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 _____	12/12/2013

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
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to develop a care plan for pressure ulcers for 1 of 3 residents reviewed for pressure ulcers (Resident #28). The facility also failed to develop a care plan for 1 of 3 residents reviewed for indwelling urinary drainage devices (Resident #64). The findings included: 1. Resident #28 was admitted into the facility on 6/4/13. Diagnoses included Pressure Ulcer. The quarterly minimum data (MDS) set completed on 12/18/13 was listed as in progress for transmission. The annual MDS completed on	F 279	F279 For the residents involved, corrective action has been accomplished by: 1. Resident #28 The Care Plan was corrected adding a Care Plan for Pressure Ulcers on December 10, 2013. 2. Resident #64 The Care Plan was corrected adding a Care Plan for Indwelling Urinary Catheter on December 10, 2013 (Exhibit One).	12/20/13

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

Electronically Signed | 12/23/2013

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F 279	Continued From page 1 9/17/13 indicated Resident #28 was at risk for pressure ulcer development, with no pressure ulcers present. Extensive assistance of two person's physical assist was required with bed mobility. Extensive assistance of two person's physical assist was required with transfer. A review of the weekly pressure ulcer report dated 11/22/13 revealed a stage II pressure ulcer to the left trochanter (hip) that was identified with an onset date of 11/20/13 that measured 2 cm (length) x 1 cm (width) x .1 cm (depth) with 100% granulation tissue. Treatment included a duoderm to be applied every three days. A review of the weekly pressure ulcer report dated 12/4/13 revealed with an onset date of 11/20/13 revealed a stage II to the left thigh (front) that measured 1.2 centimeters (cm) (length) x 0.4 cm (width) x 0.1 cm (depth) described with "100 % granulation tissue, decreased surface area, dressing calcium alginate with dry protective dressing every day." A review of the clinical record revealed there was no care plan related to pressure ulcers. A review of the treatment record for December 2013 revealed there was active treatment being provided to the "left thigh wound." Treatment read "left thigh wound calcium alginate with dry protective dressing every day." A review of the wound care specialist evaluation of the left lateral thigh completed on 12/10/13 by the physician in part read "MDS stage II duration greater than 19 days healing: anatomic location of previously existing wound examined today: epithelialized and resolved - follow up as	F 279	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. A complete audit of all Care Plans was completed on December 20, 2013 (Exhibit Two).At that time, any corrections needed were made. Measures put into place or systemic changes made to ensure that the deficient practice does not occur: All residents will now be reviewed for Catheters or Wounds upon admission by the DON and/or SDC when admitting the resident. If noted, these occurrences will be added to the Interim and Comprehensive Care Plans. For all current residents, the DON and/or SDC will review MD orders as they are entered into PCC and the weekly Wound MD report to determine any new orders for wounds or catheters. If noted, they will be added to the Care Plan at that time. The facility has implemented a quality assurance monitor: The Care Plan Team will monitor for compliance with Care Plans weekly for twelve weeks using the Care Plan Quality Assurance Monitor (Exhibit Three). Each week five residents will be audited during the Care Plan Meeting by the Care Plan Team for compliance. At this time the	

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F 279	Continued From page 2 needed." During an observation on 12/11/13 at 11:00 am, of wound treatment provided by Nurse #1, the left thigh pressure ulcer was observed to be resolved with redden skin color. In an interview on 12/11/13 at 1:47 pm, the director of nursing when questioned regarding a care plan for pressures ulcer while care was provided to the left lateral thigh stated that per her review of the clinical record, she did not see a care plan for pressure ulcers, and that a care plan should have been initiated. 2. Resident #64 was admitted into the facility on 6/19/13. Diagnoses included neurogenic bladder and urinary tract infection. The quarterly minimum data set completed on 10/2/13 indicated an indwelling urinary device as a bladder appliance. A review of the clinical record revealed that Resident #64 was admitted into the facility with an indwelling urinary device on 6/19/13 described as "16 French, 30 cc (centimeter) balloon." A review of the care plan dated 10/8/13 did not indicate a care plan for an indwelling urinary device for the bladder. A review of the treatment record for December 2013 revealed an indwelling urinary device to the pubic area to be changed every month. In an interview on 12/10/13 at 10:51 am, the director of nursing indicated that per her review of the electronic record that she did not see a care plan for an indwelling urinary device for Resident #64.	F 279	DON will make corrective actions as necessary. The results of each monitor will be presented at the Monthly Quality of Life Meeting for three months. For any month where an over all compliance is less than 100%, the audits will be extended for an additional month	

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F 279	Continued From page 3 In an interview on 12/10/13 at 10:55 am, the administrator stated that she expected a care plan to have been initiated. During an observation on 12/10/13 at 2:45 pm, a urinary drainage collection device was observed on the floor located on a towel, draining yellow urine. In an interview on 12/11/13 at 2:39 pm, accompanied by nursing assistant #1, Resident #64 was observed with an indwelling urinary device into the pubic area.	F 279		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to maintain a medication error rate less than 5% for 2 of 5 residents observed during a medication pass, out of 26 medication opportunities, which resulted in a 15.38 % medication error rate (Resident #13, #32). The findings included: 1 a. Resident #13 was admitted into the facility on 5/23/11. Diagnoses included depression, schizoaffective disorder and episodic mood disorder. A review of the physician telephone order dated	F 332	F332 For the residents involved, corrective action has been accomplished by: 1. Resident #13 The Medication Aide was transferred temporarily to a Patient Care Technician position where she was not responsible for medication administration. 2. Resident #32 The Medication Aide was transferred temporarily to a Patient Care Technician position where she was not responsible	12/18/13

