  B. WING _		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED  C 05/20/2016		
	ROVIDER OR SUPPLIER	VILLE	5	STREET ADDRESS, CITY, STATE, ZIP CODE  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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 312	daily living receives t	e 45 he necessary services to on, grooming, and personal	F 312				
	by: Based on observation and staff interviews the residents with a shown dependent on staff for sampled for activities and #34).  The findings included 1) Resident #40 was facility on 02/15/11 a 03/27/15 with diagnor paraplegia, Diabetes disorder. A review of Minimum Data Set (Nindicated Resident #40 require person physical assis (ADL) and was totally bathing and had not refusal of care.  A review of a docume Report" dated 11/25/indicated Resident #40 require person physical assis (ADL) and was totally bathing and had not refusal of care.	initially admitted to the and was re-admitted on ses which included Mellitus, and seizure a significant change MDS) dated 04/01/16 40 was cognitively intact for g. The MDS also indicated d extensive assistance of 2 st for activities of daily living a dependent on staff for locumented behaviors or		F 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  Golden Living Center - Asheville (GLC-Asheville) ensures a resident who unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene.  1. The corrective action accomplisher for Residents #40, and #34, is shower preferences were reviewed with these residents to obtain showers at their preference. This was completed on M 25, 2016.  2. Residents who have been identified by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads and their assistants, and Unit Manager/Coordinator) to have the potential to be affected are those residents who are total dependent on a for bathing and are cognitively intact for daily decision making. The residents the who were identified again asked by the Unit Manager/Coordinator their showe preferences and new shower schedule was completed to allow these residents.	ed ay ed staff or nat e		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345010	B. WING			С	
				05/2	20/2016		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOI DEN I	LIVINGCENTER - ASHE\	/III F		50	00 BEAVERDAM ROAD		
COLDLIN				Α	SHEVILLE, NC 28804		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIDE DEFICIENCY)			(X5) COMPLETION DATE
F 312	Continued From page	e 46	F;	312			
	A review of nurse's n	otes dated from 05/01/16			new residents will be asked at admission	วท	
	through 05/18/16 rev				their shower preferences and added to	_	
	_	Resident #40 had refused			the shower schedule. The shower		
	baths or showers.				schedules will be updated quarterly du	rina	
					the residents' assessment/care plan	9	
	A review of an update	ed care plan for physical			cycle. This was completed on May 25,		
		ted 04/04/16 indicated			2016.		
	_	dent request of 3 showers a			3. The measures put in place or		
		ds, and assist as needed.			systemic changes made are: Nursing		
	•				Staff and Leadership Team have been		
	Resident #40 was ob	served on 05/15/16 at 3:30			re-inserviced and new employees will be	ре	
	PM to be lying in his	bed, eyes closed, and			educated on the importance of residen		
	sleeping. He was obs	served to have short hair and			having the opportunity right to choose		
	his scalp was noted t	o be greasy and shiny			activities, schedules, and health care		
	looking. Further obse	rvation revealed a sweaty			consistent with his/her interest,		
	underarm type body	odor.			assessments, and plans of care.		
					Leadership Team will ask during Room		
	Resident #40 was ob	served on 05/16/16 at 9:00			Rounds five residents who are cognitiv	е	
		ped eating his breakfast with			intact for daily decision making if they a	are	
		calp greasy and shiny			receiving showers according to their		
	looking, and a sweaty	y type body odor.			preference. This monitoring will be		
					completed five days a week for four		
		ducted on 05/17/16 at 11:30			weeks, three times a week the following		
	·	NA) #6. She stated she had			four weeks and then one time a week f	or	
		bed bath earlier in the			four weeks.		
		st before leaving for his			4. GLC-Asheville will monitor the		
	• •	. NA #6 indicated she had			corrective plan to ensure the practice v	/as	
	_	t a shower because she was			corrected and will not reoccur is the	_	
	_	as not enough time or staff			Leadership Team will bring the results		
	to complete all the ca	re needs of the residents.			the monitoring of the showers to the EI	)	
					and/or DNS at Morning/Stand-Down		
		ducted on 05/18/16 at 9:20			Meetings. The ED will report the finding	js	
	AM with Resident #40				of the reviews to Quality Assurance		
		shower at least 3 times per			Performance Improvement Committee		
		lity being short staffed he			(QAPIC). The QAPIC will review and		
	had not received a sh	,			analyze for patterns and trends. The		
		40 further stated "the nurse			QAPIC will evaluate the results and		
		ugh time to get the showers			implement additional interventions as		
	done because there i	s not enough start."			needed to ensure continued compliance	<del>e</del> .	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED			
		345010	B. WING			C 05/20/2016		
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	'	5672672010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 312	AM with NA #7. She Resident #40 a show of his shower days. It times when showers week due to being so best we can to give to but there is no way was 4 follow-up interview at 8:45 AM with Resi wanted a shower 3 ti Wednesday, and Fric vacuum and dressing sacral area. He re-st shower on Monday 0 given one since.  An interview was cor AM with Nurse Aide had been assigned to confirmed the resident staff for bathing. NA given Resident #40 a busy. She also indicate the resident's shower due to there not bein An interview was cor AM with Nurse #7. S resident's showers to days and if the show should be done on We because that was co Nurse #7 also stated problems with the shows	anducted on 05/19/16 at 11:00 stated she had not given wer and that she was unsure NA #7 indicated there were were not given 2 times a busy. She stated "we do the he residents their showers with as short staff as we are."  was conducted on 05/20/16 dent #40. He indicated he mes a week on Monday, day before his wound g changes were done to the ated he had received a u5/09/16 and had not been ated he had received a u5/09/16 and had not been at the process of the stated she had not a shower due to being so ated there were times when a shower due to being so ated there were times when a shower due to being so ated there were times when a shower due to being so ated there were times when a shower due to being so ated there were times when a shower due to being so ated there were times when a shower due to being so ated there were times when a shower due to being so ated there were times when a shower due to being so ated there were times when a shower free days. The shower free days. The was aware there were owers not being given 2 between in the process of	F 31	5. The correction date for subcompliance is June 24, 2016.	stantial			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345010	B. WING		05/20/2016
	ROVIDER OR SUPPLIER LIVINGCENTER - ASHE	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	1 00/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 312	PM with the Director was aware of the iss staffing and how it has getting their showers trying to implement a able to track the resist they were provided. Was aware of the fact staffing especially on she was working on the	adducted on 05/20/16 at 4:30 of Nursing. She stated she uses the facility has had with as affected the resident's not a She also stated she was a system so she would be dent's showers to ensure that The DON further stated she illity having insufficient a 2nd and 3rd shifts and that the staffing issues.  admitted to the facility on uses which included heart litus, and respiratory failure. By Minimum Data Set (MDS) ated Resident #34 was daily decision making. The Resident #34 required for activities of daily living y dependent on staff for documented behaviors or documented behaviors or lent titled "Resident Bathing" dated 03/20/16 through esident #34 had received a of 04/03/16, one shower the week of nower the week of 05/15/16, ars in 2 months.	F 3	·	
	05/18/16 revealed th that Resident #34 ha	otes dated 05/01/16 through ere was no documentation d refused baths or showers.			
	A review of an updat	ed care plan for physical			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345010	B. WING			C <b>05/20/2016</b>	
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	•	00/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 312	Continued From pag		F 3	12			
		ted 05/05/16 indicated ipate resident needs and ded.					
	observed in her whe	PM Resident #34 was elchair setting in the hallway her clothes disheveled, and nce.					
	in her wheelchair sel	Resident #34 was observed f-propelling in the hallway braided, messy, un-clean,					
	need more help here week and I want 3 sh #34 also stated she I	AM, Resident #34 stated "we e, I don't get but one shower a nowers a week." Resident had asked for more showers are was not enough staff to hal showers.					
	AM with NA #7. She Resident #34 a show were on Monday and there were times who times a week due to "we do the best we do	nducted on 05/19/16 at 11:00 stated she had not given ver and that her shower days if Thursday. NA #7 indicated en showers were not given 2 being so busy. She stated can to give the residents their no way with as short staff as					
	she had been given a 05/19/16 and "Oh, it much better." Resid	was conducted with 20/16 at 8:45 AM. She stated a shower "yesterday" felt so good and I feel so ent #34 indicated she had ice the first week of 05/2016.					
