

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

PRINTED: 08/07/2015  
FORM APPROVED  
OMB NO. 0938-0391

15th 9/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/29/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - MOUNTAIN VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 1360 BYPASS ROAD WINCHESTER, TN 37398
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(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
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F 000  F 323 SS=D	<p><b>INITIAL COMMENTS</b></p> <p>A Recertification survey and complaint investigation #34686 and #35388, were completed at Golden LivingCenter-Mountain View on 7/27-29/15. No deficiencies were cited related to the complaint investigations under CFR Part 483, Requirements for Long Term Care Facilities. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>	F 000  F 323	<p>This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid Requirements. Submission of this plan of correction does not constitute an agreement that the deficiencies actually exist, nor is it an admission that they exist. This submission is a good faith expression of the facility's desire to fully comply with Medicare and Medicaid requirements.</p>	
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	<p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety device was in place to prevent falls for one resident (#87) of 32 residents reviewed.</p> <p>The findings included:</p> <p>Medical record review revealed Resident #87 was admitted to the facility on 3/23/15 with diagnoses including Alzheimer's Disease, Anxiety, Peripheral Vascular Disease, History of Falls, Osteoporosis, Urinary Retention, and Congestive Heart Failure.</p> <p>Medical record review of a Quarterly Minimum Data Set (MDS) dated 6/30/15 revealed the resident was moderately impaired for daily decision making, required extensive assistance of</p>	F323 1) 2)	<p>On 7/28/15, Resident #87 pressure pad alarm was connected and water pitcher placed within reach.</p> <p>Residents within the facility have the potential to be affected. The Director of Nursing Services completed an audit of residents with pressure pad alarms to ensure alarms were connected with no others identified as unsecure. The Executive Director completed an audit of residents with water pitchers with no others identified as out of reach.</p>	8/27/15
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jessie Beckman, Executive Director</i>	TITLE	(X6) DATE 8/20/15
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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 323	Continued From page 1 2 for bed mobility, and transfers.  Medical record review of the Care Plan dated 3/24/15 revealed "...At risk for falls...call light or personal items available and in easy reach...pressure pad alarm to bed..."  Observation on 7/28/15 at 2:35 PM, in the resident's room revealed the resident lying on the bed, the pressure pad alarm not connected, and the water pitcher not within reach of the resident.  Interview with the Licensed Practical Nurse #1 on 7/28/15 at 3:50 PM, in the resident's room confirmed the resident's alarm was not attached and the water pitcher was not within reach of the resident.	F 323	3) a) On 7/28/15, the Director of Nursing Services re-educated LPN #1 related to proper usage of pressure pad alarms and ensuring water pitchers are within reach of residents. b) On 7/28/15, the Director of Clinical Education began re-education with nursing staff related to proper usage of pressure pad alarms and ensuring water pitchers are within reach of residents. c) On 7/28/15, an audit was completed by the Executive Director and Director of Nursing Services to ensure all pressure pad alarms are connected and all water pitchers are within reach of residents.	
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F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS  The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to arrange dental services for 1 resident (#4) of 4 residents reviewed for dental services of 32 residents	F 412	4) a) Weekly walking rounds observing pressure pad alarms will be conducted by the Director of Nursing Services with findings reported monthly to the QA Committee x 3 months or until resolved. b) Weekly walking rounds observing resident water pitchers will be conducted by the Executive Director with findings reported monthly to the QA Committee x 3 months or until resolved.	
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F 412	Continued From page 2 sampled.  The finding included:  Medical record review revealed Resident #4 was admitted to the facility on 5/29/15 with diagnoses including Lower Limb Amputation, Above Knee, Pure Hypercholesterolemia, Iron Deficiency, Heartburn, Essential Hypertension, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease.  Medical record review of a Consent for Dental Treatment, undated revealed "...I consent for dental treatment..."	F 412	F412  1) On 8/3/15, the Director of Social Services contacted mobile dental to schedule services for Resident #4.  2) Residents within the facility have the potential to be affected. The Director of Social Services completed an audit ensure the facility offered dental services to all current residents.  3)	8/25/15
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F 431 SS=D	Medical record review of an admission Clinical Health Status assessment dated 5/29/15 revealed "...broken, loose, or carious teeth..." box checked.  Observation and interview with Resident #4 on 7/29/15 at 10:10 AM, in the resident's room revealed he had several missing teeth, upper and lower, existing teeth in bad condition and stained. The resident stated he had tooth pain that would go away at times and had not seen a dentist, since admission to the facility "...thought his teeth were just rotting away..."  Interview with the Administrator in the Administrator's office, on 07/29/2015 at 10:57 AM confirmed the facility failed to offer the resident dental services since his admission to the facility. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of	F 431	a) On 8/3/15, the Executive Director implemented a process to ensure all new residents were offered dental services upon admission and annually while residing within the facility. b) On 8/3/15, the Executive Director provided education to the Director of Nursing Services, Director of Social Services, Director of Alzheimer's Care and the Director of Admissions/Marketing related to the newly implemented process to ensure all residents residing within the facility are offered dental services.	
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F 412	<p>Continued From page 2 sampled.</p> <p>The finding included:</p> <p>Medical record review revealed Resident #4 was admitted to the facility on 5/29/15 with diagnoses including Lower Limb Amputation, Above Knee, Pure Hypercholesterolemia, Iron Deficiency, Heartburn, Essential Hypertension, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease.</p> <p>Medical record review of a Consent for Dental Treatment, undated revealed "...I consent for dental treatment..."</p>	F 412	<p>4)</p> <p>a) The Executive Director will audit all new admissions to ensure the facility offers dental services to all residents upon admission with findings reported monthly to the QA Committee x 3 months or until resolved.</p> <p>b) The Director of Social Services and/or MDS Coordinator will use the annual MDS schedule to ensure the facility offers dental services to all residents while residing within the facility with findings reported monthly to the QA Committee x 3 months or until resolved.</p>	
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	<p>Medical record review of an admission Clinical Health Status assessment dated 5/29/15 revealed "...broken, loose, or carious teeth..." box checked.</p> <p>Observation and interview with Resident #4 on 7/29/15 at 10:10 AM, in the resident's room revealed he had several missing teeth, upper and lower, existing teeth in bad condition and stained. The resident stated he had tooth pain that would go away at times and had not seen a dentist, since admission to the facility "...thought his teeth were just rotting away..."</p>			
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F 431 SS=D	<p>Interview with the Administrator in the Administrator's office, on 07/29/2015 at 10:57 AM confirmed the facility failed to offer the resident dental services since his admission to the facility.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of</p>	F 431		
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F 431	<p>Continued From page 3</p> <p>a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility policy, review of Change of Shift Controlled Substances Count Sheet, medical record review, observation, and interview, the facility failed to maintain an</p>	F 431	<p>F431</p> <p>1) a) On 07/27/15, the Director of Nursing Services began an investigation into the inaccurate Controlled Drug Record for Hydromorphone 2 mg in the custody of LPN #1. b) On 07/27/15, the Director of Nursing Services removed 6 expired Hema screens and 1 unlabeled Enoxaparin 80 mg from the B-Wing Nurses Station.</p> <p>2) a) Residents within the facility have the potential to be affected. The Director of Nursing Services, MDS Coordinator, Director of Clinical Education, and Wound Care Nurse completed an audit of all controlled drug records on all medication carts within the facility to ensure all controlled drug records were accurate with no others identified as out of compliance. b) Residents within the facility have the potential to be affected. The Director of Nursing Services, MDS Coordinator, Director of Clinical Education, Director of Alzheimer's Care and Wound Care Nurse completed an audit of all Nurses Stations medication rooms within the facility to ensure no medications were expired and/or missing labels with no others identified as out of compliance.</p> <p>3) a) On 7/27/15, the Director of Alzheimer's Care took temporary possession of the medication cart on E Wing while the Director of Nursing Services conducted an investigation</p>	8/29/15	

