STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING ______ B. WING ______	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREENSBORO	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to notify the physician of significant weight loss for 1 of 4 sampled residents with a	F 157	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of	10/21/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 10/21/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 gastric tube (Resident #1). The findings include Resident #1 was admitted to the facility on 7/8/15. The diagnosis included dysphagia, gastric tube, diabetes, cerebral vascular accident. The Minimum Data Set (MDS) dated 9/15/15 indicated Resident #1 had severe cognition impairment with altered mental status. Resident #1 was fed by gastric tube and required total assistance with all activities of daily living. Review of the nutritional care area assessment (CAA) dated 7/16/15, indicated weight variation noted. Daily weight monitor, weight trend 7/9/15 148 pounds and 7/15/15 143 pounds. Review of the weight history revealed on 7/8/15 Resident #1 ' s admission weight was 148 pounds and weighed daily. The weights were as follows: 1. 7/9/15 148 pounds 2. 7/10/15 144 pounds 3. 7/11/15 143 pounds 4. 7/13/15 143 pounds, 5. 7/14/15 138 pounds, 6. 7/16-26/15 142 pounds, 7. 7/26/15-8/4/15 140 pounds, 8. 8//4/15 137 pounds, 9. 8/5/15 135 pounds, 10. 8/7-8/10/15 33 pounds, 11. 8/11/15 134 pounds, 12. 8/12-14/15 132 pounds, 13. 8/16/15 130 pounds, 14. 8/17-21/15 132 pounds, 15. 8/20-8/27/15 134 pounds, 16. 8/29/15 132 pound, 17. 8/30/15 134 pounds, 18. 9/1/15 132 pounds, 19. 9/2/15 130 pounds, 20. 9/3-5/15 128 pounds 21. 9/5-7/15 126 pounds. Review of the physician notes dated 7/17/15, 8/14/15 and 9/4/15, revealed there were no	F 157	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. F157 Resident #1 is no longer at the facility. The resident was admitted on July 8, 2015 with diagnosis including cerebrovascular infarction, heart failure, dysphagia, and type 2 diabetes mellitus. Resident #1 was ordered Glucerna 1.5 1 can every 4 hours with 175cc free water flush before and after each feeding. On 7/9/15 decubivite was ordered. 7/10/15 MD evaluated resident. 7/13/15 Labs were obtained and psychiatric services evaluated. 7/14/15 ST initiated treatment. 7/15/15, 7/17/15, and 8/6/15 dietary reviewed resident. 8/6/15 Prostate was initiated. 8/13/15 Psychiatric services reassessed resident. 8/14/15 Dietary reviewed resident. 8/21/15 MD reviewed resident. 8/27/15 Psychiatric services followed up with resident. An audit of all residents has occurred to review weight changes for Education on weight monitoring and notification of MD/NP. 10/25/15 Residents that have been at the facility less than 30 days, those with 30/90/180 day weight loss and anyone eating less than 50% will be reviewed by the Director of Nursing Services, Director of Clinical Education, or Unit Managers in morning	

