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 10/10/2014

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

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F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156	Preparation and/or execution of this plan of correction does not constituet admission or by 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 excuted soley because it is required by provisions of federal and state law. F156 It was determined by an interdisciplinary team resident #4 and #29 no longer met the criteria for Medicare part A benefits. A Medicare part B notice of non-coverage was issued instead of a Medicare part A notice of non-coverage letter. Neither patient had a negative outcome. The staff member who issued the incorrect Medicare Notices of Non-Coverage is no longer employed by Golden Living however, the current MDS coordinator and Business Office Manager will be re-educated by the Director of Nursing/designee on issuing the proper Notice of Medicare Non-coverage letters. All residents who currently utilize Med A insurance the Bus. Office Mgr. will audit their files to insure the correct Notice of Med A Non-coverage has been issued. The Administrator/designee will audit all issued Medicare Notices of Non-coverage for accuracy for two months. Then he/she will audit 5 Notices of Non-coverage per month for two additional months.	11-18-14

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

Executive Director 11/11/14

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: 11-3-14

NC DHSR Received Black Hole Unit NOV 12 2014 by: SKH

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F 156	Continued From page 1 funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156	A QAPI will be performed by the Administrator/designeeand reviewed by the QA committee for three months to assure the ongoing compliance of the Medicare Notices of Non-Coverage.	

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F 156	Continued From page 2	F 156		

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to provide residents with the Denial of Payment of Medicare Coverage and their appeal rights for 2 of 3 residents. (Resident # 4, Resident # 29)

The findings included:

A record review of the Liability Notices/Notice of Medicare Provider Non-Coverage forms revealed Resident #4 was not provided with the correct CMS form for notification which informed the resident/family of the resident's right to have a claim or demand bill submitted to Medicare as the resident no longer qualified for services.

During an interview on 10/10/14 at 10:14 AM the Business Office Manager (BOM) reported the Minimum Data Set (MDS) Coordinator was responsible for completing the CMS form for notification which informed the resident/family of the resident's right to have a claim or demand bill submitted to Medicare when the resident is no longer qualified for services. She further stated the MDS Coordinator that completed the incorrect forms was no longer employed with the company. The BOM stated she only kept copies of the forms in her office.

During an interview on 10/10/14 at 6:38 PM the Administrator revealed it was her expectation that the CMS/Medicare guidelines should have been followed and that the appropriate paperwork was completed.

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F 156	Continued From page 3 2. A record review of the Liability Notices/Notice of Medicare Provider Non-Coverage forms revealed Resident #29 was not provided with the correct CMS form for notification which informed the resident/family of the resident's right to have a claim or demand bill submitted to Medicare as the resident no longer qualified for services. During an interview on 10/10/14 at 10:14 AM the Business Office Manager (BOM) reported the Minimum Data Set (MDS) Coordinator was responsible for completing the CMS form for notification which informed the resident/family of the resident's right to have a claim or demand bill submitted to Medicare when the resident is no longer qualified for services. She further stated the MDS Coordinator that completed the incorrect forms was no longer employed with the company. The BOM stated she only kept copies of the forms in her office. During an interview on 10/10/14 at 6:38 PM the Administrator revealed it was her expectation that the CMS/Medicare guidelines were followed and that the appropriate paperwork was completed.	F 156		
F 241 SS=D	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 review and staff	F 241	To assure the dignity of all residents of all residents are maintained. Resident #122's clothes were reviewed by his/her Social Worker and all clothes that were too large were removed from the resident's closet and his family was contacted regarding his clothing size. All clothing of residents living ing the Alzheimer's Care Unit will be reviewed for proper fit. Any poorly fitting clothing will be removed from the residents closet and their family will be notified and request to take the	11/18/14

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F 241	Continued From page 4 interviews the facility failed to treat resident with dignity when they dressed the resident in pants that were to large resulting in exposure for 1 of 4 residents with cognitive impairment. (Resident #122) The findings included: Resident #122 was admitted on 05/14/14 with diagnosis including dementia, anxiety and colitis. Review of the latest Minimum Data Set (MDS) dated 08/21/14 revealed the resident was cognitively impaired with short term and long term memory deficits. The MDS also revealed the resident required staff assistance with dressing and toileting and extensive assistance with personal hygiene. Review of Resident #122's care plan dated 09/19/14 revealed resident forgets things due to his diagnosis of dementia and a goal of being safe and having his dignity maintained. Approaches were for staff to help resident maintain his dignity, help him with reminders and cues, help him make safe choices and remember that he is an adult and to treat him accordingly. On 10/06/14 at 3:22 PM resident was observed holding up his pants with both hands as he ambulated in the dining room and throughout the secured unit passing staff and residents. On 10/07/14 at 3:17 PM resident was observed in light colored jeans and a red shirt holding up his pants with both hands and his pants were unzipped as he ambulated throughout the dining room and the secured unit with staff and visitors present.	F 241	the poorly fitted clothing home and provide better fitted clothing. This will be done by the Social Worker/designee.All nursing staff and Social Services will be re-educated about placing properly fitted clothing on residents and contacting family member when residents require new clothing. The Director of Nursing/designee will observe the fitting five residents of clothing five times a week for one month. Then the Director of Nursing/desingee will observe the fitting of three residents' clothing a week for one month then, one resident's fitting of clothing a week for one month. A QAPI will be performed by Director of Nursing and reviewed by the QA team for 3 months to assure compliance of residents' wearing properly fitted clothing at all times.	