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F 431	<p>Continued From page 4</p> <p>accurate Controlled Drug Record (Individual Patient's Narcotic Record) for 1 Resident (#91) of 6 residents reviewed for medication administration, failed to discard expired Hema Screens (used to obtain occult blood) in 1 of 3 medication storage rooms, and failed to maintain medication labeling for 1 medication in 1 of 3 medication rooms.</p> <p>The findings included:</p> <p>Review of facility policy, Controlled Substances, dated 10/07 revealed "...The Director of Nursing and the Pharmacist monitor for compliance...in the handling of controlled medications...when controlled medication is administered the licensed nurse administering the medication immediately enters their information on the accountability record...At each shift change, a physical inventory of controlled medications...is conducted by two licensed clinicians..."</p> <p>Review of the Change of Shift Controlled Substances Count Sheet dated July 26, 2015, 7PM-7AM revealed the signatures of the nurses that arrived and departed had signed all items had been accounted for and no discrepancies noted.</p> <p>Medical record review revealed Resident #91 was admitted to the facility on 3/24/14 with diagnoses including Alzheimer's Disease, Osteoarthritis, and Chronic Pain Syndrome.</p> <p>Medical record review of a Controlled Drug Record date received 7/22/15 revealed "...Hydromorphone [narcotic] 2 mg [milligram]...1 tablet orally four times daily...Total amount received 58..." Continued review revealed 18</p>	F 431	<p>into the inaccurate Controlled Drug Record for Hydromorphone 2 mg in the custody of LPN #1.</p> <p>b) On 7/27/15, the Director of Nursing Services re-educated LPN #1 related to the facility's Controlled Substances Policy.</p> <p>c) On 7/27/15, the Director of Clinical Education began re-education with all nursing staff related to the facility's Controlled Substances Policy.</p> <p>d) On 8/4/15, the Pharmacist re-educated facility Charge Nurses related to controlled substance policies.</p>	
			<p>e) On 7/28/15, the Executive Director re-educated the Director of Nursing Services related to the proper storage and labeling of medications in accordance with currently accepted professional principles including the appropriate accessory and cautionary instructions and the expiration date when applicable.</p> <p>f) On 7/27/15, the Director of Clinical Education began re-education with nursing staff related to the proper storage and labeling of medications in accordance with currently accepted professional principles including the appropriate accessory and cautionary instructions and the expiration date when applicable.</p>	