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F 157	Continued From page 2 physician orders that addressed the weight loss. Review of nutrition weight/wound review dated 8/14/15, indicated Resident #1 was referred by occupational therapy due to weight loss of 140 pounds to 132 pounds. During an interview on 9/30/15 at 3:00PM, the dietary manager (DM) indicated that Resident #1 had been referred to dietary for weight loss by nursing and the dietician also reviewed the weight loss. The DM indicated she was uncertain whether the weight loss had been reviewed or discussed with the physician. She confirmed there was no supplemental interventions or change in current feeding status after the weights were reviewed. During a telephone interview on 9/30/15 at 3:24PM, the registered dietician (RD) indicated that she had reviewed the weight loss pattern from admission to 8/11/15. The RD confirmed with the continued weight loss the physician should have been made aware of the increased weight loss of 22 pounds within in a short period of time. During an interview on 9/30/15 at 9:30AM, the director of nursing indicated knowledge of Resident #1 ' s weight loss and indicated the resident had been discussed and reviewed through weight management committee and stand-up meetings. She further stated the resident was referred to dietary for evaluation and discussed with the physician. The DON reviewed the record and confirmed there was no supplemental interventions or documentation the physician had reviewed the resident ' s weight concerns during monthly or routine visits. During a telephone interview on 9/30/15 at 6:01PM, the physician indicated that Resident#1 weight loss had not been discussed with her during her rounds or routine visits. The physician	F 157	meeting five times weekly for two months to ensure weight losses or those with the potential are addressed as needed with MD/NP notification. Weekly weight/ At risk meetings will be held with interdisciplinary team including nursing and dietary department. MD or NP will be presented with meeting information and dietary recommendations weekly times 2 months by the Director of Nursing Services or Unit Manager. MD or NP will also be notified weekly of patient weight losses. 10/25/15 The results of these audits will be reviewed by and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. Audits will be reviewed monthly x 6 months at Quality Assessment Performance Improvement Committee. 10/25/15	

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F 157	Continued From page 3 indicated had she been aware of the increased weight loss she would have documented the concern and interventions. She further stated if she did not address it in her routine or monthly progress notes she had not seen the resident. The physician indicated the expectation would have been for nursing or dietician to report significant weight loss as soon as possible and put the information in her communication folder for review. She acknowledged that a resident on gastric tube feedings with a significant weight loss should be reviewed for additional weight management supplements or change in current regime. During an interview on 10/1/15 at 9:40AM, Nurse #2 reported she had not spoken with the physician about the resident ' s weight loss since it was reported to the nurse manager who would make the referral to dietary or put something in the physician ' s communication book. During an interview on 10/1/15 at 10:00AM, NA# 7 indicated that she was responsible for reporting to nursing any weight changes through a daily weight report to the charge nurse. She indicated that any resident on daily weights should be report when there was a 5 pound increase or decrease. She further stated she printed the weight report for the nurse manager/supervisor review. She indicated any time she noticed a significant weight change she would highlight the sheet to alert the nurse there was a change. Resident #1' s weight changed and the report was given to the charge nurse. During a follow-up interview on 10/1/15 at 10:35 AM, director of nursing indicated the process included the nursing assistant documents the weights in the system and a weight report was generated. The weight/wound management team reviews the weight/wound concerns and discuss	F 157		

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F 157	Continued From page 4 the intervention or action plan necessary. She indicated the expectation was once the concern was identified the nurse manager would put a communication form in the physician ' s box. The nurse manager would do rounds with the physician to ensure the resident was seen and any recommendations, labs, new orders and referrals to other departments are followed up and completed. She acknowledge and confirmed there was no documentation per facility process and Resident #1 was not seen by the physician for weight loss intervention or management. During an interview on 10/1/15 at 10:25AM, Nurse #5 indicated that she was aware of Resident#1 ' s weight loss and was responsible for ensuring the weight concern was reported to the physician through the facility process. Nurse #5 indicated the expectation was when the charge nurse did rounds with the physician the weight report should be reviewed and discussed. If there were any changes or recommendations or referrals the nurse manager would put the information in the physician ' s box. The nurse manager and should follow-up by the end of the week. In addition, if the physician requested a referral to another department the nurse manager was responsible for ensuring the referral or action was complete. Nurse #5 acknowledged the information for Resident #1 weight loss had not been submitted to the physician.	F 157		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels,	F 325		10/21/15

