STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345367	A. BUILDING _____ B. WING _____ DEC 10 2012	11/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS NURSING HOME	P O BOX 40 FALCON, NC 28342

(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
F312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure fingernails were trimmed for 1 of 16 sampled residents that were dependent upon the facility staff for assistance (Resident #50). The findings included: Resident #50 was readmitted into the facility on 2/21/12. Diagnoses included Quadriplegia (unspecified). The quarterly Minimum Data Set (MDS) completed on 10/4/12 indicated short and long term memory problems. Resident #50 required extensive assistance with bed mobility and transfers. Hygiene and bathing was indicated as needed total assistance. The MDS listed range of motion as impaired on both sides of the upper extremities which included the shoulder, wrist and hand. The care plan dated 10/10/12 stated "Require assistance with activities of daily living at risk for complications related to dependence." The care plan listed no indicated approaches or interventions that ensured fingernail care was provided. A review of the nurse's notes dated 9/29/12, 10/4/12 and 10/5/12 revealed no documentation	F 312	**For the resident involved, corrective action has been accomplished by:** Resident #50: His nails were cleaned, trimmed and assessed for appropriateness by the nurse. Nail care was added to his daily care guide **(Exhibit One).** **Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:** All residents were potentially affected by this alleged deficient practice. On November 27, 2012 an audit of all residents' nails was completed by the Staff Development Coordinator. Any issues identified at that time were referred to the nurse for correction **(Exhibit Two).** On November 28, 2012 all residents were issued nail care kits. On November 30, 2012 a follow up audit was completed by the staff nurse to ensure that all residents' nails were appropriate. Any corrections needed were completed at that time **(Exhibit Three).** **Measurements put into place or systematic changes made to ensure that the deficient practice does not occur:** As of December 3, 2012 nail care has been added for every resident to the Treatment Administration Record. The direction is to "check weekly and trim fingernails and toenails as needed" **(Exhibit Four).**	120412

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F 312	Continued From page 1 that Resident #50 refused fingernail care. A review of the personal care report for personal hygiene that read "Nail care cleaned/nails trimmed" revealed fingernail care was not documented as provided from 10/18/12 through 11/15/12. On 11/14/12 at 3:55 pm, Resident #50 fingernails were observed extended beyond the fingertips on both hands (long in length). In an interview on 11/15/12 at 11:15 am, NA (Nursing Assistant) #1 indicated she was the primary NA for Resident #50 to date and floated throughout the facility on other resident assignments. NA #1 indicated she did not know when Resident #50 fingernails were last cared for or trimmed. NA #1 added the residents fingernails were usually expected to be trimmed once a week. In an interview on 11/15/12 at 11:35 am, the Director of Nursing (DON) stated she expected fingernail care to be documented in the electronic smart charting that fingernail was provided. The DON added the nursing assistants and the activity personnel had access to the smart charting. In an interview on 11/15/12 at 12:10 pm, the DON concluded fingernail care for Resident #50 was documented as not provided per the smart charting care record.	F 312	As of December 4, 2012 nail care also "fires" for charting on each resident each shift. The direction is to "check and clean finger/toenails every shift" **(Exhibit Five)**. **The Facility has implemented a quality assurance monitor:** The Nail Care Quality Assurance Monitor will be completed each week for three months by the Staff Development Coordinator. The weekly reports will be reported to the Monthly Quality of Life team at the Monthly Quality of Life Meeting. For each and every month that the results are less than 95%, the monitor will be extended an additional month and corrective action will be taken as indicated under the direction of the Monthly Quality of Life Committee **(Exhibit Six)**.	

