STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/Clinica IDENTIFICATION NUMBER:

345191

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

05/04/2012

NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTRE - SURRY COMMUNITY

STREET ADDRESS, CITY, STATE, ZIP CODE

542 ALLRED MILL ROAD

MOUNT AIRY, NC 27030

F 441 483.65 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 transport linens so as to prevent the spread of infection.

(F 441) 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.

Isolation notices indicating the transmission based precautions needed were posted on resident room numbers 23, 220, 221, and 230.

An audit of all resident orders was completed by the Director of Nursing, Assistant Director of Nursing, and Director of Resident Assessment on 5/23/12 to ensure all residents who had orders for isolation had isolation notices indicating the transmission based precautions needed posted on their doors. No other residents were found to be affected as a result of this audit.

The facility nursing staff were educated by the Director of Nursing Services, the Assistant Director of Nursing, & the Director of Clinical Education regarding posting the appropriate isolation notices indicating the transmission based precautions needed. All education will be completed by 06/19/2012.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator

G-15-12

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.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345191

(x2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(x3) DATE SURVEY COMPLETED: 05/04/2012

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

(x4) ID/PREFIX/TAQ SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>x4</th>
<th>ID PREFIX/TAQ</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 1</td>
<td></td>
</tr>
</tbody>
</table>

This REQUIREMENT is not met as evidenced by:

Based on observations, record review, and interviews with staff, the facility failed to post isolation notices to indicate the type of required transmission based precautions needed to prevent the spread of infection in the facility. This was evident in 4 of 4 residents (Res. #’s 23, 220, 221, and 230) in the survey sample, who required special precautions.

Review of the facility Infection Control Policy revised October 2009 entitled Isolation - Notices of Transmission - Based Precautions read, “Policy Statement: Appropriate isolation notices will be used to alert staff of the implementation of Transmission-Based Precautions, while protecting the privacy of the resident. Posting isolation notices - Policy Interpretation and implementation. When Transmission-Based Precautions are implemented, an appropriate sign (example: color coded) will be placed at the entrance/doorway of the resident’s room. Signs will be used to alert staff of the implementation of Transmission-Based Precautions and to alert visitors to report to the nurses’ station before entering the room, while respecting the resident’s privacy.”

1. Observations were conducted on 5/1/12 at 12:55 PM in the room (R 315) of resident # 23. A sign (which consisted of a white legal piece of paper) was posted on the resident’s door which read “Please see nurse before entering.” The posted sign did not indicate the type of transmission based precautions needed to prevent the spread of infection.

<table>
<thead>
<tr>
<th>x5</th>
<th>ID PREFIX/TAQ</th>
<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 1</td>
<td></td>
</tr>
</tbody>
</table>

The Director of Nursing Services, Assistant Director of Nursing Services, Director of Resident Assessment, or Director of Clinical Education will discuss all residents who have orders for isolation precautions to ensure the notices indicate the transmission based precautions. This audit will be conducted during Clinical Start Up daily five times per week for two months, then three times per week for one month.

The findings will be reviewed and brought to the Quality Assessment and Assurance Committee Meeting by the Director of Nursing Services, Assistant Director of Nursing Services, or the Director of Resident Assessment for three months. Any issues or trends identified will be addressed by the Quality Assurance Committee as they arise and the plan will be revised as needed to ensure continued compliance.
F 441  Continued From page 2

Additional observations were conducted on 5/2/12 at 12:30 PM and on 5/3/12 at 8:50 AM and at 12:45 PM. The signs (which consisted of a white legal piece of paper) and read, "Please see nurse before entering" remained on the resident's door. The posted sign did not indicate the type of transmission based precautions needed to prevent the spread of infection.

Review of the Hospital Inquiry Report dated 4/26/12 indicated the type of infection resident # 23 had was C-Diff (Clostridium Difficile). Isolation Precautions started on 5/1/12 when the resident was admitted to the facility.

A staff interview was conducted on 5/3/12 at 5:50 PM with Nursing Assistant (NA) #1 who was assigned to the resident. When asked how she knew what Isolation precautions a resident had, the NA indicated, "I have to ask my nurse. There is a sign on the door that says please see nurse before entering and it is also on the resident's Care Card."

2. Observations were conducted on 5/1/12 at 1:10 PM in the room (R 112) of resident # 220. A sign (which consisted of a white legal piece of paper) was posted on the resident's door which read "Please see nurse before entering." The posted sign did not indicate the type of transmission based precautions needed to prevent the spread of infection.

