DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ____	R 08/29/2013

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 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		9/18/13

F 241 SS=E — 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews and staff interviews, the facility failed to promote dignity during the dining experience in the special care unit for 7 of 24 residents residing in the special care unit. Residents #41 and #74 ' s plates were switched without explanation and Residents #117, #24, #31, #37, and #113 were not supervised to prevent eating foods from other used plates of other residents.

The findings included:

Continual observations were made in the Alzheimer ' s Care Unit (ACU) during the noon meal on 08/29/13 beginning at 11:31 AM and lasting until 12:44 PM by 2 surveyors. At 11:31 AM, three Nurse Aides (NA) #1, #2, #3, and the unit manager were pouring glasses of water and tea and distributing the fluids and utensils and napkins to each table.

Resident #41 ' s diagnoses included Alzheimer ' s disease and she was assessed on the quarterly Minimum Data Set (MDS), dated 07/04/13, as having long and short term memory impairment, having severe cognitive skills and requiring assistance with eating. Resident #74 ' s diagnoses included Alzheimer ' s Disease and she was a assessed on the significant change

Provider's Plan of Correction (F 241):

Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law.

F241
This plan of correction is submitted as the facility's credible allegation of compliance.

Residents # 41,74,117,24,31, 37, and 113 were assessed using the Alzheimer's Care Unit Admission Criteria for appropriate placement in the Alzheimer's Unit. The Alzheimer's Care Unit Admission/Discharge Criteria reviews residents cognitive and physical abilities, including eating. This is reviewed by the Director of Nursing or designee. Residents deemed inappropriate by cognitive or physical abilities were moved to a care area capable of meeting their cognitive and physical needs.

An assessment of all residents in the Alzheimer's Care Unit were reviewed for appropriate placement using the Alzheimer's Care Unit Admission/ Discharge Criteria. Residents will be reviewed quarterly or with a significant change in physical or mental status by the Director of Nursing or designee.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 9/18/13

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.

Original Signature Date : 9/13/13

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F 241	Continued From page 1 MDS, dated 05/20/13, with long and short term memory impairments, having moderately impaired decision making skills, and requiring assistance with eating. Residents #41 and #74 sat at the same table in the dining room. At 12:01 PM, NA #1 got a tray from the meal cart which held the plates of food for Residents #41 and #74. NA #1 proceeded to place the items for Resident #41 in front of Resident #74 and the items for Resident #74 in front of Resident #41. When questioned, NA #1 stated that both residents received the same diet. Upon review of the diet cards it was noted that Resident #41 had large portions of pureed foods compared to Residents #74 who was to receive a regular portion of fortified pureed food. When brought to the attention of NA #1, she proceeded to just switch the plates around without any explanation to the residents. NA #1 offered no explanation for the manner she delivered or switched the food. Resident #117 ' s diagnoses included dementia with behaviors and he was assessed on the quarterly MDS, dated 07/11/13, as having severely impaired cognitive skills, other behaviors 1 - 3 days out of the previous 7 days, and wandering behaviors 4 - 6 days out of the previous 7 days. He was assessed as requiring extensive assistance with eating. Resident #24 ' s diagnoses included Alzheimer ' s disease and she was assessed on her quarterly MDS, dated 05/20/13, with long and short term memory impairments and moderately impaired decision making skills. She was assessed as requiring supervision for eating. At 12:38 PM, Resident #117, who received a pureed diet stood up and walked to Resident #24, who sat across from him at the same table, and used a spoon to stir Resident #24 ' s salad which was in front of	F 241	Nursing Staff were in-serviced regarding residents being served and receiving the correct diet, providing assistance with meals, correct dining room seating and table placement, infection control practices at meals and the total dining experience of a calm, interactive, pleasant atmosphere. The Alzheimer's Care Unit Charge Nurse is assigned to oversee all meals to ensure residents are supervised to prevent residents from eating off used plates, for the table and seating arrangement, tray delivery process, pre and post meal activities such as hand washing with lemon scented cloths, magazines, soft music, and Hostess duties. The Main Dining Area will be monitored by licensed nursing staff, department head or designee to ensure residents dignity is protected. A Dining Room Audit will be completed in each dining room at each meal and report any concerns to the administrator. Education will be completed by 9/18/13 and on hire and yearly thereafter. The nurse or designee will immediately report any concerns noted on the Dining Room audit tool to the Administrator or designee. The QA committee will review any concerns and corrective action required and make appropriate recommendation, if needed.	

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F 241	Continued From page 2	F 241		

Resident #24. Resident #117 continued to stand over Resident #24, and played in her salad until 12:40 PM when the unit manager removed the salad. No staff member was at this table during this time. NA #2 was at an adjacent table feeding another resident.