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F 241	Continued From page 5 On 10/08/14 at 4:19 PM resident was observed ambulating throughout the dining room and secured unit. His khaki pants were so large on him he was having to hold his pants up by keeping his hands in his pockets. Resident #122 went to sit down in a chair in the dining room where a family member and other residents were present. As he was attempting to sit down his pants fell down to his ankles when he took his hands out of his pants to sit in the chair. Resident reached down and pulled his pants up falling into the chair. On 10/09/14 at 3:39 PM Resident #122 was observed holding his khaki shorts up with his hands. As he was walking into the dining area his shorts slid down exposing his bottom to those behind him. He reached down and pulled them up. The Director of the Dementia Care Unit spoke to resident as he was adjusting his pant and asked him if he was going to the dining room. Other staff and residents were also in the room. An interview on 10/07/14 at 3:18 PM with the Nurse Aide #3 that cared for Resident #122 stated resident did not have a belt to use for Resident #122 or pants that he could wear without the resident having to hold them up. He further stated no male residents on the secured unit had anything to aide in holding up their pants. An interview on 10/07/14 at 3:19 PM with the Nurse #3 caring for Resident #122 confirmed resident did not have a belt and the staff were going to purchase belts for them. The Nurse stated she had not seen any family visiting Resident #122 to let them know what he needed. An interview on 10/10/14 at 1:59 PM with the	F 241		

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F 241	Continued From page 6 Director of Dementia Care (social worker-SW) revealed the facility had 72 hour conferences with the families when a resident is first admitted to get there input and ensure that the resident gets the care and services they need. It then becomes her responsibility to talk with families and make sure the resident has what they need. The SW further revealed she had not spoken to Resident #122's family about his pants being too large. She stated she thought the resident had suspenders but could not confirm this. An interview with the Director of Nursing (DON) on 10/10/14 at 6:04 PM stated her expectation would have been for the staff to let someone know that Resident #122 had a clothing need so that the SW or the DON could call the family and try to get them clothes that fit.	F 241		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to remove fecal matter from the commode and wall in 1 of 32 resident bathrooms for 4 days of the survey (Room #112). The findings included: Observations during the initial tour of the facility on 10/06/14 at 5:40 PM revealed a strong fecal odor in the hallway between rooms 110 and 112. Visual inspection of the bathroom for those 2	F 253	To assure the facility provides housekeeping services necessary to maintain a sanitary and orderly interior. Room #112 bathroom was cleaned by a housekeeper immediately. All resident bathrooms were inspected by the Department Managers for cleanliness. Staff will be educated on reporting any noted fecal matter to housekeeping and if no housekeeper is available to clean the area themselves. Department Managers will audit all residents bathrooms during manager rounds five days a week and the Administrator/designee will review all audit sheets for one month and also observe 5 bathrooms five days a week for one month, then review 5 audit sheets and bathrooms a week for one month, then review on audit sheet and one bathroom a week for one month.	11-17-14

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F 253	Continued From page 7 rooms revealed a large puddle of liquid feces to the left of the commode with feces on the commode seat, the inside rim of the commode, the side of the commode and the wall behind the commode. On 10/06/14 at 6:05 PM Housekeeper #1 was observed entering the bathroom for rooms 110 and 112 with a mop and mop bucket and he removed the feces from the bathroom floor with the mop. Observation of the bathroom for rooms 110 and 112 on 10/06/14 at 6:27 PM revealed a plastic bag containing towels visibly soiled with feces in the bathroom floor. The feces was gone from the commode seat but splatters of fecal matter remained on the inside rim of the commode, the majority of the left side of the commode and widely splattered on the wall and baseboard behind the commode. Observation of the bathroom for rooms 110 and 112 on 10/07/14 at 5:00 PM revealed splatters of fecal matter on the inside rim of the commode, the majority of the left side of the commode and widely splattered on the wall and baseboard behind the commode. Observation of the bathroom for rooms 110 and 112 on 10/08/14 at 2:00 PM revealed splatters of fecal matter on the inside rim of the commode seat, the majority of the left side of the commode and widely splattered on the wall and baseboard behind the commode. Observation of the bathroom for rooms 110 and 112 on 10/09/14 at 11:35 AM revealed splatters of fecal matter on the majority of the left side of the	F 253	A QAPI will be performed by the Administrator and will be reviewed by the QA team for 3 months to assure ongoing compliance of sanitary bathrooms.	

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F 253	Continued From page 8 commode and widely splattered on the wall and baseboard behind the commode. An interview with Housekeeper #2 on 10/09/14 at 9:33 AM revealed she was responsible for cleaning the rooms and bathrooms on the hall where the bathroom for rooms 110 and 112 was located. She stated she had been the housekeeper for that hall on 10/07/14, 10/08/14 and 10/09/14. When asked what her duties included, Housekeeper #2 stated she was responsible for sweeping and mopping the floors in the rooms and bathrooms and for cleaning the sinks and commodes every day. Housekeeper #2 stated she had cleaned the bathroom for rooms 110 and 112 on 10/07/14 and 10/08/14 but hadn't yet cleaned that bathroom on 10/09/14. An interview on 10/09/14 at 3:36 PM with Housekeeper #1, who was the interim Housekeeping Supervisor, about his expectation for the cleaning of residents' bathrooms revealed he expected the commodes to be cleaned thoroughly and wiped down including under the lids and the side of the commode every day. He stated the back wall behind the commode should be cleaned every day. When asked if he recalled mopping the floor in the bathroom for rooms 110 and 112 on 10/06/14 around 6:00 PM, he stated he did recall mopping the floor. Housekeeper #1 stated he told Housekeeper #2 the morning of 10/07/14 that she would need to clean behind the commode in that bathroom real well. Visual inspection of the bathroom for rooms 110 and 112 on 10/09/14 at 3:45 PM with Housekeeper #1 revealed splatters of feces on the side of the commode and the wall behind the commode. Housekeeper #1 stated he had not	F 253		

