STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 06/07/2012

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

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Survey event ID# T6I411.	F 000	***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.***	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure food was not stored beyond the expiration date. During the initial tour of the kitchen on 06/04/12 at 10:15 AM, observation of the walk-in refrigerator revealed a gallon size container labelled "Pork Roast 6/3 -6/7" with full container of meat. A second observation of the same refrigerator on 06/06/12 at 9:08 AM revealed the same gallon size container labelled "Pork Roast 6/3 - 6/7" with full container remained on the shelf and available for use. A third observation of the same refrigerator on 06/07/12 9:30 AM revealed the same gallon size container labelled "Pork Roast 6/5 - 6/8" with full container on shelf and available for use.	F 371	**F 371** The identified food was removed from refrigerated storage and disposed of by the dietary manager. No residents were affected. Dietary staff will be in-serviced on the proper storage guidelines and the need to maintain accurate **use by dates** on all re-refrigerated food items by 06/25/12. All new dietary staff will be in-serviced during orientation on this procedure. Additionally, dietary staff will be in-serviced on the new procedures to ensure accurate **use by dates**, to include: Yellow Stickers will be printed for everyday use with the **use by dates** already printed on them. These stickers will be provided to the staff so that they do not have to hand write dates. The posted menu will be referenced for all items to ensure accurate beginning **use by date** and that the label has the appropriate number of days allowed for that item.	

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

Angela K Pauline — Executive Director — 06-22-12

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.

JUN 29 2012
BY:

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F 371	Continued From page 1 Review of food menus from 6/3/12 - 6/9/12 revealed pork roast was listed on the menu for lunch on 6/3/12. During an interview on 06/07/12 at 9:30 AM the Assistant Dietary Manager stated: "I re-labelled it this morning because juice had been spilled on it. I thought the old label said 6/3." During an interview on 06/07/12 at 10:08 AM with the Dietary Manager and the Assistant Dietary Manager about the pork roast being available for use, both staff confirmed the pork roast would have remained in the refrigerator and available for resident use through 06/08/12 as a result of being incorrectly labelled. During an interview on 06/07/12 at 10:18 AM with Cook #1, she stated she cooked the pork roast on 06/02/12 because it had to be cooked the day before it was served which was 06/03/12. An interview on 06/07/12 at 11:10 AM with the Dietary Manager revealed she expected staff to discard any unused left over food items after the third day.	F 371	The walk-in and reach-in refrigerators will be monitored and audited to ensure that items that have been repackaged and labeled appropriately. At the beginning and end of each morning shift for two weeks, each item will be audited/checked. Then, at the beginning of each morning shift for three months, each item will be audited/ checked. All audits will be appropriately initialed/documented on a Dietary Audit Log. The results of this audit will be reviewed by the Executive Director or designee, and then brought to the Quality Assessment and Assurance Committee Meeting monthly for 3 months and quarterly thereafter. Any issues or trends identified will be addressed by the Quality Assurance Committee as they arise and the plan will be revised as needed to ensure continued compliance. We will be in compliance on July 6, 2012.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	**F 431** The identified medications were removed from storage and disposed of by the unit coordinator. No residents were affected. An audit of- facility designated areas for the storage of medications was completed by the Director of Nursing from 06/08/12 to 06/10/12 to identify potentially expired medications. No other medications were identified.	

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F 431	Continued From page 2 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to check and discard the out-dated over-the-counter stock pharmaceuticals (Liquid pain relief Acetaminophen Elixir) for one (1) of one (1) central supply medication storage area. The findings include: A review of the facility policy and procedures on Medication Storage section 4.1 dated 12/08	F 431	The Central Supply Clerk was educated on 06/12/12 by the Director of Nursing on the storage and supplying of over the counter medications. Licensed nursing staff will be in-serviced by the Director of Nursing and/or the Director of Clinical Education by 06/25/12 on the storage, dating, and expiration of medications and related processes. New licensed nursing staff will be in-serviced on this procedure during orientation. The Director of Nursing Services, Assistant Director of Nursing Services, Director of Clinical Education and/or the Unit Coordinators will audit facility medications to ensure that there are no expired medications . This audit will be conducted two times per week for four weeks, then once weekly for four weeks. The results of this audit will be reviewed by Director of Nursing and/or the Executive Director and then brought to the Quality Assessment and Assurance Committee Meeting monthly for 3 months and quarterly thereafter. Any issues or trends identified will be addressed by the Quality Assurance Committee as they arise and the plan will be revised as needed to ensure continued compliance. We will be in compliance on July 6, 2012.	