Additional observations were conducted on 5/2/12 at 12:20 PM and on 5/3/12 at 8:30 AM and at 12:20 PM. The sign (which consisted of a white legal piece of paper) and read, "Please see nurse
F 441 Continued From page 3

before entering" remained on the resident 's door. The posted sign did not indicate the type of transmission based precautions needed to prevent the spread of infection.

Review of the Hospital Discharge Summary dated 4/17/12, indicated the type of infection resident # 220 had was, MRSA (Methicillin Resistant Staphylococcus Aureus) of the right hip. The resident was admitted to the facility from the hospital with the infection. Isolation Precautions started on 4/18/12 at the time of the resident 's admission.

A staff interview was conducted on 5/3/12 at 6:10 PM with NA #2. When asked how NA #2 was made aware a resident may have an infection, the NA indicated, "Our nurse will tell us, and it will be on our Care Card."

3. Observations were conducted on 5/1/12 at 12:45 PM in the room (R 107) of resident # 221. A sign (which consisted of a white legal piece of paper) was posted on the resident's door which read "Please see nurse before entering." The posted sign did not indicate the type of transmission based precautions needed to prevent the spread of infection.

Additional observations were conducted on 5/2/12 at 12:15 PM and on 5/3/12 at 8:25 AM and at 12:15 PM. The sign (which consisted of a white legal piece of paper) and read, "Please see nurse before entering" remained on the resident 's door. The posted sign did not indicate the type of transmission based precautions needed to prevent the spread of infection.
**F 441 Continued From page 4**

Review of the Hospital Discharge Summary dated 4/13/12 indicated the type of Infection resident # 221 had was, MRSA (Methicillin Resistant Staphylococcus Aureus) of sputum. The resident was admitted to the facility with the infection. Isolation Precautions started on 4/13/12 at the time of the resident’s admission.

The resident’s assigned Nursing Assistant was unavailable for interview.

4. Observations were conducted on 5/1/12 at 1:00 PM in the room (R 201) of resident # 230. A sign (which consisted of a white legal piece of paper) was posted on the resident’s door which read “Please see nurse before entering.” The posted sign did not indicate the type of transmission based precautions needed to prevent the spread of infection.

Additional observations were conducted on 5/2/12 at 12:45 PM and on 5/3/12 at 8:40 AM and at 12:40 PM. The sign (which consisted of a white legal piece of paper) and read, “Please see nurse before entering” remained on the resident’s door. The posted sign did not indicate the type of transmission based precautions needed to prevent the spread of infection.

Review of the Specimen Inquiry Report of 4/27/12 indicated the type of Infection resident # 230 had was, Respiratory MRSA (Methicillin Resistant Staphylococcus Aureus). The resident went to hospital on 4/26/12 and was re-admitted back to facility on 5/1/12 with the MRSA infection. Isolation Precautions started on 5/1/12.

A staff interview was conducted on 5/3/12 at 6:20
F 441 Continued From page 5

PM with NA #3 who worked with Resident # 230. When asked how NA #3 was made aware a resident has an infection, the NA indicated, "We ask our nurse and she will tell us the precautions to use, and it is also on our Care Card. The Care Card will tell us what kind of precautions to use and if we need a mask, and to wash our hands before and after we have contact with the resident."

A staff interview was conducted on 5/3/12 at 5:35 PM with the Infection Control Coordinator. When asked the reason the generic sign is posted, the Infection Control Nurse indicated, "We feel it is a HIPPA privacy violation to post the type of infection a resident has. The sign is for any visitor not to go in the room before asking the nurse, and then the nurse will explain what precautions to take. Every morning in Start up meeting we go over every resident that may have any kind of infection. That is when I get all my information about infections the residents may have. The Nurses pass on the diagnosis and precautions each resident has to the Nursing Assistants. The precaution information is also on the Nursing Assistants’ Care Cards for each resident who has isolation precautions."

A staff interview was conducted with the Director of Nurses (DON) on 5/3/12 at 6:30 PM. When asked what her expectations were related to the current signs being posted on resident room doors, the DON indicated, "We don't post the type of precaution because of privacy and dignity issues related to the HIPPA Privacy Act. We feel like it would be a violation of the HIPPA Privacy Act to post the type of precaution because visitors..."
F 441 Continued From page 6

or anyone would know the type of infection the resident had. I had not seen the facility policy."

