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 10/23/2014

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 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to follow physician orders for 1 of 4 residents (Resident #113) who required psychiatric consultation. The findings included; 1. Resident #113 was admitted to the facility on 8/27/14 with a diagnosis that included anxiety state, pressure ulcer unspecified site, dysphasia due to cerebrovasulcar disease, and diverticulitis of the colon. Minimum Data Set indicated Resident #113 was severely cognitively impaired. Review of physician order dated 9/3/14 indicated lorazepam 1 tab 60miligrams for anxiety as needed. Doctors order sheet dated 9/25/14 indicated Urinalysis (UA) and Culture and sensitivity (C&S) lethargy and Comprehensive Metabolic Panel (CMP), Complete Blood Count (CBC). The note continued with psych evaluation for decreased cognitive function. Review of the psychiatry referrals in the eldercare psychiatric services (EPS) book located at the nurses station for the month of September 2014	F 250	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. 1) Psychiatric were contacted immediately for resident number 113. Psychiatric doctor came in to see resident number 113 on 10/21/14. (Same day issue was identified.) 2) Social Worker completed 100% audit of all residents that have orders for psychiatric consult to ensure all residents have been seen by psychiatric services and to ensure timely consultation was compelted. 3) Director of Clinical Education will re-educate nurses to ensure orders are put in computer and noted off for appropriate follow up to ensure orders are not missed. Director of Clinical Education	11/21/14

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

Electronically Signed | 11/14/2014

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 10/23/2014

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 250	Continued From page 1 and October 2014 revealed resident #113 was no on the list. Interview with the Social Worker on 10/22/14 at 11:40 am revealed the psyche list was developed by nurses and the social worker in morning meetings. When the list was complied the social worker indicated she provides the list to the psych doctor. The Social Worker continued that the facility has a book that nurses are to write the issue the resident is currently having. When EPS/psych enters the building to provide services they pull the book that contains the names of the residents needing to be seen. Psych services provides services every 2 weeks or sooner if needed. It normally takes two weeks for a resident to be seen by psych services. The socials worker continued that psych services was in the building on October 1st, and October 14th. Once psych has seen the resident a consultation report would be emailed as evidence of the appointment. The Social Worker indicated the named resident was not on the list of residents seen in October and was not on the list to be seen. Interview with the outside psychiatric services representative (EPS) on 10/22/14 at 1:5pm revealed she becomes aware of residents that have been referred to psych services by written communication provided by the facility nurse. The representative indicated that resident names are written in binders located at the nurse's station. In the instance there the resident was not placed on the referral sheet the resident would not be seen. The representative indicated that she did not recall the resident's name. Referrals were screened on 10/1/14 and 10/14/14.	F 250	will also re-educate nurses when psychiatric orders are obtained, the order must also be placed in the ElderCare Psychiatric Services Book. Order by order code report will be brought to Clinical Start Up Meeting daily for follow up on psychiatric consults to ensure residents are seen by psychiatric services in a timely manner. Social Services Director or designee will bring ElderCare Psychiatric Services book to Clinical Start Up daily to ensure psychiatric consults are completed. Social Services Director or designee will complete weekly random audits to ensure all psychiatric consults are followed up on in a timely manner. Will implement a new psychiatric log to be maintained by Social Services Director or designee, to include new admissions will psychiatric diagnosis and/or medications, as well as follow up for existing psychiatric needs. 4) Director of Nursing Services or designee will monitor order by order code report daily in Clinical Start Up. Social Services Director or designee will bring psychiatric log and ElderCare Psychiatric Services book to Clinical Start Up Meeting daily to monitor for compliance. Social Services Director or designee to bring findings of audits to QAPI x 3 months.	

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 10/23/2014

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 250	Continued From page 2 Interview with the Director of Nursing (DON) on 10/23/14 at 8:32 am revealed it was her expectation for physician orders to be followed though on as soon as possible.	F 250		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain occult blood stool specimens x3 and a Basic Metabolic Panel (BMP) per physician's order for 1 of 1 resident (Resident #12). Findings included: Resident #12 was admitted to the facility on 6/14/14 with diagnosis of congestive heart failure, hypertension and anemia. The quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/13/14 revealed that Resident #12 was cognitively intact and required limited assistance with Activity of Daily Living (ADL's). The initial care plan dated 6/16/14 with an update on 9/12/14 included a problem at risk for complications related to anticoagulant or antiplatelet medication due to daily use of aspirin (ASA). The goal indicated that Resident #12 will remain without complications from bleeding or injury. The interventions included to observe for	F 281	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. 1) Medical Director notified immediately labs had been missed for resident number 12. Outstanding labs for resident number 12 were obtained immediately. Lab results given to Medical Director for follow up as soon as received. 2) Charge Nurse completed 100% audit on all labs to identify any missed labs. 3) Director of Clinical Education will re-educate nurses on lab book and ensuring labs are obtained in a timely manner and followed up on per physicians order. Director of Clinical Education will	11/21/14

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 10/23/2014

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 281	Continued From page 3 signs and symptoms of bleeding such as tarry stools, blood in urine, bruising and to obtain and monitor lab/diagnostic work as ordered. Report results to physician and follow up as indicated. The physician progress note dated 8/7/14 revealed an acute visit for Resident #12 for anemia and ordered occult blood stool checks x 3. Record review revealed no occult blood stools were obtained as ordered by the physician as of 10/21/14. The physician progress note dated 9/2/14 revealed an acute visit due to continued lower extremity edema and congestive heart failure and the physician ordered to increase lasix (diuretic) to 40 milligrams (mg) twice a day and recheck Basic Metabolic Panel (BMP) in one week (9/9/14). Record review revealed no BMP was obtained as ordered by the physician as of 10/21/14. During an interview with the assistant director of nursing (ADON) on 10/22/14 at 1:22PM revealed that the occult blood stools ordered on 8/7/14 and the BMP ordered on 9/2/14 were not done and the physician was notified today (10/22/14) and the first occult blood stool check and BMP will be done 10/22/14. An interview with the director of nurses (DON) on 10/23/14 at 9:30AM revealed that her expectations were that all labs are to be done by third shift nurses and if they are not able to get the labs done the first shift charge nurse will complete what is not done. The labs that are ordered by the physician is communicated in a lab book and documented on the lab sheet to alert the nurses that a lab is due.	F 281	also re-educate nurses to enter a discontinue date into the Electronic Medication Administration Record. In the computer upon completion of occult blood stools to ensure these labs are not taken out of the computer prior to completion of labs. Director of Nursing Services or designee will bring lab book to Clinical Start Up Meeting daily to ensure all labs ordered have been obtained and followed up on. Charge Nurses to also check lab book daily as back up to ensure no labs are missed. Occult blood stools will now be put into computer without a stop date to ensure order remains on Electronic Administration Medication Record until labs are completed. Weekly random lab audit to be completed by Director of Nursing Services or designee to ensure all labs ordered have been obtained. 4) Director of Nursing Services or designee will monitor lab book daily in Clinical Start Up. Director of Nursing Services or designee will bring findings of audits to QAPI x 3 months.	

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 10/23/2014

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 281	Continued From page 4 During an interview with the attending physician on 10/23/14 at 10:30AM revealed that since Resident #12 had a gradual decline with her Hemoglobin and Hematocrit (H/H) and the occult blood stool check on 10/22/14 was positive an iron supplement would be indicated. On 10/23/14 the attending physician ordered ferrous sulfate 325 mg twice a day, Complete Blood Count (CBC) next week, refer to gastro-intestinal (GI)-occult blood positive.	F 281		