	An interview was cor	nducted on 05/20/16 at 10:00					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			71. 5012511			С	
		345010	B. WING_			05/	20/2016
	ROVIDER OR SUPPLIER LIVINGCENTER - ASHEV	<b>ILLE</b>		50	TREET ADDRESS, CITY, STATE, ZIP CODE  10 BEAVERDAM ROAD  SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	when she worked and another shower earlied confirmed she had give on 05/19/16. NA #5 and asked her about of #5 further stated there resident's showers we not being enough state.  An interview was con AM with Nurse #7. Showers to days and if the showers should be done on W because that was cor Nurse #7 also stated problems with the showers with	NA) #5. NA #5 stated d a shower every Thursday d was supposed to have er in the week. NA #5 ven Resident #34 a shower dso stated Resident #34 had getting another shower. NA e were times when the ere not given due to there eff.  ducted on 05/20/16 at 11:10 he stated she expected the be done on their assigned ers were not done they ednesday or Saturday hisidered "shower free days." she was aware there were overs not being given 2 by were in the process of	F	3312			
F 314 SS=D	PM with the Director of was aware of the issustaffing and how it hat getting their showers. It is trying to implement a able to track the resident they were provided. They was aware of the facing staffing especially on the was working on the 483.25(c) TREATMENT PREVENT/HEAL PRINCE Based on the compression of the same and the same aware of the facing staffing especially on the was working on the Based on the compression.	2nd and 3rd shifts and that he staffing issues. NT/SVCS TO	F3	3314			6/24/16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345010	B. WING		05/20/2016	
	NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - ASHEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	03/20/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 314	does not develop pre individual's clinical co they were unavoidab pressure sores receiv services to promote h prevent new sores from This REQUIREMENT by:  Based on observation	y without pressure sores assure sores unless the ondition demonstrates that le; and a resident having was necessary treatment and nealing, prevent infection and orm developing.  This not met as evidenced ons, record review, resident,	F 31	F 314 TREATMENT/SERVICES TO		
	and staff interviews the facility failed to provide ordered weekly wound assessments and failed to provide incontinence care to a resident with facility acquired pressure sores for 1 of 1 residents reviewed for pressure sores (Resident #40).  The findings included:  Resident #40 was initially admitted to the facility on 02/15/11 and was re-admitted on 03/27/15 with diagnoses which included paraplegia, osteomyelitis (infection of the bone), diabetes mellitus, seizure disorder, depressive disorder, and kidney disorder.			Golden Living Center - Asheville (GLC-Asheville) ensures that a resi who resides at Golden Living Center without pressure sores does not de pressure sores unless the individual clinical condition demonstrates that were unavoidable; and a resident re treatment and services to promote healing, prevent infection and preve sores from developing.  1. The corrective action accompli for Resident #40 is that according to Wound Evaluation Flow Sheet date February 17, 2011 (time of admission	dent er velop ul s they eceives ent new shed to the d	
	Set (MDS) dated 04/0 was cognitively intact. The MDS also indicatextensive assistance for activities of daily I the MDS titled Behave to have no rejection of Further review of the Section M titled Skin	ant change Minimum Data 01/16 indicated Resident #40 if for daily decision making. ited Resident #40 required of 2 person physical assist iving (ADL) and Section E of rior Resident #40 was coded of care type behaviors. MDS indicated under Conditions that Resident eveloping pressure sores		Stage IV Length 8.7cm by width 6.5 depth 1.4cm. and another Stage III Length 2.3 cm by width 6.6cm by do 0.3cm both areas were located on the resident sacrum. Resident #40 acquire a pressure sore while in the facility to his/her sacrum. Resident #40 currently has a subput catheter and colostomy; therefore, not require assistance with toileting however, he/she is checked every sacrum.	area epth che did not e ubic does ;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345010	B. WING _			05/	20/2016	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
COLDENI	LIVINGCENTER - ASHEV	/II I E		50	00 BEAVERDAM ROAD			
GOLDEN	LIVINGCENTER - ASHEV	VILLE		Α	SHEVILLE, NC 28804			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 314	Continued From page	e 52	F3	314				
	and having 1 stage 4		' '		and/or as needed for catheter and/or			
	unstageable pressure				colostomy care. This was completed a			
	unstageable pressure	, 30163.			of May 20,2016. Resident #40 and with			
	A review of an undate	ed care plan with a date of			his permission his family were asked			
	-	problem statement of at risk			about his care as it relates to the			
		ity related to incontinence,			allegation he did not receive incontinen	ce		
	_	rs, and non-compliance with			care and when it occurred. This was se			
	•	ated resident would not have			the facility could do an appropriate			
		n and the interventions			investigation and grievance/concern			
	were listed in part to			according to facility policies and				
	after incontinent episo			procedures. Completed as of June 17,				
	provide treatments as			2016.				
	skin inspections, and	conduct weekly wound			2. Residents who have been identifie	d		
	assessments.				by the Executive Director ((ED)			
					Administrator), Director of Nursing			
		updated care plan dated			Services (DNS), and Leadership Team			
		problem statement of a			(comprised of Department Heads, their	'		
	sacral pressure sore,				assistants, and Unit			
		dent is noncompliant with			Manager/Coordinator) to have the			
	-	The goal indicated was the			potential to be affected are those			
		heal without complication			residents who have a pressure ulcer.  These residents have been assessed f	or		
	with interventions liste					or		
	_	t resident with turning and it to roll side to side, turn and			pressure sores and will be continued weekly.			
	_	wound consults as ordered,			3. The measures put in place or			
		nt to reposition off sacral			systemic changes made are: Nursing			
	area.	it to reposition on sacial			Staff were educated on resident			
					continence care, turning and reposition	ina		
	A wound physician pr	ogress note dated 01/12/16			by the DNS and Assistant Director of	<del>9</del>		
		ndation for the use of a			Nursing Services (ADNS) at various tin	nes		
		o follow-up with infectious			from June 3, 2016 to June 9,2016.			
		ndations in regards to			Nurses who care for residents who have	e l		
	antibiotic coverage.	<u> </u>			pressure ulcers were re-inseviced on h			
	<b>3</b> ·				to assess wounds, pressure ulcer			
	A review of a docume	ent titled "Wound Evaluation			treatment protocol, and preventive			
		Veeks" dated 12/18/15			interventions by ADNS on June 16, 20	16.		
	·	sore (facility acquired)			All new nursing staff will be educated			
	identified on 09/01/15	of the coccyx (a small bone			during orientation. Wound assessmen	ts		
	at the base of the spir	nal column) with a			will be brought to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDII			(	C
		345010	B. WING _			l	20/2016
	ROVIDER OR SUPPLIER  LIVINGCENTER - ASHE	VILLE		50	TREET ADDRESS, CITY, STATE, ZIP CODE 00 BEAVERDAM ROAD SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	by width 2.0 by depth A facility physician's PM was verbally obta (Nurse #1) for Woun dressing. 2) Clean w 3) Rinse with normal 4x4 gauzes. 5) Apply Dakins solution mois sacrum. Cover with a Change twice daily a dislodged dressing a The order was signe dated 02/12/16.  Another physician's o PM was verbally obta Care: 1) Cleanse wit saline. 2) Pat dry wit wound vacuum to wo mercury (mmHg), us for open wounds and needed for wound ca dislodgement every of Wednesday, and Frie order was signed by dated 02/12/16.  Another physician's o PM was verbally obta discontinue Dakin's o site, gauze, ABD pac cover two times a da Open Wound of Uns encounter. The orde physician and dated	timeters (cm) as length 6.5 in 5.7 and unstageable.  order dated 02/11/16 at 2:43 ained by the wound nurse d Care: 1) Remove old ith cleanser or normal saline. I saline. 4) Pat dry with sterile y one-quarter (1/4) strength stened gauze to wound bed of abdominal pad (ABD). Individual as needed if soiled or and every day and night shift. Individual by the facility physician and sterile 4x4 gauze 3) Apply bund bed. Use 125 milliliters are GranuFoam (foam used d wound vacuums) as are. Replace for soiling and day shift every Monday, day for wound care. The the facility physician and order dated 02/11/16 at 2:54 ained by Nurse #1 to solution to sacrum wound ds, cloth surgical tape to any related to Unspecified pecified Buttock, Initial r was signed by the facility	F	314	Morning/Stand-Down Meetings to be reviewed for accuracy and completene These records will be reviewed weekly ED and/or DNS at Morning/Stand-Dow Meetings. This monitoring will be completed ever week for four weeks, every other week the following four we and then one time a month for four weeks. The facility is also reaching out our Quality Improvement Organization (QIO) for assistance on prevention of pressure sores.  4. GLC-Asheville will monitor the corrective plan to ensure the practice we corrected and will not reoccur is the ED will report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions as needed to ensure continued compliance.  5. The correction date for substantial compliance is June 24, 2016.	by n eks to	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345010	B. WING		C <b>05/20/2016</b>		
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	1 00/23/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION		
F 314	Continued From page	e 54	F 31	4			
	dated 02/16/16. The in (cm) was length 6.	of the coccyx wound was coccyx wound measurement 5 by width 0.5 by depth 0.1 akin's solution wet to dry					
	The facility was unab evaluation document	ole to provide wound s from 12/18/16 to 02/16/16.					
	revealed an assessm was dated 03/16/16. measurement on 03/ measurement in (cm by depth 4.5 and a tr	urther review of the weekly wound evaluations vealed an assessment of the coccyx wound as dated 03/16/16. The coccyx wound easurement on 03/16/16 indicated a easurement in (cm) was length 5.5 by width 3.5 of depth 4.5 and a treatment of Dakins solution set to dry dressing twice a day (BID).					
		ole to provide weekly wound s from 02/16/16 to 03/16/16.					
	for subsequent week	the weekly wound 2 additional assessments s also dated 03/16/16 with ccyx wound measurements.					