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F 325	Continued From page 5 unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on family interviews, staff interviews and record review, the facility failed to reassess and intervene for 1 of 4 gastric tube residents with continuous weight loss (Resident #1). The findings included Resident #1 was admitted to the facility on 7/8/15. The diagnosis included dysphagia, gastric tube, diabetes and cerebral vascular accident, The Minimum Data Set (MDS) dated 9/15/15 indicated Resident #1 had severe cognition impairment with altered mental status. Resident #1 was fed by gastric tube and required total assistance with all activities of daily living. Review of the physician ' s order dated 7/9/15, documented 1 can of Glucerna 1.5 bolus feeds every 4 hours through gastric tube. Review of the care plan dated 7/9/15, identified the problems as dependent upon tube feedings/inadequate oral intake due to cerebral vascular accident, dysphagia. The goal included no signs and symptoms of aspirations, would be free of gastro intestinal discomfort related to tube feeding, improve nutritional status and/or body weight and be free from signs and symptoms of dehydration. The approaches included daily weights, monitor signs and symptoms of intolerance of tube feeding, refer to registered dietician for assessment as needed, external	F 325	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. F325 Resident #1 is no longer at the facility. The resident was admitted on July 8, 2015 with diagnosis including cerebrovascular infarction, heart failure, dysphagia, and type 2 diabetes mellitus. Resident #1 was ordered Glucerna 1.5 1 can every 4 hours with 175cc free water flush before and after each feeding. On 7/9/15 decubivite was ordered. 7/10/15 MD evaluated resident. 7/13/15 Labs were obtained and psychiatric services evaluated. 7/14/15 ST initiated treatment. 7/15/15, 7/17/15, and 8/6/15 dietary reviewed resident. 8/6/15 Prostate was initiated. 8/13/15 Psychiatric services reassessed resident. 8/14/15 Dietary reviewed resident. 8/21/15 MD reviewed resident. 8/27/15 Psychiatric services followed up with resident.	

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F 325 Continued From page 6

formula and feedings as ordered.

Review of the nutritional care area assessment (CAA) dated 7/16/15, indicated weight variation noted. Daily weight monitor, weight trend 7/9/15 148 pounds and 7/15/15 143 pounds. The diet NPO(nothing by mouth), Glucerna 1.5 every 4 hours to provide 2136 calories, 118 grams of protein, 1080 free water plus 175 flush every 4 hours (1050 cc) plus 30cc flush before and after meds

Review of the weight history revealed on 7/8/15 Resident #1 ' s admission weight was 148 and weighed daily. The weights were as follows: 1. 7/9/15 148 pounds 2. 7/10/15 144 pounds
3. 7/11/15 143 pounds
4. 7/13/15 143 pounds,
5. 7/14/15 138 pounds,
6. 7/16-26/15 142 pounds,
7. 7/26/15-8/4/15 140 pounds,
8. 8//4/15 137 pounds,
9. 8/5/15 135 pounds,
10. 8/7-8/10/15 33 pounds,
11. 8/11/15 134 pounds,
12. 8/12-14/15 132 pounds,
13. 8/16/15 130 pounds,
14. 8/17-21/15 132 pounds,
15. 8/20-8/27/15 134 pounds,
16. 8/29/15 132 pound,
17. 8/30/15 134 pounds,
18. 9/1/15 132 pounds,
19. 9/2/15 130 pounds,
20. 9/3-5/15 128 pounds
21. 9/5-7/15 126 pounds.

Review of the physician notes dated 7/17/15, 8/14/15 and 9/4/15, revealed there was no physician orders that addressed the weight loss.

Review of nutrition weight/wound form dated 8/14/15, indicated Resident #1 was " referred by family member due to weight loss 140 to 132.

F 325

An audit of all residents has occurred to review weight changes for all current residents by the Director of Nursing Services and Registered Dietician. 10/13/15. All residents with weight concerns were presented to the Doctor for review. 10/16/15

The facility nursing staff was educated by the Director of Clinical Education on weight monitoring and notification of MD 10/25/15

Residents that have been at the facility less than 30 days, those with 30/90/180 day weight loss and anyone eating less than 50% will be reviewed by the Director of Nursing Services, Director of Clinical Education, or Unit Managers in morning meeting five times weekly for two months to ensure weight losses or those with the potential are addressed as needed with MD/NP notification. Weekly weight/ At risk meetings will be held with interdisciplinary team including nursing and dietary department. MD or NP will be presented with meeting information and dietary recommendations weekly times 2 months by the Director of Nursing Services or Unit Manager. MD or NP will also be notified weekly of patient weight losses. 10/25/15