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F 253	Continued From page 9 checked to ensure that Housekeeper #2 cleaned the bathroom as instructed. During a visual inspection of the bathroom for rooms 110 and 112 on 10/09/14 at 3:50 PM with the Administrator, the Administrator stated she expected residents' bathrooms to be cleaned thoroughly every day and as needed.	F 253	F309 SS-D A Resident with chronic pain, had a prescription written to increase the dose of pain medication. The change was not made for two days. The facility will ensure that each resident receives and the facility will provide the necessary care and services to attain or maintain	11-18-14
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to provide an increase in medication to assist with pain control for 1 of 5 residents. (Resident #73) The findings included: Resident #73 was admitted to the facility on 05/20/10 with diagnosis including vascular dementia, chronic pain and osteoporosis. She was discharged to the hospital on 09/18/14 and readmitted to the facility on 09/19/14. Resident #73 encountered a ground level fall from her hospital bed which resulted in a skin tear to the elbow. Her most recent Minimum Data Set (MDS) was completed on 7/30/14. The MDS indicated	F 309	the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1. Resident #73 medication for pain was increased. The Director of Nursing performed a pain evaluation assessment. The Palliative Care team was	

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F 309	Continued From page 10 she had severely impaired cognitive skills for daily decision making and impaired short term and long term memory deficits. The MDS indicated Resident #73 received routine and as needed (PRN) pain medications. A review of Resident #73 care plan dated 09/19/14 revealed Resident #73 was being monitored for pain management, agitation, risk for falls and potential for drug related complications. Approaches were listed as administer pain meds as ordered, if current pain control regime not adequate contact physician for possible adjustment, observe for side effects, refer to rehab as needed and utilize pain monitoring tool to evaluate effectiveness of interventions. A review of the physicians progress note dated 10/02/14 stated Resident #73 was having increased back pain unrelieved by scheduled and as needed (PRN) pain medications. The resident was on 7.5/325 mg routine and PRN. A review of the Physicians orders for 10/02/14 revealed Resident #73 had order for Norco 7.5/325 mg to be discontinued on 10/02/14. An order for Norco 10/325mg by mouth three times a day was written on 10/02/14. A review of the October 2014 Medication Administration Record (MAR) revealed an order to start Norco 7.5/325 mg was discontinued on 10/03/14 with the last dose given at 8pm. The Norco 10/325 mg was started on 10/04/14 with the 8:00 AM dose. A review of the pain assessment that was to be completed each shift showed Resident #73	F 309	consulted, for ongoing pain management. Pain evaluation will be completed each shift by licensed nurse. Director of Nursing and/ or designee will validate completion of pain evaluation in daily start up meeting. 2. A Pain evaluation assessment will be completed on all residents by 11/07/14 by Director of Nursing Services and/ or designee. A 100% audit will be performed to ensure all orders have been processed and accuracy of orders. All licensed staff will be in-serviced on pain assessments, and processing orders from prescriber by Director of Clinical Education and/ or designee. 3. All new orders will be checked daily by the night shift nurse to ensure processing, and accuracy. All residents will be assessed for pain every shift by the licensed nurse. The Director of Nursing	cont. 11-18-14

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F 309	Continued From page 11 continued to experienced pain on 10/02/14 and 10/03/14. There was no pain assessment completed on Resident #73 during the evening shift on10/03/14. Resident #73 was noted as not experiencing any pain on 10/04/14 through 10/10/14. An observation on 10/09/14 at 3:29 PM with Resident #73 ambulating down the hallway with the therapy aide (TA). Resident #73 had facial grimacing and her head was tilted slightly forward. The TA asked the resident was ok to which she replied, "NO". During an interview on 10/09/14 at 3:32 PM with the TA confirmed that Resident #73 was experiencing pain. The TA reported the Resident #73 had been hurting so bad she could not ambulate but she had improved even though she continued to experience pain. An interview on 10/09/14 at 4:32 PM with the Nurse Practioner reported Resident #73 had been on routine and PRN pain meds related to increased back pain. She reported Resident #73's pain was unrelieved and she had increased the dose of Norco from 7.5/325 mg to 10/325 mg. She further stated the nurses would let her know if the medication was available or not. She did not remember the nurse telling her the medication was unavailable. The Nurse Practioner stated it was her expectation the medication increase should have been given that day or the next day. An interview on 10/10/14 at 4:45 PM with the Director of Nursing (DON) stated it was her expectation for the nurses to assess the resident for pain and the increase in Resident #73's pain	F 309	and/ or designee will validate new order checks, and completion of pain assessments daily in start up meeting. 4.The Director of Clinical Education and/or designee will audit compliance weekly x 4 weeks then monthly x 3 then ongoing as determined by the Executive Director or designee. Results of the audit will be immediately reported to the Executive Director or designee. Audit results will be discussed in the monthly Quality Assurance Performance Improvement committee meeting x 3 months, and ongoing as determined by the committee.	cont.