Resident #31 ' s diagnoses included senile dementia and psychosis and she was assessed on the quarterly MDS, dated 07/05/13, as being severely cognitively impaired, having wandering behaviors 1 -3 days the previous 7 days and requiring supervision with eating. Resident #37 ' s diagnoses included Alzheimer ' s disease and she was assessed on the quarterly MDS dated as being severely cognitively impaired, wandering 4 - 6 days in the previous 7 days, having other behaviors 1 - 3 days over the previous 7 days, and required supervision with eating. At 12:19 PM Resident #31, who had already eaten and left the dining room, returned to the dining room. Resident #31 sat down at the place where Resident #37 had eaten and left unfinished food. Resident #31 then took bites of the food and drank the tea left from Resident #37. This table was in the back of the room and staff was observed up in the front of the room finishing feeding other residents. There was no staff intervention. Resident #31 proceeded to leave the table after drinking the tea. Meanwhile Resident #37 was walking around the room, gathering up left over plates and food off other table places where residents had left the dining room. NAs #1 and #2 were observed redirecting her as to where the garbage was located to throw the trash and food she had in her hand. One of the plates Resident #37 fingered and picked up food from was Resident #113 ' s partially eaten and left plate of food.

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F 241	Continued From page 3	F 241		

Resident #113 ' s diagnoses included dementia with behavioral disturbances and he was assessed on his quarterly MDS, dated 05/30/13, with severely impaired cognitive skills, having wandering behaviors and other behaviors 1 - 3 days out of the previous 7 days and requiring limited assistance with eating. At 12:38 PM, Resident #113 returned to the dining room and sat at a different table where Resident #120 ' s unfinished plate was. Resident #120 had already left the room and her unfinished plate remained where she was sitting. Resident #113 then scooped up a bite of Resident #120 ' s left over food with the left over silverware and was about to take a bite until the surveyor intervened and got staff ' s attention from across the room. At 12:42 PM, NA #2 went to Resident #113 ' s original place, got his plate which Resident #37 had been playing in and sat with Resident #113 and was about to feed him a bite when the second surveyor intervened and stopped the nurse aide from feeding the resident the food Resident #37 had fingered.

On 08/29/13 at 3:05 PM, NA #1 was interviewed. NA #1 stated that today ' s dining activity was not usual. She stated that there were too many people in the dining room, indicating that the surveyors were extra unfamiliar faces to the residents. She further stated the seating arrangements had been changed on Monday and tables rearranged to have the fire extinguisher more accessible. NA #1 stated she had been instructed she was only able to feed one resident at a time and there were normally 3 nurse aides in the dining room to assist with feeding and the unit manager was not always present to assist. She further stated that sometimes there were

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F 241	Continued From page 4 less nurse aides in the dining room. When asked how she had been instructed to supervise the residents in the dining room, she replied she tried to watch the resident to resident interactions. On 08/29/13 at 3:10 PM, NA #2 stated that this date, the trays came out wrong causing staff to spend more time looking thorough the trays to serve residents table by table. NA #2 stated the table arrangements were changed on Monday and they needed to get used to the new arrangement. She also stated that Resident #37 was moved from her usual table and sat with more residents which was disruptive to her routine as Resident #37 did better in a quieter setting. NA #2 stated she had been instructed to only feed one resident at a time. She stated normally there are 3 aides in the dining room to feed and assist residents. She did not give any explanation as to how staff observe the residents to ensure food is not shared and/or contaminated by others. On 08/29/13 at 3:15 PM NA #3 stated that currently there were more residents in the unit that required feeding than in the past. She stated the nurse aides tried to watch the other residents and redirect them as the residents came and left the dining room. She also stated that sometimes there was not as many staff in the dining room to observe residents. On 08/29/13 at 4:30 PM Nurse #1 was interviewed. Nurse #1 stated Resident #113 has had his medications recently changed due to his wandering/pacing behaviors. She stated Resident #113 was usually the resident requiring the most supervision during dining. She stated that she will help out in the dining room	F 241		

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F 241	Continued From page 5 sometimes but that she was assisting another nurse on a different hall this date. When asked what she expected from the staff in terms of supervising residents in the unit during meals, she never provided a response. On 08/29/13 at 4:45 PM the unit manager stated that this day was very unusual, he described it as " chaotic " with lots of distractions, indicating the resident he was feeding was distracted by the surveyors in the room. In general, he stated that the trays were first passed to those residents who did not need as much assistance and staff then sat and fed those who needed that assistance. He stated normally the ambulatory residents were not as mobile during the meal as they were this date. He also stated the tables had been rearranged to make the fire extinguisher more accessible which caused two tables to be pushed together and more compact for the residents. The unit manager stated there were 7 residents on the unit that required feeding and the unit was only permitted to staff 3 nurse aides, 1 nurse and himself. He stated the staff tried to redirect residents out of the dining room and to keep them from reentering, but this date they kept coming back in the dining room. He repeated that the chaos was due to the residents being unfamiliar with the surveyors. The Administrator was interviewed on 08/29/13 at 7:21 PM. She stated that typically the dining experience in the ACU was smooth and she has had no complaints from families relating to the dining in the ACU. She attributed the difference to the unfamiliar faces of the surveyors in the dining room. She stated she expected the unit manager to supervise the dining room during the meals while the nurse aides provided needed	F 241		

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F 241	Continued From page 6 assistance to the residents. When the surveyors ' observations were described to her, the Administrator stated it sounded like staff did not manage the situation of the ACU dining room.	F 241		