STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - SURRY COMMUNITY	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview, family interview and record review the facility failed to ensure residents were free from excessive dosage of sedative medication for 1 of 1 sampled residents receiving several medications with sedation potential (resident #1). Findings include:	F 329	***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.*** The attending physician, the consultant pharmacists, and responsible party were notified by the Director of Nursing Services on 07/24/12 of the doses. An order was received on 07/24/12 to discontinue the Ativan. The consultant pharmacist and the attending physician reviewed the drug regimen again on 08/28/12 and made no other changes. The Director of Nursing Services, Assistant Director of Nursing Services, Consultant Pharmacist will complete an audit of all residents drug regimen to identify any medications that may be considered for reduction or discontinuation. Any resident found to be identified will have those medications The Director of Clinical Education and Consultant Pharmacist will inservice the facility nursing staff on the medication administration process and the drug regimen review process with specific emphasis on transcribing and administering medications as ordered and identifying side effects of medications.	9/4/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lawrence Kramer	Administrator	8-28-12

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

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F 329	Continued From page 1 Resident #1 was admitted to the facility on 02/14/12 with cumulative diagnoses of hypertension, osteoarthritis, hypothyroidism and status post fracture of the humerus and femur. Record review of the clinical chart revealed orders for: 1. Zoloft 75 mg (milligrams) daily at bedtime (antidepressant) 2. Risperdal 0.25 mg at bedtime (antipsychotic) 3. Flexeril 5 mg three times a day as needed for muscle spasm (sedating skeletal muscle relaxant) 4. Lortab 2.5/500 mg one tablet every four hours as needed for pain (opiate) 5. Ativan 0.25 mg daily one hour before PT (physical therapy), per PT request as needed for anxiety. Lexi-comp's Geriatric Dosage Handbook, 14th edition, stated that all of the medications listed have significant sedation potential. Record review of the Doctor's order sheet revealed an order for "Ativan .25 mg per PEG (gastrostomy tube) qd (daily) 1 hours before PT, " written on 07/19/12. However the written prescription read "Ativan .25, one per PEG qd (daily)." The order on the MAR (medication administration record) read: Ativan (Lorazepam) Dose 0.25 mg one tablet one hour before PT as needed via G tube (gastrostomy tube), leaving off the statement per PT request. Record review of the MAR for July 2012 revealed that the resident received one dose of Ativan on 07/19/12 (time not noted), one dose of Ativan on	F 329	An audit of all new resident medication orders will be conducted during Clinical Start Up to ensure orders are transcribed as ordered and to identify any medications with side effectives. This audit will be conducted by the Director of Nursing Services, Assistant Director of Nursing Services and the Registered Nurse Assessment Coordinator. This audit will be conducted daily five times per week for two months, then three times per week for one month. The findings of this audit will be reviewed and brought to the monthly Quality Assessment Performance Improvement Committee Meeting by the Director of Nursing Services and/or the Assistant Director of Nursing Services. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. Compliance Date: 09/04/2012.	

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07/20/12 (time not noted), two doses of Ativan on 07/21/12 (at 9 AM and 9 PM), two doses of Ativan on 07/22/12 (at 9 AM and 9 PM) and one dose of Ativan on 07/23/12 at 9:30 AM.

The Medication Administration Record also revealed that when the two 9 PM doses of Ativan were given on 07/21/12 and 07/22/12, the resident also received Lortab for pain. On 07/19/12, the resident received a Flexeril tablet.

During an interview with the physical therapist on 08/07/12 at 1 PM, she stated that she had not requested the medication assessment and administration from nursing.

Record review also revealed that on 07/19/12 the resident's Zoloft had been increased from 50 to 75 mg for continuing depression.

In an interview with the physical therapist on 08/07/12 at 1 PM, she stated that she was now Resident #1's primary therapist. Progress was minimal and the department was about to discontinue services as resident had plateaued. The therapist stated they often rotate therapists before discontinuing service to see if the resident would do better with another therapist. She stated she was making good progress with the resident and he told her he wanted to get well and walk again. He actually was able to take a few steps with assistance. While working with him she noticed he would suffer some intense panic attacks and would freeze. He told her that he had fractures and was so afraid of falling and getting another fracture. She stated he would freeze in place, become short of breath and feel nauseated. The therapist went to the physician to

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ask if some medication could be given to control the panic attacks. The attending physician agreed that the patient would be better able to participate in therapy if he was calmer but requested that the therapist go to the resident's room one hour prior to the therapy session to evaluate him for anxiety and then the nurse could give the resident the Ativan. She stated then in the third week of July he was very sedated and declined therapy. She was unaware that the Ativan was being given routinely.