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F 309	Continued From page 12 medication should have been given as soon as possible. An interview on 10/10/14 at 7:00 PM with the Medical Director revealed the new system had a problem getting medications in a timely manner.	F 309		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to secure 1 of 1 oxygen emergency tank. Findings included: A record review of Golden Living Centers policy on handling and storing bottled compressed gases revealed safety rules: Cylinders should be secured at all times by chains or holders. Cylinders must always be secured against falling. Cylinders must be chained against a wall or bench, or secured through use of authorized cylinder clamps or holders.	F 328	The unsecured oxygen tank was removed immediately from resident room. Staff was re-educated on the proper storage of oxygen tanks by the Director of Nursing/ designee. All patient rooms were inspected for improperly stored oxygen tanks and no others were observed. The Department Managers will audit all patient rooms for improperly secured oxygen tanks during room rounds, five days a week. The Administrator/designee will audit all audit sheets for one month,then review 5 audit sheets a week for one month, then one a week for one month. A QAPI will be performed by the Director of Nursing/designee and reviewed by the QA teams for 3 months to assure compliance of proper oxygen storage..	11-17-14

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F 328	Continued From page 13 An observation at 4:00 PM, 5:00 PM, and 6:15 PM on 10/06/14 revealed an oxygen emergency tank was in room 235 unsecured, and sitting by window. On 10/06/14 an interview with the charge nurse at 6:16 pm verified that an oxygen emergency tank had been in room 235, and had not been secured. The nurse indicated she did not know why the oxygen tank had been left in the resident's room, and further revealed she did not know why it had been left freestanding and not secured. She also revealed that oxygen emergency tanks should not be left anywhere unsecured, and should have been placed in a carrier. She revealed the policy was oxygen tanks were to be in carriers, and not left unsecured. On 10/06/14 an interview with the Director of Nursing at 6:32 PM verified that oxygen emergency tanks were to be secured in carriers, and not left unsecured anywhere.	F 328		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility medication rate was greater than 5% as evidenced by 3 medication errors out of 27 opportunities, resulting in a medication error rate of 11.11% for 3 of 7 residents observed	F 332	F 332 SS-E The facility medication rate was greater than 5% as evidenced by 3 medication errors out of 27 opportunities, resulting in a medication error rate of 11.1% for 3 out of 7 residents observed during medication pass. (Residents #18, #117, and #120.) The facility will ensure that it is free of medication error rates of	11-18-14

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F 332	Continued From page 14 during medication pass. (Residents #18, #117 and #120.) The findings included: 1. Resident #120 was readmitted to the facility 08/30/14 with diagnoses which included diabetes mellitus and dementia. A review of Resident #120's medical record revealed a physician's order dated 08/30/14 for Metformin 850 milligrams (mg) one tablet twice a day. On 10/08/14 at 5:12 PM Nurse #1 was observed administering medications to Resident #120 which included Metformin 500 mg Extended Release (ER) one tablet. On 10/09/14 at 4:30 PM an interview was conducted with Nurse #1. He verified 1 tablet of Metformin 500 mg was administered to Resident #120 on the afternoon of 10/08/14. Nurse #1 acknowledged the physician's order was for Metformin 850 mg one tablet twice a day. Nurse #1 stated he should have caught the error in the strength of the medication that was dispensed from the facility's Automatic Dispensing Unit (ADU) and should not have given the incorrect medication. On 10/10/14 at 5:42 PM an interview with the Director of Nursing (DON) revealed it was her expectation that the nurses compare the medication label with the MAR every time they give a medication to ensure the accuracy of the dose is given in accordance with the physician's orders.	F 332	five percent or greater. 1. The Residents, Physician, and Responsible parties were made aware of the medication errors. A assessment was completed on Resident #18, #117, and #120 by the Director of Nursing. The Director of Nursing validated the correct medication, dose, and route of medication was available and compared with current orders. Staff that made the med errors were re-educated, and required to complete medication competencies. 2. An in-service for all licensed staff will be conducted by the Director of Clinical Education and or Pharmacist. Regarding medication administration, The 5 rights, prevention of med errors, order processing, and communication with the pharmacy, including Alixia process and How to Use the Alixia Dispensing Unit. A 100% audit performed on all current residents medication orders, compared with	Cont. 11-18-14

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F 332	Continued From page 15 2. Resident #18 was admitted to the facility 04/05/05 with diagnoses which included diabetes mellitus, congestive heart failure and Alzheimer's disease. A review of Resident #18's medical record revealed a physician's order for Senna 8.6 mg 2 tablets twice a day. On 10/09/14 at 5:12 PM Nurse #3 was observed administering medications to Resident # 18 which included Senna 8.6 mg 1 tablet. On 10/10/14 at 1:08 PM an interview was conducted with Nurse #3. She stated she wasn't sure if she gave Resident #18 1 or 2 tablets of Senna 8.6 mg on 10/09/14. On 10/10/14 at 5:42 PM an interview with the Director of Nursing (DON) revealed it was her expectation that the nurses compare the medication label with the MAR every time they give a medication to ensure the accuracy of the dose is given in accordance with the physician's orders. 3. Resident #117 was admitted to the facility on 01/23/14 with diagnoses including diabetes mellitus, hypertension and Alzheimer's disease. A review of Resident #117's medical record revealed a physician's order for Calcium 600 mg with Vitamin D 400 International Units (IU) 1 tablet every day. On 10/09/14 at 6:20 PM Certified Medication Aide (CMA) #1 was observed administering medications to Resident #117 which included Calcium 600 mg with Vitamin D 800 IU.	F 332	pharmacy orders, and medication on hand will be completed by Director of Nursing Services and or/ Designee. 3. New orders are checked by the Night nurse. The Director of Nursing Services and/ or designee validates orders in daily start up meeting. The Director of Clinical Education and/or designee will Observe Medication passes 3x week x 4 weeks then monthly x 3 then on going as determined by the Executive Director or designee. When medication are received from the pharmacy or dispensed by the (ADU) Alixia Dispensing Unit the licensed nurse will compare the medication and dose with the active order on the Medication Administration Record. 4.The Director of Nursing Services and/ or designee will audit compliance weekly x 4weeks then monthly x 3 then on going as	cont. 11-18-14