	03/25/16 indicated the measurement in (cm.)	) was length 5.0 by width 3.5 itinued treatment of Dakins					
	revealed 2 additional	lso dated 03/25/16 with no					
	indicated a pressure	luation dated 04/15/16 sore (facility acquired) 5 of the sacrum (a bone at					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345010	B. WING		05/20/2016		
	ROVIDER OR SUPPLIER	EVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	03/20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION		
F 314	by depth 4.7 and un treatment of Dakins BID.  A review of the wour progress note dated #40 had undergone in an operating room osteomyelitis (infect area (tail-bone) and treatment. The prog Resident #40 had "underwent a colost 3-4 weeks ago (betwand that the procedisoiling of the wound stool and the inabilitiappropriately." The measurements of the length 5.5 by width sprogress note include orders which read in clean and resume the follow-up in one more further review of the indicated an assess sacrum wound mea 3.0 by width 2.5 by the Dakins solution wet.	ebral column) with a n) as length 4.3 by width 3.5 stageable with a continued solution wet to dry dressing  and physician's follow-up 104/20/16 indicated Resident a sacral wound debridement a due to the diagnosis of ion in the bone) of the sacral intravenous antibiotic ress note further indicated  omy procedure approximately ween 03/22/16 and 03/25/16) ure was done due to extreme on a constant basis from y to use the wound vacuum wound physician's e sacral wound in (cm) was 2.0 by depth 1.0. The let the wound physician ' s n part to keep the wound ne wound vacuum with a nth.  e weekly wound evaluations ment dated 05/06/16 with the surement in (cm) was length depth 2.6 an treatment of to dry dressing.  und evaluation was also a measurement as length 3.0 th 3.0 and a treatment of a	F 314				

` '		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345010	B. WING _			l	20/2016
	/ILLE		STREET ADDRESS, CITY, STATE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	, ZIP CODE		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	/E ACTION SHOULD BI D TO THE APPROPRIA		(X5) COMPLETION DATE
05/13/16 with a meas width 2.4 by depth 2. as wound vacuum in  An interview was con 05/16/16 at 11:05 AM have laid in feces for night long in feces be Resident #40 further out as a small area a feces is what caused wound is in a really b reason I had to have they did not keep me indicated the staff har and the wound vacuu wound physician had further indicated he h wound physician "ton the wound nurse (Nu the wound vacuum ar a wet to dry type dres appointment on Tues confirmed there were compliant with staying would forget. He state placed on his left side himself on his right side there were times whe back onto his back si observed to position up onto his right side re-position his legs.  Resident #40 was se appointment by the word of the training with the word seed and the state of the	ducted with Resident #40 on I. Resident #40 stated "I hours and have even laid all fore I got the colostomy." stated "my wound started and having to lay for hours in it to get worse. I know my ad area but I believe the the colostomy is because clean." Resident #40 d not changed the dressing im 3 times a week as the ordered. The resident ad an appointment with the norrow" 05/17/16 and that rese #1) had already removed and dressing and had placed sing until after his day, 05/17/16. Resident #40 times when he was not g off of his back and that he ed the wound vacuum was and he tried to position de as much as possible but the he would forget and roll de. Resident #40 was his upper body, from his hips but was unable to move or	F	314			
review of the wound	physician orders read in part					
	CONTINUED OR SUPPLIER  SUMMARY ST (EACH DEFICIENC REGULATORY OR II  Continued From page 05/13/16 with a meas width 2.4 by depth 2. as wound vacuum in  An interview was con 05/16/16 at 11:05 AM have laid in feces for night long in feces be Resident #40 further out as a small area a feces is what caused wound is in a really b reason I had to have they did not keep me indicated the staff har and the wound vacuum wound physician had further indicated he h wound physician "ton the wound nurse (Nu the wound vacuum ar a wet to dry type dres appointment on Tues confirmed there were compliant with staying would forget. He state placed on his left side himself on his right side re-position his legs.  Resident #40 was se appointment by the wand returned to the fareview of the wound provided the wound provided to the fareview of t	An interview was conducted with Resident #40 on 05/16/16 at 11:05 AM. Resident #40 stated out as a small area and having to lay for hours in a reason I had to have the colostomy."  Resident #40 further stated "my wound sis in a really bad area but I believe the reason I had to have the colostomy is because they did not keep me clean." Resident #40 indicated the staff had not changed the dressing and the wound vacuum 3 times a week as the wound physician "had not changed the dressing and the wound vacuum and dressing and had placed a wet to dry type dressing until after his appointment on Tuesday, 05/17/16. Resident #40 confirmed there were times when he was not compliant with staying off of his back and that he would forget. He stated the wound vacuum was placed on his left side am he wound vacuum was placed on his left side and he tried to position himself on his right side but was unable to move or	ROVIDER OR SUPPLIER  LIVINGCENTER - ASHEVILLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 56  05/13/16 with a measurement as length 3.0 by width 2.4 by depth 2.7 and a treatment indicated as wound vacuum in place.  An interview was conducted with Resident #40 on 05/16/16 at 11:05 AM. Resident #40 stated "I have laid in feces for hours and have even laid all night long in feces before I got the colostomy."  Resident #40 further stated "my wound started out as a small area and having to lay for hours in feces is what caused it to get worse. I know my wound is in a really bad area but I believe the reason I had to have the colostomy is because they did not keep me clean." Resident #40 indicated the staff had not changed the dressing and the wound vacuum 3 times a week as the wound physician had ordered. The resident further indicated he had an appointment with the wound physician had ordered. The resident further indicated he had an appointment with the wound vacuum and dressing and had placed a wet to dry type dressing until after his appointment on Tuesday, 05/17/16. Resident #40 confirmed there were times when he was not compliant with staying off of his back and that he would forget. He stated the wound vacuum was placed on his left side and he tried to position himself on his right side as much as possible but there were times when he would forget and roll back onto his back side. Resident #40 was observed to position his upper body, from his hips up onto his right side but was unable to move or re-position his legs.  Resident #40 was seen for a follow-up appointment by the wound physician on 05/17/16 and returned to the facility the same day. A review of the wound physician orders read in part	ROWDER OR SUPPLIER  LIVINGCENTER - ASHEVILLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  CROWDER 1. PROVIDER'S PL. (EACH CORRECTIVE TAGS)  CROSS-REFERENCE DEFINITY INFORMATION)  CROSS-REFERENCE DEFINITY INFORMATION  F 314  F 3	A BUILDING  345010  345010  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  800 BEAVERDAM ROAD  ASHEVILLE, NC 28804  SUMMAIN STATEMENT OF DEFICIENCIES  E(ACH DEPCISION) MUST SEP PERCEIPED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 56  An interview was conducted with Resident #40 on 05/16/16 at 11:05 AM. Resident #40 on 05/16/16 at 11:05 AM. Resident #40 stated "I have laid in feces for hours and have even laid all night long in feces before I got the colostomy." Resident #40 three stated "my wound started out as a small area and having to lay for hours in feces is what caused it to get worse. I know my wound is in a really bad area but I believe the reason I had to have the colostomy is because they did not keep me clean." Resident #40 indicated the staff had not changed the dressing and the wound vacuum at imms a week as the wound physician had ordered. The resident further indicated he had an appointment with the wound physician had ordered. The resident further indicated he had an appointment with the wound physician bad ordered. The resident further indicated he had an appointment with the wound vacuum at misses a week as the wound physician the propriet in the propriet in the wound vacuum and propriet in the word of the propriet in the prop	A BUILDING

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED		
		345010	B. WING _			C 05/20/2016	
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	<b>!</b>	03/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 314	Continued From pag and surrounding area with sterile 4x4 inch	as with normal saline, pat dry	F 3	14			
	GranuFoam, and use millimeters of mercul pressure, and chang Additional orders ind vacuum in place and	e wound vacuum to 125 ry (mmHg) negative e 3 times per week. icated to leave the wound transport with the wound or follow-up in 2 months, and					
	PM sitting up in his be stated his appointme wound physician had	pserved on 05/17/16 at 12:30 and eating his lunch. He ent had went well and the diadvised him to have the divacuum back on as soon facility.					
	PM lying on his right	oserved on 05/17/16 at 3:30 side with his eyes closed. was observed to not be in					
	PM sitting up in his balert, and awake with stated he was waiting if the wound vacuum the resident stated "No, I have asked 3.5"	pserved on 05/17/16 at 5:00 and at a 45 degree angle, in his television playing. He g for his supper. When asked in had been placed back on times for it to be put back on the to do it yet." The wound and to not be in place.					