In an interview with Nurse #1 on 08/07/12 at 2 PM, she stated that the resident's behaviors had improved since admission. She stated he was on another unit when he was first admitted and was quite agitated requiring the Risperdal. He cried, "Nurse, Nurse" constantly. He was also very depressed requiring Zoloft. The nurse stated she thought he was much better now and since getting the physical therapy he seemed to be more engaged and less depressed. She was unaware that the resident had several days of over sedation.

In an interview with the family on 08/07/12 at 1:00 PM, they stated that when they visited their father he was uncommunicative and very sleepy, "the only new medication was the Ativan, and so we went to the Director of Nursing with our concern."

In an interview with the Director of Nursing on 08/07/12 at 2:30 PM, she stated she was aware of the medication error. The consultant pharmacist had come to her on 07/24/12 regarding the use of the Ativan. The family had come to her on 07/24/12 stating he was overly sedated as well. When she investigated the

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F 329	Continued From page 4 allegations she discovered the two doses of bedtime Ativan and had written up a medication error report.	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	The certified nursing assistants assigned to the perform care for resident's #2 and #4 were immediately inserviced by the Director of Clinical Education on infection control techniques with emphasis on handling soiled linen and trash and hand washing expectations before, during and after, peri care. The Director of Clinical Education will in service facility staff on infection control techniques hand washing and handling of soiled linen and trash. Observation audits for infection control techniques, linen and trash handling, and hand washing will be completed by the Director of Nursing Services, Assistant Director of Nursing Services and the Director of Clinical Education. This audit will be conducted twice daily five days per week for four weeks, then once daily five days per week for four weeks, and then three times per week for four weeks. The findings of this audit will be reviewed by and brought to the monthly Quality Assessment Performance Improvement Committee Meeting by the Director of Nursing Services and/or the Assistant Director of Nursing Services. Any issues or trends identified will be addressed by	9/4/12

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F 441	Continued From page 5 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to follow infection control procedures for handwashing during incontinent care of 2 of 5 sampled residents (Resident #2 and Resident # 4) and by carrying soiled linen next to uniform for 1 of 5 residents (Resident # 2.) Findings include: A Review of facility policy (undated) for handwashing revealed the policy was up to date and in compliance. The policy described the purpose, gave general instructions on the procedure, listed equipment needed and gave a step by step procedure for handwashing after incontinent care. During an interview on 8-7-12 at 11:45am with the Staff Development Coordinator (SDC) who also served as the Infection Control nurse, explained the facility's policy for training staff on incontinent care. She described that this was a protocol that was discussed in depth with new staff because their company did not "Like skin breakdown." When asked what in depth included, she stated that on the 2nd day of orientation, she showed a video to all new hand-on care providers on the importance of incontinence care which included hand washing. She also reported that she gave out a handout titled "Ten Commandments of Perineal Care." All	F 441	the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. Compliance Date: 09/04/2012.	

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NAs (nurse aides) were precepted with chosen, experienced NAs until they were comfortable in providing care independently. Individual inservicing was done if needed.

1. During an observation with the Staff Development Coordinator (SDC) on 8-7-12 at 1:20pm, nurse aide (NA) #1 and NA#2 were observed providing incontinent care to resident #2 on 300 hall. Once the care was completed, NA#1 removed her gloves and left the room without washing her hands. She was prompted by the SDC to return to the room to wash her hands.

While still in resident #2's room on 8-7-12 at 1:30pm, NA #2 was observed attempting to place soiled linen into a plastic bag but she was unable to get the bag to open. She held the soiled linen against her clothing while opening the bag. Once she was finished with the linen, NA #2 removed her gloves and left the room without washing her hands.

Interview with the Director of Nursing (DON), Assistant Director of Nursing (ADON) and SDC on 8-7-12 at 2:55pm revealed that the SDC had been aware of the lack of handwashing during the observation at 1:20pm. The SDC stated her expectations of staff would be to wash hands after providing incontinent care.

2. During an observation of nurse aide (NA) #3 at 1:45pm incontinent care was provided to Resident # 4. Once all care was completed, the NA reached for the door handle to leave the room. When asked about handwashing, NA# 3

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F 441	Continued From page 7 stepped back into the room and washed his hands. Interview with NA # 3 at 1:55pm revealed that NA #3 was aware of the infection control practices which included handwashing. According to NA #3, inservicing was provided during orientation. When asked why he did not wash his hands, he replied that he always washed his hands, he was just nervous because he was being watched. During an interview on 8-7-12 at 2:55pm with the Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Staff Development Coordinator (SDC), the SDC stated her expectations from staff would be to wash hands after providing incontinent care.	F 441		