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F 431	<p>Continued From page 5 doses had been documented administered and the last dose was given on 7/27/15 at 6:00 AM.</p> <p>Observation and interview with Licensed Practical Nurse (LPN) #1 on 7/27/15 at 11:32 AM, in the hallway, during a random medication administration observation revealed the Controlled Drug Record for the Hydromorphone 2 mg had shown 38 doses remained. Continued review revealed 37 doses (not 38) of the Hydromorphone 2 mg had been available for resident's use. Further interview confirmed the nurse had accounted for all narcotics at the time of arrival, before the previous nurse had departed, the controlled drug record for the resident was correct at 7AM, and the nurse could not account for the missing narcotic.</p>	F 431	<p>g) On 7/27/15, the Director of Nursing, Director of Clinical Education, MDS Coordinator, and LPN Wound Care Nurse began change of shift observations to ensure Change of Shift Controlled Substances Count Sheets were being completed according to facility policy/procedures.</p> <p>4) a) Weekly change of shift observations will be conducted by the Director of Nursing Services, Director of Clinical Education, Director of Alzheimer's Care and/or Designee to ensure continued compliance related to Change of Shift Controlled Substances Count Sheet with findings reported monthly to the QA Committee x 3 months or until resolved.</p>	
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	<p>Observation and interview with Registered Nurse (RN) #1 on 7/28/15 at 9:17 AM, in the B-Wing Nurses Station revealed 6 Hema screens with expiration dates (2) 7/14, (1) 11/14, and (3) 6/15. Continued observation revealed 1 Enoxaparin (blood thinner) 80 mg not labeled. Further interview confirmed the Hema Screens were outdated available for resident use and the Enoxaparin did not contain a medication label.</p> <p>Interview with the Director of Nursing (DON) on 7/28/15 at 10:15 AM, in the E-Wing Nurse's Station confirmed the facility had failed to maintain an accurate narcotic record and was unable to locate the Hydromorphone 2mg. Further interview confirmed the medication rooms were checked on a weekly basis for expired items.</p>		<p>b) Weekly medication room audits will be conducted by the Director of Clinical Education, Director of Alzheimer's Care and Wound Care Nurse and/or Designee to ensure compliance with proper storage and labeling of medications in accordance with currently accepted professional principles with findings reported monthly to the QA Committee x 3 months or until resolved.</p>	
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F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	F 456		
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F 456	<p>Continued From page 6</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by:                  Based on observation and interview, the facility failed to ensure the dryers were free of lint build up in 3 of 3 dryers observed in 1 laundry room.</p> <p>The finding included:</p> <p>Observation of the three laundry room dryers with the Maintenance Director on 7/27/15 at 10:45 AM, in the laundry room revealed excessive lint build up in the rear of the three dryers, around the motors and vents, and in the front dryer filters.</p>	F 456	<p>F456</p> <p>1)                  On 7/29/15, the Housekeeping Supervisor and Maintenance Director removed the excessive lint build up in the rear and front filters of the three dryers.</p> <p>2)                  All residents within the facility have the potential to be affected. The Executive Director observed the laundry room to ensure all dryers were free of excessive lint build up.</p>	8/27/15
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	<p>Interview with the Maintenance Director at the time of the inspection confirmed the dryers had excessive lint build up in the rear of the three dryers and the front filters of the three dryers. Continued interview with the Maintenance Director on 7/29/15 at 10:45 AM in the laundry room confirmed the lint build up was a potential fire hazard.</p>		<p>3)                  a) On 7/29/15, the Executive Director educated the newly hired Maintenance Supervisor related to the facility's preventative maintenance program and the procedures related to ensuring the dryers are free of lint build up.                  b) On 8/3/15, the facility's Safety Committee held an ad hoc meeting to address safety concerns related to excessive lint build up in the facility dryers and to implement an immediate plan of correction.</p>	
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F 458	<p>Continued From page 6</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the dryers were free of lint build up in 3 of 3 dryers observed in 1 laundry room.</p> <p>The finding included:</p> <p>Observation of the three laundry room dryers with the Maintenance Director on 7/27/15 at 10:45 AM, in the laundry room revealed excessive lint build up in the rear of the three dryers, around the motors and vents, and in the front dryer filters.</p> <p>Interview with the Maintenance Director at the time of the inspection confirmed the dryers had excessive lint build up in the rear of the three dryers and the front filters of the three dryers. Continued interview with the Maintenance Director on 7/29/15 at 10:45 AM in the laundry room confirmed the lint build up was a potential fire hazard.</p>	F 458	<p>4) Weekly observation rounds of the laundry room will be conducted by the Executive Director to ensure continued compliance with the facility's preventative maintenance program as it relates lint build up in the dryers with findings reported monthly QA Committee x 3 months or until resolved.</p>	