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F 332	Continued From page 16 On 10/10/14 at 9:55 AM an interview was conducted with CMA #1. He stated he didn't realize the strength of Vitamin D in the tablet he gave was incorrect until he went back and checked the medications after he had administered them on 10/09/14. He stated he only had Calcium 600 mg with Vitamin D 800 IU on the medication cart containing Resident #117's medications but there were different strengths of Calcium with Vitamin D available on other medication carts. On 10/10/14 at 5:42 PM an interview with the Director of Nursing (DON) revealed it was her expectation that the nurses and CMAs compare the medication label with the MAR every time they give a medication to ensure the accuracy of the dose is given in accordance with the physician's orders.	F 332	determined by the Executive Director or designee. Results of the audit will be reported immediately to the Executive Director or designee. Audit results will be discussed in the monthlly Quality Assurance Performance Improvement committee meeting x 3months, and ongoing as determined by the committee.	cont
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to ensure that 2 of 6 residents were free of significant medication errors. (Residents #120 and #73). The findings included: 1. Resident #120 was admitted to the facility on 05/05/14 with diagnoses including diabetes mellitus type 2, hypertension and dementia. She	F 333	F 333 SS-D Significant medication errors were discovered on 2 of 6 residents. The facility will ensure that residents are free of any significant medication errors. 1. Resident # 73 pain medication was increased. Director of Nursing Services performed a pain evaluation assessment. The palliative care team was consulted for ongoing pain management. Pain will be	11-18-14

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F 333	Continued From page 17 was discharged to an acute care hospital on 08/27/14 and readmitted to the facility on 08/30/14. Her most recent quarterly Minimum Data Set (MDS) was completed on 08/08/14. The MDS indicated she had severely impaired cognitive skills for daily decision making and impaired short term and long term memory. The MDS indicated she received insulin injections every day of the observation period. Further review of Resident #120's medical record revealed an order dated 05/13/14 for Metformin 850 milligrams (mg) to be given twice a day. The medication was reordered on 08/30/14 at 4:00 PM when Resident #120 was readmitted to the facility. Metformin is a medication used to treat high blood sugar. Resident #120 also had orders for: 1) Levemir insulin 8 units subcutaneously (SQ) twice a day and 2) Capillary Blood Glucose (CBG) monitoring before meals and at bedtime. Review of the August, September and October 2014 Medication Administration Records (MARs) revealed Metformin 850 mg scheduled to be given at 8:00 AM and 4:00 PM. Nurses' initials on the MARs indicated the medication was given as ordered, including the dose scheduled for 10/08/14 at 4:00 PM. Review of the CBG results recorded on the September and October 2014 MARs revealed 53 instances of blood sugars over 150 according to the September 2014 MAR and 21 instances of blood sugars over 150 according to the October 2014 MAR. During observation of Nurse #1 administering medication to Resident #120 on 10/08/14 at 5:12 PM, Nurse #1 removed 1 tablet of Metformin 500	F 333	assessed every shift by a licensed nurse. The Director of Nursing and / or designee will validate completion in daily start up meeting. Resident #120 was assessed by the Director of nursing Services. The physician, resident, and Responsible party were notified. The Director of Nursing validated the correct medication, dose, and route of medication was available and compared with current orders. Staff that made errors were re-educated, and counseled. 2. An in-service for all licensed staff will be conducted by The Director of Clinical Education and or Pharmacist. Regarding medication administration, the 5 rights, prevention of medication errors, order processing, and communication with the pharmacy, including Alixia process and How to use the ADU. A 100% audit will be performed on all current residents, including medication orders compared with pharmacy orders and	Cont. 11-18-14