A staff interview was conducted with the Administrator on 5/3/12 at 6:40 PM. When asked what his expectations regarding posting transmission based precaution signs were, the Administrator indicated, "I did not know we needed to put what the resident was on precautions for. We had other signs (referring to the signs which consisted of a white legal piece of paper which read "Please see nurse before entering"), so that the visitors and staff knew what protective equipment they would need to have before going into the resident's room."
<table>
<thead>
<tr>
<th>K 018 NFPA 101 LIFE SAFETY CODE STANDARD</th>
<th>K 018 NFPA 101 LIFE SAFETY CODE STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS = F</td>
<td></td>
</tr>
<tr>
<td>Doors protecting corridor openings in</td>
<td>Preparation and or execution of this</td>
</tr>
<tr>
<td>other than required enclosures of</td>
<td>plan of correction do not constitute</td>
</tr>
<tr>
<td>vertical openings, exits, or</td>
<td>admission or agreement by the provider</td>
</tr>
<tr>
<td>hazardous areas are substantial doors,</td>
<td>of the truth of the facts alleged or</td>
</tr>
<tr>
<td>such as those constructed of 1/2 inch</td>
<td>conclusion set forth in the statement</td>
</tr>
<tr>
<td>solid-bonded core wood, or capable of</td>
<td>of deficiencies. The plan of</td>
</tr>
<tr>
<td>resisting fire for at least 20</td>
<td>correction is prepared and executed</td>
</tr>
<tr>
<td>minutes. Doors in sprinklered buildings</td>
<td>solely because the provision of federal</td>
</tr>
<tr>
<td>are only required to resist the</td>
<td>and state laws requires it.</td>
</tr>
<tr>
<td>passage of smoke. There is no</td>
<td></td>
</tr>
<tr>
<td>impediment to the closing of the doors.</td>
<td></td>
</tr>
<tr>
<td>Doors are provided with a means</td>
<td></td>
</tr>
<tr>
<td>suitable for keeping the door closed.</td>
<td></td>
</tr>
<tr>
<td>Dutch doors meeting 19.3.6.3.6 are</td>
<td>Dutch doors meeting 19.3.6.3.6 are</td>
</tr>
<tr>
<td>permitted.</td>
<td>permitted.</td>
</tr>
<tr>
<td>19.3.6.3</td>
<td></td>
</tr>
<tr>
<td>Roller latches are prohibited by CMS</td>
<td></td>
</tr>
<tr>
<td>regulations in all health care</td>
<td></td>
</tr>
<tr>
<td>facilities.</td>
<td></td>
</tr>
</tbody>
</table>

This STANDARD is not met as evidenced by:
Based on observation on Thursday 8/2/12 at approximately 9:00 AM the following was noted:
1) The corridor doors to resident rooms, 201, 113 and shower room corridor door across from Env. Services off did not have positive latching.
2) The corridors doors to the dining room (Café Dining) have a gap in the bottom half of the door between the double doors.
3) The dining room corridor doors have kick down stops that will prevent the door from closing.

42 CFR 483.70(a)

<table>
<thead>
<tr>
<th>K 038 NFPA 101 LIFE SAFETY CODE STANDARD</th>
<th>K 038</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS = F</td>
<td>9-14-12</td>
</tr>
<tr>
<td>Criteria 1</td>
<td>Door to the garden shower room, room 201 and 113 were adjusted to ensure that when doors close, they latch. Kick stops to the doors were removed. The Dining Room Doors were adjusted to ensured that the gap at the bottom of the door was closed. The Maintenance Director was educated regarding self closing, fire-rated doors.</td>
</tr>
<tr>
<td>Criteria 2</td>
<td>All other facility fire-rated doors were inspected to ensure self-latching when closed.</td>
</tr>
<tr>
<td>Criteria 3</td>
<td>The Maintenance Director or his assistant in his absence, will monitor 6 fire rated doors weekly to ensure self-latching. Any doors found out of compliance will be corrected immediately.</td>
</tr>
<tr>
<td>Criteria 4</td>
<td>The results from the monitoring will be brought to the QA committee to monitor regulatory compliance monthly X 3 months or until no longer deemed necessary.</td>
</tr>
</tbody>
</table>

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.
K 038 Continued From page 1
SS=D

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:
Based on observation on Thursday 8/2/12 at approximately 9:00 AM the following was noted:
1) Staff was not familiar with the master override switch at the nurse station to unlock the magnetically locked doors.