Melissa Hobbs Administrator December 4, 2012

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345367	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS NURSING HOME	P O BOX 40 FALCON, NC 28342

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III -protected construction, one story, with a complete automatic sprinkler system. Facility is using NCSBC specical locking. The deficiencies determined during the survey are as follows:	K 000	**K038** **Corrective action will be taken by the facility to correct the alleged deficient practice by:** On December 6, 2012 an in-service was held for all employees present on the location of the emergency override switch for un-locking doors for special locking **(Exhibit One).** **Other Life Safety issues having the potential to affect residents by the same alleged deficient practice will be corrected by:** The Environmental Service Director and the Staff Development Coordinator continued to in-service each employee as they returned to work. **Measures put into place or systemic changes made to ensure that the alleged deficient practice does not incur:** The location of the emergency override switch for un-locking doors for special locking has now been added to the orientation process. Each new hire will be in-serviced on this particular device during the Emergency and Safety portion of orientation.	12/21/12
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 2:00 pm onward, the following items were noncompliant, specific findings include: on interview with several staff they did not know where emergency override switch for un-locking doors for special locking was located at (nurse station). 42 CFR 483.70(a)	K 038		12/21/12
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard	K 056		

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

Melissa Hobbs — Administrator — 12/21/12

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

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K 056	Continued From page 1 for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 2:00 pm onward, the following items were noncompliant, specific findings include: escutcheon cover is missing in rooms 20 and 22 bedroom closets. 42 CFR 483.70(a)	K 056	**The facility has implemented a quality assurance monitor:** The Environmental Service Director will complete the Emergency Override Switch Quality Assurance Monitor **(Exhibit Two)** monthly times three and report to the Monthly Quality of Life Meeting. Corrective action will be taken by the Environmental Service Director upon discovery and systemic problems will be addressed and changes made to the system as indicated in the Monthly Quality of Life Meeting. **K056** **Corrective action will be taken by the facility to correct the alleged deficient practice by:** On December 18, 2012 the escutcheon cover was replaced in the closets of rooms 20 and 22.	12/21/12 mm
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Surveyor: 27871	K 072	**Other Life Safety issues having the potential to affect residents by the same alleged deficient practice will be corrected by:** The Environmental Service Director surveyed every possible site for missing escutcheons on December 7, 2012 **(Exhibit Three)**. Any that were found were repaired at that time.	12/21/12

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K 072	Continued From page 2 Based on observations and staff interview at approximately 2:00 pm onward, the following items were noncompliant, specific findings include: resident bed was stored in exit egress path to exit(across from room 24). 42 CFR 483.70(a)	K 072	**Measures put into place or systemic changes made to ensure that the alleged deficient practice does not incur:** Missing escutcheons has been added to the Monthly TELS program. This will provide a monthly visual check of all sprinkler heads to ensure the escutcheons are present and properly fitting to the sheetrock. The TELS program will prompt this process and provide on-going focus of this issue. **The facility has implemented a quality assurance monitor:** The Environmental Service Director will complete the Escutcheon Quality Assurance Monitor **(Exhibit Four)** monthly times three and report to the Monthly Quality of Life Meeting. Corrective action will be taken by the Environmental Service Director upon discovery and systemic problems will be addressed and changes made to the system as indicated in the Monthly Quality of Life Meeting. K072 **Corrective action will be taken by the facility to correct the alleged deficient practice by:** On December 6, 2012 the bed was removed from the hall by the Environmental Service Director after he finished the tour of the facility with the Life Safety Officer.	

Other Life Safety issues having the potential to affect residents by the same alleged deficient practice will be corrected by:

The Environmental Service Director completed a facility wide tour for other items stored improperly on December 6, 2012. Any irregularities were corrected at that time.

Measures put into place or systemic changes made to ensure that the alleged deficient practice does not incur:

Daily Supervisor Rounds now include observation of exit egresses for any items that may be blocking the egress. This will translate into an increased awareness of items improperly stored and a check at least four times daily **(Exhibit Five).**

The facility has implemented a quality assurance monitor:

The Environmental Service Director will complete the Exit Egress Quality Assurance Monitor monthly times three and report to the Monthly Quality of Life Meeting **(Exhibit Six).** Corrective action will be taken by the Environmental Service Director upon discovery and systemic problems will be addressed and changes made to the system as indicated in the Monthly Quality of Life Meeting.