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F 333	Continued From page 18 mg Extended Release (ER) from a plastic bag labeled with Resident # 120's name and the name of the medications in the bag, which included Metformin 500 mg ER and were scheduled to be given on 10/08/14 at 4:00 PM. Nurse #1 was observed administering the 500 mg tablet of Metformin to Resident #120. On 10/09/14 at 12:30 PM the medication cart which contained Resident #120's medications was checked with Nurse # 2 and revealed a plastic bag labeled with Resident #120's name and the medications scheduled for 10/09/14 at 4:00 PM. Included in the plastic bag was Metformin 500 mg 1 tablet. Nurse#2 removed a bubble pack card from a different area of the cart that was labeled with the name of Resident #120 and Metformin 850 mg 1 tablet twice a day. The label indicated the medication was dispensed on 08/06/14 and originally contained 30 tablets. There was 1 tablet remaining in the pack. Nurse #2 stated she had been assigned to give medications to Resident #120 for 2 weeks on the 7:00 AM to 3:00 PM shift and she gave the dose of Metformin 850 mg scheduled for 8:00 AM from the bubble pack. An interview with Nurse #1 on 10/09/14 at 4:30 PM revealed the incorrect dose of 500 milligrams of Metformin was dispensed from the facility's Automatic Dispensing Unit (ADU) which was a pharmacy error. Nurse #1 stated he should have caught the error and not given the medication. Nurse #1 stated all medication orders are faxed to the offsite pharmacy and the pharmacy electronically programs the ADU, which is located in the facility, to dispense the medications. An interview with the Director of Nursing (DON)	F 333	medication on hand by the Director of Nursing Services and/ or designee. 3.New orders are checked by the Night Nurse. The Director of Nursing Services and/ or designee validates orders in daily start up meeting. The Director of Clinical Education and/ or designee will observe med passes 3x weekly x 4 weeks then monthly x 3 on going as determined by Executive Director. When medications are received from pharmacy or dispensed by ADU the licensed nurse will compare medication, dose with active orders on Medication Administration Record. The Director of Nursing and/ or designee will fax a summary of all new orders within the last 24hrs. to the pharmacy each morning for system comparison. 4.The Director of Clinical Education and/ or designee will audit compliance weekly x 4 weeks then monthly x 3 then on going as	Cont 11-18-14

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F 333	Continued From page 19 on 10/10/14 at 4:50 PM about the error in the Metformin dosage revealed the ADU only contained Metformin 500 mg tablets. She stated she contacted the pharmacy on 10/09/14 about the error and they sent a new bubble pack of Metformin 850 mg with the delivery on 10/09/14. She stated the machine dispensed the Metformin 500 mg again on 10/10/14 and she had to call the pharmacy again to get them to re-program the ADU so it wouldn't continue dispensing the incorrect dosage. When asked if she had been able to determine how many incorrect doses of Metformin 500 mg had been administered to Resident #120 since she was re-admitted to the facility on 08/30/14, she stated she had requested a resident specific dispense report for Resident #120 from the pharmacy but had not yet received the information. The DON stated the pharmacy had a list of medications that are in the ADU. She stated if the resident had a medication ordered that wasn't in the ADU, the pharmacy would send the medication in a bubble pack with the nightly pharmacy delivery on the night the order was received. The DON was unable to verify that the pharmacy had dispensed a bubble pack of Metformin 850 mg after the pack that was dispensed on 08/06/14 until she called the pharmacy on 10/09/14 when they refilled the medication. An interview with the DON on 10/10/14 at 5:42 PM about her expectation for the manner in which the nurses administer medications revealed she expected the nurses to compare the medication label with the MAR every time they give a medication to ensure the accuracy of the dosage. An interview with the Medical Director on 10/10/14 at 7:00 PM revealed there had been a	F 333	as determined by the Executive Director or designee. Results of the audit will be reported immediately to the Executive Director or designee. Audit results will be discussed in the monthly Quality Assurance Performance Improvement committee meeting x 3months, and ongoing as determined by thhe committee.	cont. 11-18-14

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F 333	Continued From page 20	F 333		

lot of glitches to work out with the ADU system. He stated he had no concern about Resident #120 being harmed by getting the lower dose of Metformin because she was being monitored closely for hypoglycemia after the higher dosage was ordered.

2. Resident #73 was admitted to the facility on 05/20/10 with diagnosis including vascular dementia, chronic pain, osteoporosis. She was discharged to the hospital on 09/18/19 and readmitted to the facility on 09/19/14. Resident #73 encountered a ground level fall from her hospital bed which resulted in a skin tear to the elbow. Her most recent Minimum Data Set (MDS) was completed on 7/30/14. The MDS indicated she had severely impaired cognitive skills for daily decision making and impaired short term and long term memory deficits. The MDS indicated Resident #73 received routine and as needed (PRN) pain medications.

A review of the Physicians orders for 10/02/14 revealed Resident #73 had order for Norco 7.5/325 mg to be discontinued on 10/02/14. An order for Norco 10/325mg by mouth three times a day was written on 10/02/14.

A review of the October 2014 Medication Administration Record revealed an order to start Norco 7.5/325 mg was discontinued on 10/03/14 with the last dose given at 8pm. The Norco 10/325 mg was started on 10/04/14 with the 8:00 AM dose.

A review of the medications that are routinely stocked in the facility's Automatic Dispensing Unit (ADU) system indicated the ADU was stocked with the Norco10/325 mg. The list of medications

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F 333	Continued From page 21 stocked in the facility's ADU system was placed by the ADU for staff convenience. An interview on 10/09/14 at 4:32 PM with the Nurse Practioner reported Resident #73 had been on routine and PRN pain meds related to increased back pain. She reported Resident #73's pain was unrelieved and she had increased the dose of Norco from 7.5/325 mg to 10/325 mg. She further stated the nurses would let her know if the medication was available in the ADU or not. She did not remember the nurse telling her the medication was unavailable. The Nurse Practioner stated it was her expectation the medication should have been given that day or the next day. An interview on 10/10/14 at 4:45 PM with the Director of Nursing (DON) verified the Norco 10/325 mg was routinely stocked in the ADU system. The DON stated it was her expectation the medication should have been given as soon as possible but not as long as it took for staff to start Resident #73's medication. An interview on 10/10/14 at 7:00 PM with the Medical Director revealed the new system had a problem getting medications in a timely manner.	F 333		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431	F 431 SS-E The facility failed to remove expired medications from 4 of 5 medication carts. Drugs and biologicals used in the facility will be labeled in accordance with currently	11-18-14