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F 332	Continued From page 4 12/5/13 in part read "seroquel 100 milligrams (mg) twice daily. A review of the medication administration record for December 2013 revealed seroquel 100 mg was ordered to be administered between 8:00-9:00 am. During a medication observation on 12/10/13 at 8:35 am, med aide #1 administered seroquel two 25 mg tablets for a total dosage of 50 mg by mouth to Resident #13. In an interview on 12/10/13 at 9:15 am, med aide #1 stated that that she did not administer seroquel 100 mg because she administered the medication according to the medication card which read to administer two 25 mg tablets and did not observe that the medication administration record read to administer 100 mg as the total dosage. Med Aide #1 acknowledged that the current physician order and medication administration record read to administer seroquel 100 mg. In an interview on 12/10/13 at 5:27 pm, the director of nursing indicated that she expected all medications to be administered as ordered by the physician. 1 b. Resident #13 was admitted into the facility on 5/23/11. Diagnoses included chronic airway obstruction. Review of the monthly physician orders signed by the physician on December 11, 2013 in part read "symbicort aerosol 160-4.5 micrograms (mcg) two puffs inhale orally two times daily, rinse mouth after each use."	F 332	for medication administration. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: Both Medication Aides were transferred temporarily to a Patient Care Technician position where they were not responsible for medication administration pending education and evaluation of skills. Measures put into place or systemic changes made to ensure that the deficient practice does not occur: Both Medication Aides were educated on the proper procedure for Medication Administration using the Medication Administration Clinical Skills Checklist (DHSR/AC 4605) by the SDC and the Consulting Pharmacist on or before December 18, 2013. After the education was completed, a Med Pass review was completed with each Medication Aide by either the SDC or the Consulting Pharmacist using the Medication Administration Clinical Skills Checklist on or before December 18, 2013 to ensure a compliance of 95% or better (Exhibit Four). In addition, all nurses and both Medication Aides were in-serviced by the Consulting Pharmacist on December 18, 2014. The extensive in-service reviewed both broad medication administration topics as well as the step by step process of medication administration (Exhibit	

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F 332	Continued From page 5 During a medication observation on 12/10/13 at 8:40 am, med aide #1 administered symbicort aerosol 160-4.5 mcg two puffs by mouth to Resident #13, followed by the resident drinking med pass (a nutritional supplement). The resident's mouth was not rinsed following the inhaler. In an interview on 12/10/13 at 9:15 am, med aide #1 when questioned why she did not rinse Resident #13's mouth as ordered, after administering the symbicort aerosol inhaler, she stated that she forgot. Med aide #1 concluded that she was trained to rinse the resident's mouth after administering inhalant medications. In an interview on 12/10/13 at 5:27 pm, the director of nursing indicated that she expected all medications to be administered as ordered by the physician. 2. Resident #32 was admitted into the facility on 3/13/12. Diagnoses included Allergic Conjunctivitis. According to the National Institute of Health Clinical Center, pages 1-2 (2008) titled "how to put in your eye drops" educates that after instilling the eye drop (medication) into the lower lid eye pocket (conjuntival sac), that one should "keep eyes closed and gentle blot with a clean tissue, then gently press on the inner part of the eye for thirty seconds, this will keep the medication in contact with the eye longer, wait at least five minutes between putting in each eye drop." A review of the monthly physician orders signed by the physician on December 11, 2013 in part	F 332	Five). The facility has implemented a quality assurance monitor: The DON or designee will monitor for compliance with Medication Adminstration weekly for twelve weeks using the Medication Administration Clinical Skills Checklist and the Medication Pass Observation Report (Exhibit Six). Each week one nurse or Medication Aide will be audited for proper medication administration. The results of each weekly medication pass observation will be presented at the Monthly Quality of Life Meeting using the Medication Administration Quality Assurance Monitor for three months (Exhibit Seven). For any month where an over all compliance is less than 95%, the audits will be extended for an additional month.	

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F 332	Continued From page 6	F 332		

read "1) pataday solution 0.2 % instill one drop in both eyes one time a day. 2) systane balance solution 0.6 % instill one drop in both eyes two times a day."

During an observation on 12/10/13 at 8:47 am, med aide #1 administered pataday eye drops directly onto the center aspect of the left and right eye, then immediately administered systane ultra eye drops directly onto the center aspect of the left and right eye. Med aide #1 did not wait between the different eye drops prior to administering the next.

In an interview on 12/10/13 at 9:20 am, med aide #1 stated that she forgot that she was suppose to administer eye drops in the lower eye pocket (conjunctival sac) of each eye, and forgot to wait between the two different types of eyes drops.

In an interview on 12/10/13 at 5:27 pm, the director of nursing indicated that she expected all medications to be administered as ordered by the physician.