	AM revealed Nurse # 05/17/16 at 5:54 PM resident went to wou Orders to continue w received. Wet to dry	e's notes on 05/18/16 at 9:00 #1 had documented on a note which read in part nd care appointment today. Yound vacuum therapy dressing in place after cuum therapy to begin					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345010	B. WING		05/20/2016		
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	1 33/10/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 314	tomorrow for Monday dressing change.  A review of the treatr (TAR) dated for May Wound Care: One tin GranuFoam with won Mon/Wed/Fri dated (discontinue date of 0 by her initials that shorder as written.  A follow-up interview Resident #40 on 05/ #40 stated the wounhim to have the staff on upon his arrival by the 7:00 PM to 7: indicated he had ask wound vacuum being was when the dressi wound vacuum was #40 stated "I do not it back on if I had not cresident further stated unless I push my cal when to change my everything because froom."  A telephone interview at 11:45 AM with Nur Resident #40 had as to have his wound vacuum distributed in the change my everything because froom."	ment administration record 2016 indicated the following: me order to use silver und vacuum therapy 05/17/16 at 11:59 PM and a 05/18/16. Nurse #5 indicated e had followed the one time  was conducted with 18/16 at 9:20 AM. Resident d physician had instructed put the wound vacuum back ack to the facility. Resident e wound vacuum was not late Tuesday night 05/17/16 00 AM nurse. Resident #40 ded Nurse #5 about the g put back on and at that time ng was changed and the placed back on. Resident think they would have put it of told them to do it." The dd "they never check on me I light. I have to tell them	F 314				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345010	B. WING _			C 5/20/2016	
	ROVIDER OR SUPPLIER	EVILLE		STREET ADDRESS, CITY, STATE, ZIP CO 500 BEAVERDAM ROAD ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 314	#5 indicated she w wound vacuum wa resident returned fr appointment. Nurse her understanding went out of the fact wound vacuum wa upon his return.  On 05/19/19 at 8:4 was conducted with stated he would had have resumed the resident 's return to order dated 05/17/ when the wound vacuum since it is an imporprocess and the refacility of our (physiconversation." The to say should the reat all times and was staying off of his base would not have been physician indicated wound and normal movements that the option for healing of the conducted by the well indicated the metallicated the	bound vacuum back on. Nurse as unaware as to why the sonot placed back on when the rom the wound physician at #5 further indicated it was that each time Resident #40 willity to an appointment that the soupposed to be started back as supposed to be started back as a telephone interview on the wound physician. He wound vacuum upon the south of the facility. He confirmed his account was to be re-started but the facility of the would be an "automatic given that part of the wound healing sident being able to advise the	F3	314			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILD	NG		,	C
		345010	B. WING			l	20/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
COLDEN	LIVINGOENTED AGUE	2015		50	00 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHE	VILLE		A	SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	conducted with Nursassessed the reside continued the treatm verbally discuss a difacility physician, wrand asked him to sig #1 stated the Dakins was supposed to be was sent out to an a wound vacuum malf she did not change wound vacuum back Resident #40's wound Nurse #1 stated "I condum vacuum because the long." Nurse #1 furt days mixed up betweed on the remember who wacuum was not put she had been filling approximately 2 weed became the full-time no explanation as to dates on the weekly discrepancies. Nurschanged the sacral and re-started the wood/13/16. She further removed the wound 05/16/16, placed a Eorder for the resident Tuesday 05/17/16 to appointment. Nurse changed the sacral the wound vacuum of confirmed she had reconfirmed she	PM an interview was se #1. Nurse #1 stated she nt's pressure sores and nents as ordered or she would afferent treatment with the lite up the physician's order, gon that particular order. Nurse is solution wet to dry dressing a used only when the resident appointment or should the function. Nurse #1 confirmed the dressing or place the con Tuesday 05/17/16 after and physician appointment. It did not continue the wound the resident stayed up too her stated "I may have my een Tuesday and Thursday. I may the resident's wound has the wound nurse until the example wound nurse. Nurse #1 stated in as the wound nurse would wound documents had the wound dressing, replaced, ound vacuum on Friday er confirmed she had	F	314			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		E SURVEY IPLETED
		345010	B. WING _		، ا	C 5/20/2016
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804		3/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	would not have been dressing on Wedneson Tuesday night.  An interview was comply with the facility phenomenate was followed by a further stated he had involvement in the trepressure sores. The production of the production of the production of the producted with the District of the assessments and sores. The DON stated to be capable of assessments to be deevery 7 days. The DOS	expected to change the lay since Nurse #5 did it on ducted on 05/20/16 at 3:18 expected. He stated Resident a wound physician. He not observed and had no atment of Resident #40's obysician indicated the by Nurse #1 and the wound endations and he signed the PM an interview was rector of Nursing (DON). In she was hired in February ed a consistent problem with treatments of pressure ed she expected every nurse essing a residents wound anges. She further stated in assessments and wound one weekly which meant on interview was aware	F3	14		
F 323 SS=D	The DON stated she weekly meeting with I resident's wounds, the ensure the treatments individual resident. Stunaware Resident #4 proper care and dress 483.25(h) FREE OF A HAZARDS/SUPERVI	Nurse #1 to discuss e measurements, and to s were working for that ne further stated she was 0 had not been provided sing changes to his wounds. ACCIDENT SION/DEVICES	F3	23		6/24/16

DRRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
	345010	B. WING		C 05/20/2016		
VIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE  500 BEAVERDAM ROAD  ASHEVILLE, NC 28804			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG				
s is possible; and ea dequate supervisior revent accidents.	ach resident receives and assistance devices to	F 323				
y: Based on observation eviews the facility fail atterventions for a rest or 1 of 1 resident revolution.  The findings included the finding the findicated the	ns, interviews and record led to implement sident with a history of falls iewed for falls (Resident  : mitted to the facility on ses which included sis, and respiratory disorder. m Data Set (MDS) dated e resident had severely id had trouble falling or lent #14 required extensive experson assist for bed ersonal hygiene, and lso indicated the resident was only able to transfer with MDS further revealed or more falls since her last sment (CAA) dated ls due to poor balance story of falls, and poor safety		environment remains as free of accide hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accident 1. The corrective action accomplisher for Resident #14 is his/her intervention were reviewed and updated to prevent future falls on June 15, 2016. A new Recreation Services Assessment will be completed by June 23, 2016 with input from Resident #14's family member an included in his/her plan of care to atter activities of choice to prevent falls.  2. Residents who have been identified by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Team (comprised of Department Heads and their assistants, and Unit Managers) to have the potential to be affected are the residents who have had a fall or potential for falls since March 18, 2016. When a resident has a potential for a fall based	nt t s. d s e d d d ed		
The second Pose of the second	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I  ontinued From page is is possible; and eadequate supervision revent accidents.  his REQUIREMENT y: Based on observation eviews the facility fail terventions for a resurt of 1 resident revent accident revent ac	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ontinued From page 62 s is possible; and each resident receives dequate supervision and assistance devices to revent accidents.  his REQUIREMENT is not met as evidenced (C) Based on observations, interviews and record eviews the facility failed to implement terventions for a resident with a history of falls or 1 of 1 resident reviewed for falls (Resident 14).  he findings included: esident #14 was admitted to the facility on 2/05/13 with diagnoses which included ementia, osteoporosis, and respiratory disorder. he quarterly Minimum Data Set (MDS) dated 2/19/16 indicated the resident had severely repaired cognition and had trouble falling or aying asleep. Resident #14 required extensive sesistance with 1 to 2 person assist for bed obbility, transfers, personal hygiene, and ressing. The MDS also indicated the resident as not steady and was only able to transfer with aff assistance. The MDS further revealed esident #14 had 2 or more falls since her last DS assessment.  he Care Area Assessment (CAA) dated 2/02/15 triggered falls due to poor balance uring transfers, a history of falls, and poor safety wareness.  care plan dated 03/03/16 was reviewed and	INGCENTER - ASHEVILLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Ontinued From page 62  Is is possible; and each resident receives dequate supervision and assistance devices to revent accidents.  Tags  This REQUIREMENT is not met as evidenced (Company)  The state of the state o	INGENTER - ASHEVILLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ontinued From page 62 si s possible; and each resident receives dequate supervision and assistance devices to revent accidents.  F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  Gross-REFERENCED TO THE APPROPRY DEFICIENCY)  F 323  FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  Golden Living Center - Asheville (GLC-Asheville) ensures that the resident receives adequate supervision and assistance devices to revent accident environment remains as free of accide hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accident receives adequate supervision and assistance devices to prevent accident receives adequate supervision and assistance devices to prevent accident 1. The corrective action accomplished for Resident #14 is his/her intervention were reviewed and updated to prevent future falls on June 15, 2016. A new Recreation Services Assessment will be completed by June 23, 2016 with input from Resident #14 fs family member an included in his/her plan of care to atten activities of choice to prevent falls. as not steady and was only able to transfer with aff assistance. The MDS further revealed esident #14 had 2 or more falls since her last DS assessment.  The Care Area Assessment (CAA) dated 2/02/15 triggered falls due to poor balance uring transfers, a history of falls, and poor safety wareness.		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345010	B. WING		C 05/20/2016
NAME OF PE	ROVIDER OR SUPPLIER	0.00.0		STREET ADDRESS, CITY, STATE, ZIP CODE	05/20/2016
NAME OF T	TO VIDER OR OUT FEEL			, , ,	
GOLDEN I	LIVINGCENTER - ASHEV	'ILLE		500 BEAVERDAM ROAD	
				ASHEVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 323	Continued From page	e 63	F 32	3	
	interventions of falls for	or Resident #14. The care		Morning/Stand-Down Meetings and/o	r l
	plan had no interventi			Weekly Risk meeting where new	
	•	l/16 which caused an injury		interventions will be added to the care	, l
		and head. Further review of		plan.	
		ndicate interventions to		3. The measures put in place or	
	increase staff observa			systemic changes made are: The	
	involvement in activiti			Minimum Data Set Coordinator (MDS	C)
				was re-educated by Clinical Assessm	
	A review of the fall ac	cident reports indicated		Reimbursement Specialist on May 18	
	Resident #14 had fall	s on the following dates and		2016 on how to assess, complete	
	times:			interventions and care plans to includ	e a
	· 01/02/16 at 10:00	) AM		potential for falls and/or a fall occurs.	