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F 431	Continued From page 22 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the 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 observation and staff interviews the facility failed to remove expired medications from 4 of 5 medication carts. The findings included: 1. Inspection on 10/10/14 at 2:19 PM of the East Wing Medication Cart #1 revealed a partially use bottle of Zinc Sulfate 220 milligram (mg) tablets with an expiration date of September 2014. An interview on 10/10/14 at 2:28 PM with Nurse	F 431	accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date. 1. All expired meds were removed from the med carts. A 100% audit will be conducted on all medication carts/ medications to ensure cleanliness/ all expired meds were removed by Director of Nursing Services and/ or designee. 2. All Licensed Nurses and Certified Medication assistants will be in-serviced on checking all medications prior to administration for expiration dates. 100% audit of all medications to ensure all expired medications have been removed by Director of Nursing Services or designee. 3. The Night Nurse will check the medication cart daily for expired meds ongoing. The Director of Nursing and/ or designee will	cont. 11-18-14

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	345223	A. BUILDING _____ B. WING _____	C 10/10/2014

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F 431	Continued From page 23 #4 and Nurse #5 about who was responsible for checking the expiration dates of over the counter (OTC) medications revealed each nurse and Certified Medication Aide (CMA) who gave medications out of a cart was responsible for checking for expiration dates of the medications. An interview on 10/10/14 at 4:45 PM with the DON about who was responsible for checking for expired medications revealed each nurse was responsible for checking to make sure the medication was not expired when they poured it and the nurse who worked the 11:00 PM - 7:00 AM shift was responsible for checking the cart every night for cleanliness such as loose tablets and expired OTC medications. When asked what her expectation was regarding expired medications, the DON stated the nurses should be checking for expired medications and removing them from the cart. 2. Inspection on 10/10/14 at 2:29 PM of the East Wing Medication Cart #2 revealed a 100 tablet bottle of Acetaminophen 500 mg labeled with a date opened sticker of 10/01/14 but no manufacturer's expiration date on the bottle. There were 8 tablets remaining in the bottle. An interview on 10/10/14 at 2:28 PM with Nurse #4 and Nurse #5 about who was responsible for checking the expiration dates of over the counter (OTC) medications revealed each nurse and Certified Medication Aide (CMA) who gave medications out of a cart was responsible for checking for expiration dates of the medications. An interview on 10/10/14 at 4:45 PM with the DON about who was responsible for checking for expired medications revealed each nurse was	F 431	audit compliance weekly x 4weeks then monthly x 3 then on going as determined by the Executive Director or designee. Results of the audit will be reported immediately to the Executive Director or designee. Audit results will be discussed in the monthly Quality Assurance Performance Improvement committee meeting x 3months, and ongoing as determined by the comittee.	

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F 431	Continued From page 24 responsible for checking to make sure the medication was not expired when they poured it and the nurse who worked the 11:00 PM - 7:00 AM shift was responsible for checking the cart every night for cleanliness such as loose tablets and expired OTC medications. When asked what her expectation was regarding expired medications, the DON stated the nurses should be checking for expired medications and removing them from the cart. 3. Inspection on 10/10/14 at 3:13 PM of the Alzheimer's Unit Medication Cart revealed a partially used 60 capsule bottle of Fish Oil Concentrate with an expiration date of September 2014. An interview on 10/10/14 at 3:20 PM with Nurse #6 about who was responsible for checking expiration dates of OTC medications revealed each nurse and Certified Medication Aide (CMA) who gave medications out of a cart was responsible for checking for expiration dates of the medications. An interview on 10/10/14 at 4:45 PM with the DON about who was responsible for checking for expired medications revealed each nurse was responsible for checking to make sure the medication was not expired when they poured it and the nurse who worked the 11:00 PM - 7:00 AM shift was responsible for checking the cart every night for cleanliness such as loose tablets and expired OTC medications. When asked what her expectation was regarding expired medications, the DON stated the nurses should be checking for expired medications and removing them from the cart.	F 431		

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F 514 SS=D	Continued From page 26 483.75(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 record review and staff interview the facility failed to include the drug strength on the Medication Administration Record (MAR) or the monthly recapitulation of physician's orders for 1 of 6 residents reviewed (Resident # 135). The findings included: Resident #135 was admitted to the facility on 08/15/14 with diagnoses which included unspecified cerebral artery occlusion with infarct, hypertension and retention of urine. His admission Minimum Data Set (MDS) dated 08/22/14 indicated he was cognitively intact for daily decision making, required extensive assistance from staff with all activities of daily living and received diuretic medication every day of the assessment period. Further review of his medical record revealed the	F 514 F 514	F 514 SS-D The facility failed to include the drug strength on the Medication Administration Record for 1 of 6 residents reviewed. The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systemically organized. 1. The strength of the medication order was verified and added to the medication administration by the Director of Nursing. The medication in the med cart was the dose verified of 40mg. 2.A 100% audit will be completed by 11/07/14 of all orders and compared with medication available and pharmacy orders by Director of Nursing Services and/ or designee. 3. The night shift nurse will	11-17-14