42 CFR 483.70(a)
K 045 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

Illumination of means of egress, Including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area In darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8

This STANDARD is not met as evidenced by:
Based on observation on Thursday 8/2/12 at approximately 9:00 AM the following was noted:
1) Emergency lighting must be arranged to provide light from the D-Hall exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the surface. Failure of any single lighting unit does not result in an illumination
<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>K045</td>
<td>Continued</td>
<td>From page 2</td>
<td>Level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K052</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>SS=F</td>
<td>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 73 and 72. 9.6.1.4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This STANDARD is not met as evidenced by: Based on observation on Thursday 8/2/12 at approximately 9:00 AM the following was noted: 1) Upon testing the dialer at the Fire Alarm Control Panel an audible/visual signal was not provided for when phone line number #1 was disconnected.

| K054 | NFPA 101 LIFE SAFETY CODE STANDARD | SS=F | All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 | | |

Criteria 1
The Fire Alarm Control Panel was assessed and was found to have no connection to phone line #1, however had a connection to phone line #2. The Fire Control Panel was fixed to have it connected to line #1.

Criteria 2
Both telephone lines were assessed to ensure that both telephone lines were connected to the Fire Alarm Control Panel.

Criteria 3
The Maintenance Director will monitor the Fire Alarm Panel weekly to ensure that both telephone lines are working in the Fire Alarm Control Panel monthly times three months.

Criteria 4
The results from the monitoring will be brought to the QAA committee for three month to ensure regulatory compliance.
K 054  Continued From page 3

This STANDARD is not met as evidenced by:
   Based on observation on Thursday 8/2/12 at
   approximately 9:00 AM the following was noted:
   1) The smoke duct detectors located in the
      HVAC units in the attic have not been maintained
      clean and in good repair.

   42 CFR 483.70(a)

K 076  NFPA 101 LIFE SAFETY CODE STANDARD
       SS=O

   Medical gas storage and administration areas are
   protected in accordance with NFPA 99,
   Standards for Health Care Facilities.

   (a) Oxygen storage locations of greater than
       3,000 cu.ft. are enclosed by a one-hour
       separation.

   (b) Locations for supply systems of greater than
       3,000 cu.ft. are vented to the outside. NFPA 99
       4.3.1.1.2, 19.3.2.4

This STANDARD is not met as evidenced by:
   Based on observation on Thursday 8/2/12 at
   approximately 8:00 AM the following was noted:
   1) Full and empty oxygen cylinders were stored
      together. If stored within the same enclosure,
      empty cylinders shall be segregated and
      designated (with signage) from full cylinders.
      Empty cylinders shall be marked to avoid
      confusion and delay if a full cylinder is needed
      hurriedly. (NFPA 99 4.3.6.2.2b(2)) (oxygen
      storage near the nurses station)

<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>ID</th>
<th>TAG</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 054</td>
<td></td>
<td>K 054</td>
<td></td>
<td>9-14-12</td>
</tr>
<tr>
<td>SS = F</td>
<td></td>
<td>Criteria 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criteria 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criteria 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criteria 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
K 076  Continued From page 4

42 CFR 483.70(a)

K 144
NFPA 101 LIFE SAFETY CODE STANDARD SS = D

Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.

This STANDARD is not met as evidenced by:

Based on observation on Thursday 8/2/12 at approximately 9:00 AM the following was noted:

1) The generator annunciator panel located at the Terrace nurse station did not show generator supplying load when tested.

42 CFR 483.70(a)

K 076
SS = D

Criteria 1
Oxygen cylinders were immediately separated to ensure cylinders containing oxygen were separate from the empty cylinders.

Criteria 2
Two racks will be utilized to store oxygen cylinders; one rack will hold empty cylinders with signage in place to direct staff of appropriate container to utilize, another rack will hold the cylinders containing oxygen with signage in place in order to ensure staff is directed of appropriate rack to utilize. All staff will be educated, by the DCE, of the requirement to store empty oxygen cylinders separate from those containing oxygen.

Criteria 3
The Maintenance Director and/or BD in his absence will monitor storage process of oxygen cylinders 3 times weekly to ensure compliance of proper storage.

Criteria 4
The results of the monitoring will be brought to the QAA committee monthly for monitoring of regulatory compliance, for a minimum of three months or until no longer deemed necessary.

K 144
SS = D

Criteria 1
The generator annunciator panel was assessed and found to have a loose connection therefore no audible signal at the Terrace nursing station.

Criteria 2
The loose wire was reconnected and audible signal noted. No other areas identified that produce audible signal.

Criteria 3
The Maintenance Director will monitor the audible signal 3 times weekly to ensure there is audible signal.

Criteria 4
The results of the monitoring will be brought to the QAA committee monthly for a minimum of three months or until no longer deemed necessary to ensure regulatory compliance.