The results of these audits will be reviewed by and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services. Any issues or trends

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F 325	Continued From page 7 Resident #1 remained on tube fed 1 can of Glucerna 1.5 every four hours with flushes as ordered. Resident started prostat max 8/4/15 to support nutrition/wound healing. Current tube feeding regimen provides 2240 calories and 128 grams of protein. Estimated needs to support wound healing 2000 calories and 108 grams of protein, 2000ml (milliliters) fluid. Current nutrition regimen as ordered meals 100% nutritional needs. Resident also received decubi-vite to support wound healing. Anticipate weight to stabilize. Will continue to monitor weight wound per nursing. " Review of the nurse ' s notes and medication administration record(MAR) dated 7/9/15 through 9/7/15 revealed that Resident #1 wore an abdominal binder and accepted his bolus tube feed without any difficulty. There was no documentation that indicated that Resident #1 consistently pulled at or out the G-tube or refused bolus feedings. During an interview on 9/30/15 at 9:18AM, family member #1 indicated that Resident #1 had not been seen by the physician the since the weight loss had been discussed and reported to the nursing staff since admission. The family member reported they were consistently told by nursing staff that Resident #1 would be referred to the dietician and physician for additional supplements or change in feeding with possible increase in feeding. The family member also indicated the director of nursing was also aware of the continued weight loss and no action was taken. Family member indicated when Resident #1 ' s loose stool increased after feedings they became concerned and were uncertain whether the resident was on any medications that would cause the increase of stool. Resident #1 began to look very frail and weaker than usual. The	F 325	identified will be addressed by the Quality Assessment Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. Audits will be reviewed monthly x 6 months at Quality Assessment Performance Improvement Committee. 10/25/15	

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F 325	Continued From page 8 dietician nor the physician had gotten back with the family on the action that would be taken to address the weight loss. The weight loss was very noticeable and quick by the day and week. During an interview on 9/30/15 at 3:00PM, the dietary manager (DM) indicated that Resident #1 had been referred to dietary for weight loss by nursing and the dietician also reviewed the weight loss and felt the 1 can of Glucerna every 4 hours met the estimated nutritional needs the resident. The DM indicated she was uncertain whether the weight loss had been reviewed or discussed with the physician. She confirmed there was no supplemental interventions or change in current feeding status after the weights were reviewed. During a telephone interview on 9/30/15 at 3:24PM, the registered dietician (RD) indicated that she had reviewed the weight loss pattern from admission to 8/11/15. She indicated that 30 ml of prostat was added (8/8/15)for wound healing and as supplemental increase to the resident ' s current caloric and protein intake. The RD indicated she had not spoken with the family and that nursing had discussed the concern with the family and the current regime met the estimated nutritional needs of the resident. The RD confirmed with the continued weight loss the physician should have been made aware of the increased weight loss of 22 pounds within in a short period of time. During an interview on 9/30/15 at 9:30AM, the director of nursing indicated knowledge of Resident #1 ' s weight loss and indicated the resident had been discussed and reviewed through weight management committee and stand-up meetings. She further stated the resident was referred to dietary for evaluation and discussed with the physician. The DON reviewed the record and confirmed there was no	F 325		