	· 01/11/16 at 3:06	PM		Licensed Nurses were re-educated or	า
	· 03/04/16 at 5:10	AM		June 9, 2016, new nursing staff durin	
	· 03/23/16 at 9:00	AM		orientation will be educated on how to	)
	· 04/04/16 at 5:20	PM		complete fall assessment and docum	ent
	· 04/16/16 at 6:32	PM		falls and/or potential for falls. The MI	DSC
	· 05/06/16 at 7:09	PM		and other Interdisciplinary Team Mem	
				will be attending an education session	ו
		to have occurred from the		with the North Carolina Resident	
		mpting to transfer. Review of		Assessment Instrument Coordinator	
		dicated the facility had		related to MDS accuracy, and care pl	
		t post a fall, had provided		to include interventions to prevent fall	S.
	•	on of the falls, and had		Resident's CAAs and MDS will be	
		and the resident's legal		updated/completed according to the	.
		nterventions to prevent		resident assessment/care plan sched	
		es were not always indicated		and/or as new interventions are adde	
		ne summary or outcome of		be brought to the Morning/Stand-Dow	
	the fall was not alway	s accumentea.		Meetings to be reviewed. These reco	
	D : ( ( ( )			will be reviewed weekly by ED and/or	
		t dated 04/04/16 indicated		DNS at Morning/Stand-Down Meeting	
		vent a fall occurrence was		This monitoring will be completed every	
		staff observation with better		week for four weeks, every other week	
	_	tervention was not added to		following four weeks and then one time	le a
	the care plan or to the	e nurse aide care guides.		month for four weeks.	
	Davious of the staffing	on the dates of Desident		4. GLC-Asheville will monitor the	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	_	on the dates of Resident		corrective plan to ensure the practice	
	#14's falls indicated th			corrected and will not reoccur is the E	ט:
	· 01/02/16 at 10:00	AM, 6 nurse aides (NAs)		will report the findings of the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X	B) DATE SURVEY COMPLETED
		345010	B. WING _			C <b>05/20/2016</b>
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CO 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	DE	33/23/23 13
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	55 residents, Resident to her bed with a to remind the resident other interventions to identified.  • 01/11/16 at 3:06 2nd shift (3:00 PM urresidents, Resident her lap belt and rolled floor, with interventio the resident for anxieted of the resident for 55 residents, administration Resides sounding and the resident for 55 residents, administration Resides out of her bed and we interventions was the better staff coverage to the care plan inclusion a concave mattress. already on the care pronew interventions coverage or observation of the belief of the the form of the second of the belief of the the care pronew interventions coverage or observation of the belief of the second	ft (7:00 AM until 3:00 PM) for an intervention implemented at to use the call bell, no the care plan were  PM, 4 NAs scheduled for at 11:00 PM) for 54  ft 4 was observed to un-do defrom her wheelchair to the ans implemented to monitor at y and restlessness.  AM, 3 NAs scheduled for 3rd 7:00 AM) for 55 residents  AM, 6 NAs scheduled for 1st during medication ent #14's alarm was heard aident was found lying in the line No additional interventions are plan.  PM, 3 NAs scheduled for ents, Resident #14 had rolled as found in the floor, are recommendation to include and the interventions were and the interventions were old an and were updated with added. An increase in staff	F 3		y Assurance Committee view and nds. The ults and ntions and compliance. substantial	
	new interventions ad	hematoma, there were no ded to the care plan. PM, 3 NAs scheduled 2nd				

	IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  AN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		COMF	(X3) DATE SURVEY COMPLETED		
		345010	B. WING_			C / <b>20/2016</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	03/	20/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	the floor scooting on care plan revisions of 05/06/16 at 7:09 2nd shift for 61 resid found at the foot of the crawling type position indicated care plan readditional intervention noted.  A review of the nurse 10:19 PM indicated flowhich was not indicated which was not indicated for the fall mat face distribution of the fall mat face distributio	Resident #14 was found on her bottom. There were no reinterventions added. PM, 3 NAs scheduled for ents, Resident #14 was ne bed face down in a n. The accident report evisions were made but no ons to the care plan were  est's notes dated 04/14/16 at Resident #14 had another fall ted on the fall report. Oted to be lying on the edge own on her right side with forehead and a bump dician and RP were notified.  uide indicated Resident #14 which included bed alarms, a fall mats to both sides of w, low bed position, concave	F3	23		
	accidents. NA #1 als	to help avoid falls or other o indicated when a resident I with a mechanical lift they				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345010	B. WING			C 05/20/2016	
	ROVIDER OR SUPPLIER	:VILLE	STREET ADDRESS, CITY, STATE, ZIP CODE  500 BEAVERDAM ROAD  ASHEVILLE, NC 28804			03/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	An interview was co PM with Resident #' is not enough staff h watch her like they s falling." The RP furth night with Resident; no one had checked Resident #14 was o AM in her room setti seatbelt in place and Resident #14 was o PM lying in bed on a low position, fall mat bed alarm in place a An interview was co PM with NA #2. She assigned and respon hour shift. NA #2 inc included incontinent and showers was no	nducted on 05/16/16 at 2:20 14's RP. The RP stated "there lere to take care of her and should to keep her from her stated she had stayed all #14 with 1 NA on the hall and I on the resident all night.  bserved on 05/17/16 at 11:30 ing in her wheelchair with the I the chair alarm functional.  bserved on 05/17/16 at 2:30 in concave mattress, bed in its on both sides of the bed,	F 32	23			
	indicated "Yes, we hour-self using the monone else to assis unable to keep an eavoid falls or other a responsible for the con a shift.  On 05/18/16 at 4:00 observed in her bed	for each resident. NA #2 also have to transfer a resident by echanical lift because there is to us." NA #2 stated she was experiently a resident to help accidents with being hare of 30 or more residents.  PM Resident #14 was with the bed in low position, and fall mats in the floor on both					

PRINTED: 08/02/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345010	B. WING			1	20/2016	
	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE  00 BEAVERDAM ROAD  ASHEVILLE, NC 28804	1 03/	20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 323	resident. The RP state past 3 months could be staff which causes not the residents frequent.  An interview was con AM with the 100 hall be stated she expected to residents prone to accompart to the residents prone to accompare to the residents prone to accompare to the residents prone to make so that particular resident.  On 05/19/16 at 2:05 For observed to be out of and in an activity play time Resident #14 was since 05/15/16.  An interview was con PM with NA #3. She so prone to falls and that but should an NA be in providing care there was one available to NA #3 also stated she care is provided to the always possible where help.  An interview was con AM with the Director of stated she was award documentation for fall.	the RP in the room with the ed "I believe the falls in the one attributed to the lack of one to be able to check on the ed to be able to check on the ed to check of	F	323				

STATEMENT OF AND PLAN OF (	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	(X3) DATE COMP	SURVEY
		345010	B. WING			C <b>20/2016</b>
NAME OF PRO	OVIDER OR SUPPLIER	0.00.0		STREET ADDRESS, CITY, STATE, ZIP CODE	05/	20/2016
	IVINGCENTER - ASHEV	ILLE		500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
F 353 SS=E	aware of the issues the staffing and that it was of the issues the facility DON stated she expetheir observations of rishe expected the care the appropriate interversinvestigation. She furt that insufficient staffin shifts were part of the working to improve the An interview was cone AM with the MDS Nurplans were typically unan intervention was not she also stated the fameeting every mornin updated at that time for an immediate interver confirmed Resident # inadequate and income 483.30(a) SUFFICIEN PER CARE PLANS  The facility must have provide nursing and remaintain the highest pand psychosocial well determined by resider individual plans of car.  The facility must provinumbers of each of the personnel on a 24-hores.	ON further stated she was the facility has had with as an important part of many ty was dealing with. The cted the staff to improve on residents prone to falls and the plans to be updated with the entions after a fall ther stated she was aware grespecially on 2nd and 3rd issue and that she was the staffing.  Inducted on 05/20/16 at 10:30 rese. She stated the care plated quarterly and when the edded such as after a fall. Indicitly had a managers grand care plans were for any resident that needed that inclining the managers and the scare plan was applete.  In 24-HR NURSING STAFF  The sufficient nursing staff to be elated services to attain or contact and the services by sufficient that assessments are sufficient that assessments and the services by sufficient that assessments are sufficient that assessment as a sufficient that are sufficient that are sufficient that are sufficient that are sufficien		323		6/24/16

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345010	B. WING		05/20/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
GOI DEN I	LIVINGCENTER - ASHE	/II I F		500 BEAVERDAM ROAD		
COLDEN	ENTINOCENTER - AONE	· ILLE		ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 353	Continued From page	e 69	F 353	3		
		under paragraph (c) of this ses and other nursing				
	section, the facility m	under paragraph (c) of this ust designate a licensed harge nurse on each tour of				