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F 514	Continued From page 27 September and October 2014 recapitulation of physician's orders listed "Furosemide (Lasix) give 1 tablet by mouth in the morning related to unspecified essential hypertension." Review of the August, September and October 2014 MARs revealed the following: "Furosemide Tablet Give 1 tablet by mouth in the morning related to Unspecified Essential Hypertension - Order Date - 08/15/14 with the medication listed to be given at 6:00 AM." Review of Resident #135's admission medication list revealed Furosemide (Lasix) 40 milligrams (mg) by mouth daily at 6:00 AM On 10/10/14 at 11:00 AM visual inspection of Resident #135's medications in the medication cart revealed a package labeled Lasix 40 mg 1 tablet in the cart available for use. An interview on 10/10/14 at 4:45 PM with the Director of Nursing (DON) about the facility's system for transcribing orders revealed the nurse who receives the order enters the information into the electronic record. She stated each nurse is assigned certain residents to compare the monthly recapitulation of physician's orders with the original order and the electronic MAR. She stated there had not been a second check for accuracy of transcription into the electronic record until about a week ago when she began implementing a system of having the nurses who work the 11:00 PM to 7:00 AM shift verify the accuracy of transcription of new orders. The DON stated the new system was not fully implemented because she had not yet provided training to all the nurses. The DON was asked what she would expect a nurse who was administering medication	F 514	3. Chart checks on all new orders. The Director of Nursing and/ or designee will validate new orders in daily start up meeting. 4.The Director of Clinical Education and/ or designee will audit compliance weekly x 4 weeks then monthly x 3 then on going as determined by the Executive Director or designee. Audit results will be discussed in the monthly Quality Assurance Performance Improvement committee meeting x 3 months, and ongoing as determined by the committee.	cont.

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F 514	Continued From page 28 to do if the strength of a medication wasn't listed on the MAR. The DON stated she would expect the nurse to get the medication order clarified and make the correction on the MAR.	F 514		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to	F 520	F520 Refer to F156 for compliance, monitoring, auditing and QAPI process for resident # 4 and #29. Refer to F333 for the monitoring, auditing and compliance with the QAPI process for resident # 120 and # 73 . Refer to F431 for the monitoring, auditing and compliance with the QAPI process. Refer to F241 for the compliance, monitoring and auditing and QAPI process for resident #122. The Director of Clinical Education reeducated the QAPI committee reviewed Golden Living QAPI policies on identifying issues and systems of care, root cause analysis, and the implementation of the plan of correction. The regional nurse consultant will audit all QAPI meetings for one year.	11-18-14

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F 520	Continued From page 29	F 520		

maintain implemented procedures and monitor interventions that the committee had previously put into place. This failure related to four deficiencies which were originally cited during the facility's 07/26/13 recertification survey and were recited during the facility's current recertification survey. The recited deficiencies were in the areas of notice of resident rights, dignity, free of medication errors and labeling and storage of medications. The facility's continued failure during two consecutive recertification surveys shows a pattern of the facility's inability to sustain an effective Quality Assurance Program.

The Findings included:

This tag is cross referred to:

1a. F 156: Rights: Based on observations, record review, and staff interviews the facility failed to provide the residents with the Denial of Payment of Medicare Coverage and their appeal right for 2 of 3 residents. (Resident #4 and Resident #29).

During the recertification survey of 10/10/14 the facility was cited for not informing the resident/family of the resident's right to have a claim or demand bill submitted to Medicare as the resident no longer qualified for services. During the recertification survey on 07/26/13 the facility failed to post the contact information for filing a complaint with the State licensure and certification agency.

1b. F 333: Free of significant medication errors: Based on observations, record review and staff interviews the facility failed to ensure that 2 of 6 residents were free of significant medication errors. (Resident #120 and Resident #73).

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F 520	Continued From page 30 During the recertification survey of 10/10/14 the facility was cited for failing to provide residents free of any significant medication errors. During the recertification survey on 07/26/13 the facility failed to administer the accurate dose of Coumadin to 1 of 11 sample residents on Coumadin. 1c. F 431: Safe and secure storage and accurate labeling of all medications: Based on observations and staff interviews the facility failed to remove expired medications from 4 of 5 medications carts. During the recertification survey of 10/10/14 the facility was cited for failing to remove expired medications from the medication carts. During the recertification survey on 07/26/13 the facility failed to remove expired medications from 2 of 6 medication carts and 1 emergency drug kit. 1d. F 241: Dignity: Facility must promote care for residents in a manner and in environment that maintains or enhances each residents dignity and respect in full recognition of his or her individuality. Based on observations, record review and staff interviews the facility failed to treat residents with dignity when they dressed the resident in pants that were too large resulting in exposure for 1 of 4 residents with cognitive impairment. (Resident #122). During the recertification survey of 10/10/14 the facility was cited for failing to treat resident with dignity. During the recertification survey on 07/26/13 the facility failed to ensure 1 of 4 sampled residents reviewed for assistance was dressed appropriately and left in a hospital gown	F 520		

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F 520	Continued From page 31 all day. On 10/10/14 at 6:30 PM an interview with the Administrator and Director of Nursing (DON)was conducted about the facility's Quality Assessment and Assurance (QAA) Committee. The DON stated the facility's QAA committee meetings were held monthly and their action plan was driven by the plan of correction they developed as a result of the previous recertification survey completed on 7/26/13. The Administrator and the Director of Nursing explained that the facility had experienced a large turnover in staff and it was difficult to make needed changes. The Director of Nursing explained that if the facility was out of compliance, they would discuss this as a team and develop an action plan. She explained that the staff was educated about the action plan through monthly staff meetings and in-services. The DON further stated that this was a work in progress and acknowledged the facility was still not in compliance in some areas.	F 520		