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F 431	Continued From page 3 included all outdated medications are immediately removed from stock. Medication storage areas including medication storage rooms, medication carts and central supply room storage area were observed for medication storage requirements. A review of the bulk stock medications stored in the central supply room with 'over-the-counter' (OTC) stock medications revealed the following: On 06/06/2012 at 9:33 AM observation of the bulk OTC medications revealed 2 pints (2 x 473 milliliters) Liquid pain relief Acetaminophen Elixir bottles outdated in November 2011, one pint of Liquid pain relief Acetaminophen Elixir outdated in January 2012 and one pint of Liquid pain relief Acetaminophen Elixir outdated in March 2012. The four outdated pint bottles of Acetaminophen Elixir were available for use on the shelf with additional bottles Acetaminophen Elixir. An interview with the central supply staff person on 06/06/12 at 9:35 AM revealed that he checked for all outdated medications every month and had not noticed the outdated bottles. The interview revealed he was responsible for removing the outdated medications in the bulk storage area and stated that all licensed nurses had access to this medication storage area. An interview with the Director of Nursing (DON) and Licensed Nurse #1 on 06/07/12 at 8:57 AM confirmed it was the responsibility of the central supply staff member to pull all outdated pharmaceuticals and the expectation was to check the medication stock every month for outdated medications.	F 431		

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F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to document the administration of laxatives for one (1) of seven (7) residents. (Resident # 97) The findings are: 1. Resident #97 was admitted to the facility with diagnoses including dementia, hypothyroidism and constipation. The most recent Minimum Data Set (MDS) dated 05/25/12 revealed Resident #97 had severely impaired cognition and required limited assistance with toilet use. Constipation was not listed as a problem on the most recent MDS. Review of Resident #97's medical record revealed physician's orders for Colace (stool softener) 100 mg (milligrams) one tablet twice a	F 514	**F 514** Resident # 97 was assessed by the Director of Nursing on 6/1/2012. The attending physician was notified of the documentation for resident #97. No new orders received. No negative outcomes noted. Licensed Nurse #1 , Medication Aide # 1, and Medication Aide #2 were in-serviced immediately by the Director of Clinical Education on documentation of as needed medications. Nursing staff will be in-serviced by the Director of Clinical Education on the facility clinical guidelines regarding bowel movement tracking, interventions and documentation of those interventions. This in-service will be completed by 06/25/2012. An audit of residents without documented bowel movements will be conducted by the Director of Nursing, Assistant Director of Nursing, Unit Mangers, Nursing Supervisors and or the Director of Clinical Education daily five times per week for four weeks, then daily, three times per week for four weeks, then weekly for four weeks. This audit will be conducted to ensure that residents that require interventions have those interventions completed and documented on the Medication Administrator Record.	

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F 514	Continued From page 5 day and Miralax (laxative) 17grams with eight (8) ounces liquid every day as needed for constipation. Resident #97 also had standing orders which included Milk of Magnesia (laxative) 30 mls (milliliters) every day for 7 days PRN (as needed) for constipation and/or Fleets enema (laxative) every day for 7 days PRN for constipation. Review of Resident #97's bowel movement (BM) reports for May of 2012 revealed the following: - No BM from 05/10/12 through 05/13/12. (four (4) days) - No BM from 05/15/12 through 05/19/12. (five (5) days) Review of Resident #97's Medication Administration Record (MAR) from 05/10/12 through 05/19/12 revealed she received Colace 100 mg by mouth twice daily: one in the morning and one at bedtime. Further review of the MARs revealed no documentation that Miralax was administered. The MAR indicated Resident #97 was given Milk of Magnesia 30 mls on 05/16/12 and on 05/17/12. There was no documentation on the MAR indicating any other interventions for constipation were administered. The electronic medical record did not contain any documentation of administration of standing order medications in the month of May 2012. An interview with Licensed Nurse (LN#1) on 06/07/12 at 2:05 PM revealed the days shift (7:00 AM to 3:00 PM) Unit Manager printed the "No BM or Small BM in last 9 shifts Report" every morning and gave it to the LN or Medication Aide (MA). The interview further revealed LN #1 reviewed the list, administered Milk of Magnesia to residents	F 514	The results of this audit will be reviewed by the Director of Nursing and/or Executive Director and then brought to the Quality Assessment and Assurance Committee Meeting monthly for 3 months and quarterly thereafter . Any issues or trends identified will be addressed by the Quality Assessment and Assurance Committee as they arise and the plan will be revised as needed to ensure continued compliance. We will be in compliance on July 6, 2012.	

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F 514	Continued From page 6	F 514		

without a BM for three days as needed, and returned the report to the Unit Manager with a notation that Milk of Magnesia had been administered. LN #1 stated she did not document administration of the medication on the MAR.

In an interview with LN #1 on 06/07/12 at 2:15 PM, LN #1 stated she recalled giving Resident #97 Milk of Magnesia 30 mls on 05/13/12. LN #1 stated: " I should have documented that I gave it on the MAR and also the results."

An interview with the Assistant Director of Nursing (ADON) on 06/07/12 at 2:22 PM revealed she expected LNs and MAs to document all medications administered on the resident's MAR.

An interview with MA #1 on 06/07/12 at 2:35 PM revealed she recalled giving Milk of Magnesia to Resident #97 on 05/12/12. MA #1 stated she usually documented administration of PRN medications on the back of the MAR but must have forgotten to document it on 05/12/12.

An interview with MA #2 on 06/07/12 at 2:35 PM revealed she recalled giving Milk of Magnesia to Resident #97 on 05/18/12. MA #2 stated she usually documented administration of PRN medications on the back of the MAR but must have forgotten to document it on 05/18/12.

During an interview on 06/07/12 at 2:46 PM, LN #1 revealed she recalled giving Milk of Magnesia to Resident #97 on 05/14/12. LN #1 stated she should have documented giving the medication on the MAR.