	by: Based on observation staff, and resident into provide sufficient nur for 5 of 5 residents of staff not meeting the as showers, incontinument the residents and (Residents #40, #34, The findings included This tag is cross refermable.  1) F 242 Based on of resident, and staff into honor a resident's chance in a week for reviewed for choices and #49).  2) F 282 Based on of review, resident, and	rred to:  pservations, record review, rerviews the facility failed to oice for the number of or 4 of 4 residents who were (Residents #40, #34, #14, pservations, medical record staff interviews, the facility		F353 SUFFICIENT 24-HR NURSING STAFF PER CARE PLAN  Golden Living Center - Asheville (GLC-Asheville) has sufficient nursing staff to provide nursing and related services to attain or maintain the high practicable physical, mental and psychosocial well-being of each resid 1. The corrective action accomplish for Resident #40, #34, #19, #49, and is as follows: F242:The corrective action accomplis for Residents #40, #34, #49 was show preferences were reviewed with these residents and Resident #14 resident's representative shower preference was discussed and new shower schedule completed to allow these residents to obtain showers at their preference. T was completed on May 25, 2016.	est ent. ed #26 hed ver es s s was	
		re plan for using a of 2 residents who were or transfers (Resident #26		F282: The corrective action accomplished for Resident #26 & #40 reviewed and updated their lift assessments and plan of care on May		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345010	B. WING			C 5/ <b>20/2016</b>
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	101.02.1 01.1 00.1 2.2.1			500 BEAVERDAM ROAD		
GOLDEN LIVINGCENTER - ASHEVILLE		VILLE		ASHEVILLE, NC 28804		
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F 353	resident, and staff intassist residents with dependent on staff for sampled for activities and #34).  4) F 314 Based on or resident, and staff interventions for a residents reviewed for #40).  5) F 323 Based on or residents reviewed for #40).  5) F 323 Based on or record reviews the fainterventions for a refor 1 of 1 resident review #14).  A review of the employacility revealed a tot shifts/7days a week; PM) and night shift (7 of 13 full-time nurses adays a week; 1st shift shift (3:00 PM to 11:0 PM to 7:00 AM). The approximately 3 Nursi (NAs) which were no	poservations, record review, rerviews the facility failed to a shower who were totally or bathing for 2 of 2 residents of daily living (Resident #40 poservations, record review, rerviews the facility failed to kly wound assessments and entinence care to a resident pressure sores for 1 of 1 per pressure sores (Resident p	F 38	,	reviewed eent #14 er new ed to allow ers at their ed on May complished ing to the dated dission) a in 6.5cm by e III area by depth on the do did not in the ubpubic ore, does etting; ery shift and/or pleted as and with asked	
	tracking log dated 07	y's grievance/concern /14/15 through 05/20/16 concerns filed in regards to care as follows:		allegation he did not receive inc care and when it occurred. This the facility could do an appropri investigation and grievance/con according to facility policies and procedures. Completed as of J	s was so ate ncern d	

			ATE SURVEY DMPLETED			
		345010	B. WING			C 05/20/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	30/20/2010
				500 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHE	/ILLE		ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	answered  02/04/16 NA car  02/06/16 2 concersident not getting a related to call lights n  03/01/16 Call lightimely  04/04/16 Reside  04/14/16 Call lightimely  05/10/16 Reside  all lights not being a  05/16/16 Short s  provided  Review of the Reside  07/29/15 through 05/  concerns which were residents who attend  07/29/15 Call lightimely  10/27/15 Call lightimely and staffing co  11/05/15 Call lightimely, activities, and	e care e concerns nt showers g concerns hts g and call lights not being e cerns filed; 1 related to shower and the other not being answered hts not being answered ht not getting a shower ht not getting ice water and nswered taffed and care not being ent Council Minutes dated 10/16 revealed the following voiced by alert and oriented ed the meetings: hts not being answered	F 35	,	rventions prevent new ent will be eith input mber and to attend eills.  identified ing ip Team ds, their  the rent sures put  or ursing rector to establish required. esidents or personal to meet Review e adequate	
	· 02/25/16 Staffing · 04/14/16 Call lightimely	g concerns  hts not being answered  c concerns and call lights not		the acuity level and provide qua Facility is networking with area Homes, Community Colleges, a pools for staffing, recruitment a	ality care. Nursing and Agency	

			(X3) DATE SURVEY COMPLETED				
		345010	B. WING _			C <b>05/20/2016</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	1 00/20/2010	$\neg$
001.5511				500 BEAVERDAM ROAD			
GOLDEN	LIVINGCENTER - ASHEV	TLLE		ASHEVILLE, NC 28804			
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F 353	Continued From page	÷ 72	F 3	53			
	being answered timel	у		retention. Also partnering w	ith our QIO	on	
	the facility revealed the 100 Hall had 31 in Nurse	PM during an initial tour of ne following staff: residents with 1 NA and 1 residents with 2 NAs and 2		implementing new retention tools. Executive director wi staffing pattern with the DN the next 3 months.  4. GLC-Asheville will more corrective plan to ensure the corrected and will not reoccurrent tools will be presented.	Il review IS weekly fo nitor the ne practice wo	r /as	
	NA #1 stated she was residents on 1st shift NA #1 indicated most have 2 showers a we only get 1 shower a was residents were not chathey needed to be an short staffed and work assistance she would herself using the medindicated the resident and ADL care was no because she was unattention of the state of	from 7:00 AM to 3:00 PM. residents were supposed to ek and that sometimes they week. She stated the ecked on or changed as d due to the facility being king with no other NA for often transfer a resident by hanical lift. NA #1 further 's personal hygiene care t provided as it should be able to get around to all 31		ED and/or DNS at Morning Meetings. The ED will report of the reviews to Quality As Performance Improvement (QAPIC). The QAPIC will ranalyze for patterns and tree QAPIC will evaluate the resimplement additional intervinceded to ensure continues. The correction date for compliance is June 24, 201	/Stand-Dow ort the findin surance Committee review and ends. The sults and entions as d compliance substantial	n gs e.	
	NA #6 indicated she hand due to a staff call another staff member stated the NAs did the the facility being shorneeds were not met.  On 05/16/16 at 2:08 FNA #4 reported the fathe care of the reside	PM NA #6 was interviewed. nad worked an 8 hour shift out she was working until could relieve her. NA #6 the best they could but due to the staffed the resident care  PM NA #4 was interviewed. cility was short staffed and the nest was not being provided ked short staffed most days.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345010	B. WING _			C 05/20/2016	
	ROVIDER OR SUPPLIER	/ILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 353	NA #2 stated she was residents on 2nd shift NA #2 reported due to NAs had not had time showers, nail care, at needs were not alway them clean and dry. It were many times that resident using a mechanical litreported she had using a mechanical litreported the facility we care of the residents the NAs worked short On 05/18/16 at 4:32 food at the care needs were not being short staffed mushe had visited her loand soiled, with dried strong odor in the residents shower 2 times a week a shower but 1 time at RP further indicated or resident she would git in order for him to feet RP stated she had sp. Nursing (DON) and the to the facility being shorts at the stated she had sp. Nursing (DON) and the to the facility being she had visited being should git in order for him to feet RP stated she had sp. Nursing (DON) and the to the facility being she had the stated she had sp. Nursing (DON) and the facility being she had the stated she had sp. Nursing (DON) and the tother facility being she had the stated she had sp. Nursing (DON) and the facility being she had the stated she had sp. Nursing (DON) and the facility being she had the stated she had sp. Nursing (DON) and the facility being she had the stated she had sp. Nursing (DON) and the facility being she had the stated she had sp. Nursing (DON) and the facility being she had the stated she had sp. Nursing (DON) and the facility being she had the stated she had sp. Nursing (DON) and the facility being she had the stated she had the	PM NA #2 was interviewed. It is responsible for 28 to from 3:00 PM to 11:00 PM. It is working short staffed the et to provide oral care, and that the resident's basic sys met such as keeping NA #2 also reported there it she had transferred a chanical lift by herself to one to help assist.  PM NA #7 was interviewed. It is was short staffed and the was not being provided and it staffed most days.  PM an interview was dent's legal representative that her loved ones basic being met due to the facility ost days. The RP reported eved one when they were wet food on their clothing, and a cident room. The RP it was supposed to receive a lek and they had not received a lek and they had not received a lek and they had not received a lek and they had not smell. The looken with the Director of the Administrator in regards nort staffed and that all she as that they were working on	F3	53			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED
		345010	B. WING		C <b>05/20/2016</b>
	345010  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  500 BEAVERDAM ROAD  ASHEVILLE, NC 28804  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  ID  PROVIDER'S PLAN OF CORRECTION	1 00/20/2010			
PRÉFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE COMPLETION