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F 325	Continued From page 9 documentation of any concerns with the resident ' s refusals of bolus feeding, there was no signs of loose stools or consistent pulling out of the gastric tube. In addition, there was no supplemental interventions or documentation the physician had reviewed the resident ' s weight concerns during monthly or routine visits. During a telephone interview on 9/30/15 at 6:01PM, the physician indicated that Resident#1 weight loss had not been discussed with her during her rounds or routine visits. The physician indicated had she been aware of the increased weight loss she would have documented the concern and interventions. She further stated if she did not address it in her routine or monthly progress notes she had not seen the resident. The physician indicated the expectation would have been for nursing or dietician to report significant weight loss as soon as possible and put the information in her communication folder for review. She acknowledged that a resident on gastric tube feedings with a significant weight loss should be reviewed for additional weight management supplements or change in current regime. During an interview on 10/1/15 at 9:25AM, NA# 5 indicated she had observed nursing giving the bolus feeding, but the resident had not refused or resist the feedings. The resident did wear an abdominal binder to prevent him from pulling out the tube. NA#5 further stated that Resident #1 would pull at the binder and tube but was not successful in pulling it out if the binder was on correctly. NA#5 added that the resident was a thin person and did appear weak looking in the past few weeks more than other days. This was reported to nursing and they handled it from that point. During an interview on 10/1/15 at 9:30AM, NA#6	F 325		

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F 325	Continued From page 10 indicated that Resident #1wore an abdominal binder to prevent him from pulling out the gastric tube. The NA further stated Resident #1 would pull at it but did not pull it out that she was aware of. He was a thin person but looked even thinner for about a month. The resident seemed to be taking the bolus feeding with no problems. NA#6indicated that she was unaware of any change in his stools. She was unaware of any loose or diarrhea during the times she had worked with the resident. During an interview on 10/1/15 at 9:40AM, Nurse #2 reported that Resident #1 tolerated the bolus feedings well and was not resistant. She indicated the resident was on daily weights and when the nursing assistant reported the weights and there was significant drop or increase it would be reported to the nurse manager and the director of nursing. She indicated that Resident#1 did have some weight loss and the nurse manager was made aware, but she was unaware of any change in his current feeding regime. The only addition was the 30 ml prostat for wound healing. She indicated that the manager had not informed nursing of any supplement additions or changes and she had not spoken with the physician about the resident ' s weight loss since it was reported to the nurse manager who would make the referral to dietary or put something in the physician ' s communication book. During an interview on 10/1/15 at 10:00AM, NA# 7 indicated that she was responsible for reporting to nursing any weight changes through a daily weight report to the charge nurse. She indicated that any resident on daily weights should be report when there was a 5 pound increase or decrease. She further stated she printed the weight report for the nurse manager/supervisor review. She indicated any time she noticed a	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING ______ B. WING ______	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 325	Continued From page 11 significant weight change she would highlight the sheet to alert the nurse there was a change. Resident #1' s weight changed and the report was given to the charge nurse. During an interview on 10/1/15 at 10:10AM, Nurse #3 indicated the expectation would be once the nursing assistant submitted the weight report it would be given to the nurse manager/charge nurse and it would be reviewed by the nurse manager or director of nursing. Nurse #3 further indicated if there was a significant weight change within 3 days the physician would be notified by the nurse manager or director of nursing. During a follow-up interview on 10/1/15 at 10:35 AM, director of nursing indicated the process included the nursing assistant documents the weights in the system and a weight report was generated. The weight/wound management team reviews the weight/wound concerns and discuss the intervention or action plan necessary. She indicated the expectation was once the concern was identified the nurse manager would put a communication form in the physician ' s box. The nurse manager would do rounds with the physician to ensure the resident was seen and any recommendations, labs, new orders and referrals to other departments are followed up and completed. She acknowledge and confirmed there was no documentation per facility process, Resident #1 was not seen by the physician for weight loss intervention or management. During an interview on 10/1/15 at 10:25AM, Nurse #5 indicated that she was aware of Resident#1 ' s weight loss and was responsible for ensuring the weight concern was reported to the physician through the facility process. Nurse #5 indicated the expectation was when the charge nurse did rounds with the physician the	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 325	Continued From page 12 weight report should be reviewed and discussed. If there were any changes or recommendations or referrals the nurse manager would put the information in the physician ' s box. The nurse manager and should follow-up by the end of the week. In addition, if the physician requested a referral to another department the nurse manager was responsible for ensuring the referral or action was complete. Nurse #5 acknowledged the information for Resident #1 weight loss had not been submitted to the physician.	F 325		