F 353	On 05/19/16 at 10:3 interviewed. Nurse for a resident to have or more should the residents who were checked and change there should always was transferred using reported that the nurbule to the facility be on 05/19/16 at 11:1 interviewed. She stansist on the halls being was responsible for further stated the Noresidents clean, dry ADL were not getting staffing. Nurse #7 rehad to work as NAs the past several more should be a surface of the past several more should be	#8 stated the expectation was we at least 2 showers a week resident request more, incontinent should be at least every 2 hours, and as be 2 staff when a resident ring a mechanical lift. Nurse #8 urses had had to work as NAs being short staffed.  #10 AM Nurse #7 was ated she had been assigned to an the capacity of a Nurse Aide ring short staffed and that she in taking call also. Nurse #7 As could not keep the and to the lack of exported that the nurses have at least 1 to 2 days a week in	F 35	3	
	NA #8 stated the NA days. NA #8 further they can and that it the resident's care and shaving due to On 05/19/16 at 2:30 (DON) was interviee expectation that all resident and if certathey should be reported they should be reported they should be reported to the pool of the DON stated shidentified a problem.	As worked short staffed most			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345010	B. WING _		05/20/2016
	ROVIDER OR SUPPLIER LIVINGCENTER - ASHE	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE  500 BEAVERDAM ROAD  ASHEVILLE, NC 28804	1 00/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 353 F 502 SS=D	she did not know wh for the residents exc staffing. The DON co many instances whe agency worked in an resident's needs. 483.75(j)(1) ADMINI The facility must pro- services to meet the	s. The DON further stated at needs were not being met ept for showers due to onfirmed there had been in staff from the staffing attempt to meet the	F 3		6/24/16
	by: Based on medical reinterview the facility order for lab work for (Resident #49). The findings included 1. Resident #49 was 07/22/14 with diagnor high cholesterol, hypanemia, arthritis and Review of medical reinterview of the lab reinterview of the	admitted to the facility on uses which included diabetes, werthyroidism, renal failure, chronic pain.  ecords indicated Resident		F 502 ADMINISTRATION – LABORATORY SERVICES  Golden Living Center - Asheville (GLC-Asheville) provides laboratory services to meet the needs of our residents.  1. The corrective action accomplis for Resident #49 is the attending physician was contacted and ordere Basic Metabolic Panel (BMP), Com Blood Count (CBC), Thyroid Stimula Hormone (THS) and A1C (blood tes showing how well diabetes is contro on May 20, 2016. The same day the results were called to the attending physician; no changes were ordered 2. Residents who have been iden by the Executive Director ((ED) Administrator), Director of Nursing Services (DNS), and Leadership Te	shed ed plete ating st blled) e d. tified

CENTER	3 FOR WEDICARE &	VIEDICAID SERVICES				OIVID INC	. 0930-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345010	B. WING				20/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				50	00 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHEV	/ILLE		Α	SHEVILLE, NC 28804		
	OLIMANA DV OT	ATEMENT OF DEFICIENCIES			· 		0.17)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 502	Continued From page	÷ 76	F	502			
	· -	alth and detect a wide range	' '	502	(comprised of Department Heads and		
	of disorders including				their assistants, and Unit Managers) to		
	_	(TSH - a blood test used to			have the potential to be affected are		
	_	the thyroid gland), Lipid			current residents. An audit of the facilit	.,	
	-	ne risk of developing heart			was completed for Laboratory Services		
	, ,	inction Tests (LFT - groups			(LABs) to ensure all ordered LABs wer		
		ovide information about the			completed timely.		
		had not been completed in			3. The measures put in place or		
	March 2016. The mo	st recent labs for BMP, CBC			systemic changes made are: Licensed		
	and A1c were in Dece	ember of 2015. The TSH			Nurses were re-educated by DNS on J	une	
	was collected in Sept	ember 2015 and the LFT			9, 2016 and June 15, 2016; new nursir	ıg	
	and Lipid Panel were	collected in August 2015.			staff during orientation will be educated	l on	
	During an interview w	ith the Medical Records			LAB protocol, how to write LAB orders,		
	Director on 05/19/201				LAB requisitions, ensure LAB was		
		iewed the medical records			obtained and sent; notify the attending		
		results so she contacted the			physician of results and carry out new		
		d and they verified these six			orders. LAB book will be checked daily	-	
		mpleted this year and the			Charge Nurse. Audits and monitoring		
		e in December of 2015.			be completed five times a week for one		
	_	rith the Director of Nursing			month, three times a week, and then o		
	` <i>'</i>	7:43 AM, she stated she			a week. These audits will be brought to the Morning/Stand-Down Meetings to be		
	had identified poor la	st started working at the			reviewed. These records will be review		
	facility and she had b	•			by ED and/or DNS at	veu	
	resolution. The DON				Morning/Stand-Down Meetings.		
		nsed nurses now check to			4. The GLC-Asheville will monitor the	,	
		dictation on that day from a			corrective plan to ensure the practice v		
		lers, then they transfer the			corrected and will not reoccur is the ED		
		b book and monitor to			will report the audits from LAB services		
		through with the lab orders.			Quality Assurance Performance		
	The lab book was sta	rted in April 2016 and			Improvement Committee (QAPIC). The	e	
	identified when each	resident had labs due. She			QAPIC will review and analyze for		
		s were done through an			patterns and trends. The QAPIC will		
	_	d her expectation was for all			evaluate the results and implement		
	lab orders to be follow	ved with 100 percent			additional interventions and needed to		
	accuracy.				ensure continued compliance.		
					5. The correction date for substantial		
					compliance is June 24, 2016.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345010	B. WING		C 05/20/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  500 BEAVERDAM ROAD  ASHEVILLE, NC 28804	<b>05/20/2016</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 520 F 520 SS=E	QUARTERLY/PLANS	SERS/MEET	F 52		6/24/16	
	assurance committee nursing services; a p	e consisting of the director of hysician designated by the other members of the				
	issues with respect to and assurance activi develops and implem	ent and assurance east quarterly to identify by which quality assessment ties are necessary; and nents appropriate plans of tified quality deficiencies.				
		ords of such committee ch disclosure is related to the committee with the				
		by the committee to identify eficiencies will not be used as				
	by: Based on observation and resident interview Assessment and Assemaintain implemente these interventions the place August 2015 and for eight recited defice	ons, record reviews and staff ws the facility's Quality curance Committee failed to d procedures and monitor nat the committee put into nd October 2015. This was ciencies which were originally ne recertification survey and		F520 QAA COMMITTEE  MEMBERS/MEET QUARTERLY/PLA  Golden Living Center - Asheville (GLC-Asheville) has maintains a quali assessment and assurance committee consisting of the director of nursing services, a physician, and at least three	ity e	

			(X3) DATE SURVEY COMPLETED		
		345010	B. WING		C
NAME OF D		343010		STREET ADDRESS, CITY, STATE, ZIP CODE	05/20/2016
NAME OF PI	ROVIDER OR SUPPLIER			, , ,	
GOLDEN	LIVINGCENTER - ASHEV	/ILLE		500 BEAVERDAM ROAD	
				ASHEVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICENCY)	O BE COMPLETION
F 520	Continued From page	÷ 78	F 52	0	
	on the current recertif	ication survey. The		other members of the facility □s staff	. The
	deficiencies were in the			committee identifies issues with resp	
		eds, services to meet		which quality assessment and assur	
		ls, activities of daily living,		activities are necessary; and develop	
	-	ents, sufficient staffing, and		and maintains appropriate plans of a	
	quality assessment a			to correct identified quality deficienci	
		e facility during two federal		The corrective action accomplis	
		w a pattern of the facility's		for F242 Choices; F246 Accommoda	
	-	effective Quality Assurance		of Needs; F281 Services to meet	
	Program.	chiconic Quanty / local and		Professional Standards; F312 Activit	ies of
	9			Daily Living; F314 Pressure Sores; F	
	The findings included	:		Accidents; F353 Sufficient Staffing; i	
		-		follows:	
	This tag is cross refer	red to:		F242: The corrective action accomp	ished
	<b>.</b>			for Residents #40, #34, #49 was sho	
	1a. F242: Choices: Ba	ased on observations,		preferences were reviewed with thes	
		nt, and staff interviews the		residents and Resident #14 resident	
		a resident's choice for the		representative shower preference w	as
	•	a week for 4 of 4 residents		discussed and new shower schedule	
	who were reviewed for	or choices (Resident #40,		completed to allow these residents to	o
	#34, #14, and #49).	,		obtain showers at their preference.	
	,			was completed on May 25, 2016.	
	During the recertificat	ion survey of June 27, 2015		F246: The corrective action accomp	lished
		or F242 for failure to honor		for Residents #48 is immediately after	
		the time for getting up in the		notification the call light was not in re	each
	mornings and failed to	o honor a resident's food		of Resident #48 it was placed correct	t
	•	current recertification survey		position according to resident □s pla	
	the facility failed to ho	onor a resident's choice for		care.	
	the number of shower	r in a week.		F281: The corrective action accomp	lished
				for Residents #10 was the contents	of the
	b. F246: Accomn	nodation of Needs: Based on		medicine cup was discarded on May	16,
	observations, medica	I record review, staff, and		2016. Resident # 49 was provided t	hree
	resident interviews the	e facility failed to place a call		cups of ice water and her preference	es
	light within reach for 1	of 1 resident reviewed for		was updated to include three cups o	f ice
	accommodation of ne	eds (Resident #48).		water each shift. This was complete	ed on
				May 20, 2016.	
	During the recertificat	ion survey of June 27, 2015		F312: The corrective action	
	the facility was cited f	or F246 for failure to keep a		accomplished for Residents #40, #3	4, #34
	call bell in reach. On t	the current recertification		was shower preferences were review	ved

			TE SURVEY MPLETED			
		345010	B. WING			C = 120/2046
NAME OF DE	ROVIDER OR SUPPLIER	0.0010	<u> </u>	STREET ADDRESS, CITY, STATE, ZI		5/20/2016
NAME OF F	NOVIDER OR SUFFLIER			, , ,	IF CODE	
GOLDEN I	LIVINGCENTER - ASHE	/ILLE		500 BEAVERDAM ROAD		
				ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 520	Continued From page	e 79	F 52	20		
	reach of a resident.	ed to place a call light within s to Meet Professional		with these residents and resident s representative preference was discussed by the way of the way and	ve shower ed and new	
				shower schedule was co	•	
		observations, medical		these residents to obtain		
	· · ·	and resident interviews, the		preference. This was co	mpleted on May	
	facility failed to provid			25, 2016.	tion goognalished	
	professional standard			F314: The corrective act for Resident #40 is that		
	reviewed (Resident #	10 and #49).		Wound Evaluation Flow	•	
	During the recortificat	tion survey of June 27, 2015		February 17, 2011 (time		
		for F281 for failure to clarify		Stage IV Length 8.7cm b		
	the correct method of	-		depth 1.4cm. and another	-	
		orrect dose of medication.				
		fication survey the facility		Length 2.3 cm by width 6.6cm by depth 0.3cm both areas were located on the		
		ices that met professional		resident⊡s sacrum. Res		
	standards.	ices that met professional		acquire a pressure sore		
	staridards.			facility to his/her sacrum		
	d F312: Activitie	s of Daily Living: Based on		Resident #40 currently h		
		review, resident, and staff		catheter and colostomy;		
		failed to assist residents		not require assistance w		
		ere totally dependent on staff		however, he/she is chec		
		residents sampled for		and/or as needed for car	•	
		g (Resident #40 and #34).		colostomy care. This wa		
		g (		of May 20,2016. Reside		
	During the recertificat	tion survey of June 27, 2015		his permission his family		
		for F312 for failure to provide		about his care as it relate		
		dependent residents in need		allegation he did not rec		
		g, and fingernail care. On the		care and when it occurre		
		survey the facility failed to		the facility could do an a		
		a shower who were totally		investigation and grievar		
	dependent on staff fo			according to facility police		
	·	-		procedures. Completed		
	e. F314: Pressur	e Sores: Based on		2016.		
		review, resident, and staff		F323: The corrective act	tion accomplished	
		failed to provide ordered		for Resident #14 is his/h		
		sments and failed to provide		were reviewed and upda		
	incontinence care to	•		future falls on June 15, 2		
		res for 1 of 1 residents		Recreation Services Ass		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	COM	E SURVEY PLETED
		345010	B. WING _				C / <b>20/2016</b>
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	120/2010
				5(	00 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHEV	/ILLE			SHEVILLE, NC 28804		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 520	F 520 Continued From page 80		F 5	520			
	reviewed for pressure	e sores (Resident #40).			completed by June 23, 2016 with input from Resident #14 s family member a		
	During the recertificat	tion survey of June 27, 2015			included in his/her plan of care to atten		
		for F314 for failure to provide			activities of choice to prevent falls.	-	
	_	ordered and/or complete			F353: The measures put in place or		
		ents as ordered and failed to			systemic changes made are: Nursing		
	change a wound vacu	uum assisted closure device.			management and Executive Director		
		fication survey the facility			evaluated the staffing patterns to estab	lish	
		wound assessments and			patient acuity and staffing ratio required		
		care to a resident with			DNS evaluated the nursing staff sched		
	facility acquired press	sure sores.			to accommodate the needs of resident		
	6 F000 A				i.e. 12 hour shifts, 3 positions for perso		
		ts: Based on observations,			care assistant (PCA) was open to mee		
		reviews the facility failed to ons for a resident with a			non-nursing direct care. duties. Review daily staffing schedule to ensure adequ		
		f 1 resident reviewed for falls			nursing staff is available to accommod		
	(Resident #14).	1 resident reviewed for fails			the acuity level and provide quality care		
	(11001001111111111111111111111111111111				Facility is networking with area Nursing		
	During the recertificat	tion survey of June 27, 2015			Homes, Community Colleges, and Age		
	the facility was cited f				pools for staffing, recruitment and	- ,	
	·	ances of 2 falls and place an			retention. Also partnering with our Qua	lity	
	alarm on the bed. On	the current recertification			Improvement Organization (QIO) on		
	survey the facility faile				implementing new tools related to		
	interventions for a res	sident with a history of falls.			retention & recruitment. Executive		
					Director ((ED) Administrator) will review		
		nt Staffing: Based on			staffing pattern with the DNS weekly fo	r	
		review, family, staff, and			the next 3 months. A special called		
		e facility failed to provide			meeting of the (Quality Assessment		
	_	f to meet the needs of 5 of 5			Performance Committee (QAPIC) was		
		alls in the areas of staff not			held on June 15, 2016 to discuss their		
	_	the residents such as care, and/or services to			role in the corrections process for the areas of concern. Reporting and		
		ctivities of daily living needs			monitoring as outlined in those plans o	f	
	(Residents #40, #34,	, ,			corrections respectively will be address		
	(. 1301d011t0 II 10, II'0T,	, 10, and 20).			Residents who have been identified		
	During the recertificat	tion survey of June 27, 2015			by the Executive Director ((ED)		
	_	for F353 for failure to provide			Administrator), Director of Nursing		
	_	f to meet the needs of 63			Services (DNS), and Leadership Team		
	residents present in the				(comprised of Department Heads, their		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		PLETED
		345010	B. WING _				C 20/2016
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2010
					0 BEAVERDAM ROAD		
GOLDEN	LIVINGCENTER - ASHE	/ILLE			SHEVILLE, NC 28804		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 520	Continued From page	e 81	F 5	520			
	capacity of 77 resider	nts in the areas of timely			assistants, and Unit		
	•	ation, services to meet			Manager/Coordinator) to have the		
		needs, and services to treat			potential to be affected are current		
		ne current recertification			residents. Please see the measures p	ut	
	survey the facility faile	ed to provide sufficient			in place under section #3.		
	-	the needs of the residents			3. The measures put in place or		
	such as showers, inc				systemic changes made are: All results	3	
	services to meet the	resident's activities of daily			from the monitoring and action plan ste	eps	
	living needs.	•			will be discussed in detail at each QAP	ĺ	
					meeting for 3 months, and existing acti	on	
	During the current red	certification survey the			steps will be revised or added to ensur	е	
	facility failed to maint	ain implemented procedures			correction. The new ED has been train	ned	
	and monitor these int	erventions that the			in the Malcolm Baldrige National Quali		
	committee put into pla				Award Program and is a current Senio		
	October 2015. This w				Examiner for the Quality Award Progra	m	
		ere originally cited June 2015			with the American Health Care		
		survey and on the current			Association. He will be incorporating E	Best	
		The deficiencies were in			Practices in the QAPI program at		
		accommodation of needs,			GLC-Asheville. Also GLC-Asheville wi		
		essional standards, activities			be partnering with our QIO to help staf		
	of daily living, pressu				understand Best Practices and ways to		
		d quality assessment and			prepare the facility for the future needs	of	
		nued failure of the facility			our residents.		
		rveys of record show a			4. GLC-Asheville will monitor the		
	•	s inability to sustain an			corrective plan to ensure the practice v	vas	
	effective Quality Assu	irance Program.			corrected and will not reoccur is The	_	
	On 05/20/40 at 4:00 I	DNA the a Advance interest or at a total			monitoring tools will be presented to th		
		PM the Administrator stated			ED and/or DNS at Morning/Stand-Dow		
	•	the facility March 2016. The he had reviewed the 2567			Meetings. The ED will report the finding of the reviews to Quality Assurance	yə	
		tification survey in June			Performance Improvement Committee		
	•	itor stated he realized there			(QAPIC). The QAPIC will review and		
		ues at that time and there			analyze for patterns and trends. The		
		f issues since he became			QAPIC will evaluate the results and		
		March. He stated the Quality			implement additional interventions as		
		were being held every 2			needed to ensure continued compliance	·e	
		nonitoring of areas cited			The QAPIC will determine the scope a		
		recertification survey in the			span as well as continued necessity of		
	_	commodation of needs.			any continuing or expanded monitoring		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING				DATE SURVEY COMPLETED		
		345010	B. WING_			C
NAME OF D	ROVIDER OR SUPPLIER	343010	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE		05/20/2016
NAIVIE OF PR	ROVIDER OR SUPPLIER			500 BEAVERDAM ROAD		
GOLDEN I	LIVINGCENTER - ASHEV	ILLE		ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 520	Continued From page services to meet profe of daily living, pressur	e 82 essional standards, activities	F 5	DEFICIENCY)	ons and ties will be intained by oring the ectiveness, asure that nce	