PRINTED: 01/15/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345367	B. WING		12/12/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE P O BOX 40 FALCON, NC 28342	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 279 SS=D	A facility must use the to develop, review an comprehensive plan of the facility must develop and for each resident objectives and timetal medical, nursing, and needs that are identifiassessment. The care plan must do to be furnished to attachighest practicable plans psychosocial well-being \$483.25; and any serbe required under \$45 due to the resident's descriptions.	e results of the assessment d revise the resident's of care. elop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial red in the comprehensive escribe the services that are ain or maintain the resident's nysical, mental, and	F 27	9	12/20/13
ABORATORY	by: Based on observatio interviews, the facility plan for pressure ulce reviewed for pressure facility also failed to dresidents reviewed for devices (Resident #6. Resident #28 was 6/4/13. Diagnoses included for the facility also failed to dresidents reviewed for devices (Resident #6.) Resident #28 was 6/4/13. Diagnoses included for the facility was listed a transmission. The and	is not met as evidenced ns, record review, and staff failed to develop a care ers for 1 of 3 residents e ulcers (Resident #28). The evelop a care plan for 1 of 3 r indwelling urinary drainage 4). The findings included: admitted into the facility on cluded Pressure Ulcer. The lita (MDS) set completed on s in progress for hual MDS completed on		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 Cather on December 10, 2013 (Exhibit One).	

Electronically Signed

12/23/2013

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.

NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS NURSING HOME FO BOX 40 FALCON, NC 28342 FALCON, NC 28342 FOOD OF PROCEDED BY APPROPRIATE ACTION SHOULD BE CROSS-REPERCEDED BY PULL PREPIX TAG PROPRIATE ACTION SHOULD BE CROSS-REPERCEDED BY HEAD PROPRIATE ACTION SHOULD BE CROSS-REPERCEDED BY ALL PROPRIATE ACTION SHOULD BE CROSS-REPERC	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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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." 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		no care plan related	d to pressure ulcers.			report to determine any new orders fo	٢	
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 The facility has implemented a quality assurance monitor: The Care Plan Team will monitor for compliance with Care Plans weekly for						wounds or catheters. If noted, they wil	l be	
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 The facility has implemented a quality assurance monitor: The Care Plan Team will monitor for compliance with Care Plans weekly for		A review of the trea	tment record for December			added to the Care Plan at that time.		
"left thigh wound calcium alginate with dry protective dressing every day." A review of the wound care specialist evaluation assurance monitor: The Care Plan Team will monitor for compliance with Care Plans weekly for			•					
protective dressing every day." The Care Plan Team will monitor for compliance with Care Plans weekly for		·	•			· · · · · · · · · · · · · · · · · · ·		
The Care Plan Team will monitor for compliance with Care Plans weekly for						assurance monitor:		
A review of the wound care specialist evaluation compliance with Care Plans weekly for		protective dressing	every day."			The Orac Disa Tee		
' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		A rovious of the	and core encoiplist evelvetics				_	
TO THE RECARD HIGH COMPLETED OF 17/10/15 DV TO TWELVE WEEKS USING THE CARE PIAN CHAINV TO THE						•		
the physician in part read "MDS stage II duration Assurance Monitor (Exhibit Three). Each								
greater than 19 days healing: anatomic location Assurance Monitor (Exhibit Three). Each week five residents will be audited during			•			` '		
of previously existing wound examined today: the Care Plan Meeting by the Care Plan							-	
epithelialized and resolved - follow up as Team for compliance. At this time the								

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345367	B. WING			12/12/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE P O BOX 40 FALCON, NC 28342			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 279	of wound treatment of thigh pressure ulcer with redden skin color of the color of nursing we care plan for pressur provided to the left lareview of the clinical care plan for pressur plan should have been care indicate set completed condwelling urinary den care indicate a care plan for pressur plan for plan	on on 12/11/13 at 11:00 am, provided by Nurse #1, the left was observed to be resolved or. 2/11/13 at 1:47 pm, the then questioned regarding a resulcer while care was ateral thigh stated that per her record, she did not see a re ulcers, and that a care en initiated. admitted into the facility on included neurogenic bladder ction. The quarterly minimum on 10/2/13 indicated an vice as a bladder appliance. all record revealed that dmitted into the facility with an vice on 6/19/13 described as entimeter) balloon." plan dated 10/8/13 did not for an indwelling urinary er. ment record for December dwelling urinary device to the	F 27	DON will make corrective action necessary. The results of each will be presented at the Monthly Life Meeting for three months. If month where an over all complia less than 100%, the audits will be extended for an additional month.	monitor Quality of or any ance is		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345367	B. WING		12/12/2013	
	ROVIDER OR SUPPLIER YEARS NURSING HOME	:		STREET ADDRESS, CITY, STATE, ZIP CODE P O BOX 40 FALCON, NC 28342	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 279 F 332 SS=D	administrator stated to plan to have been initially been initially been initially been initially been initially been initially been an observation urinary drainage college on the floor located of urine. In an interview on 12 accompanied by nurs #64 was observed with device into the public 483.25(m)(1) FREE ORATES OF 5% OR More than the facility must ensure that the public floor into the public than the facility must ensure that the public floor into the pub	/10/13 at 10:55 am, the that she expected a care tiated. In on 12/10/13 at 2:45 pm, a ection device was observed in a towel, draining yellow /11/13 at 2:39 pm, sing assistant #1, Resident th an indwelling urinary area. DE MEDICATION ERROR	F 279		12/18/13	
	by: Based on observation interviews, the facility medication error rate residents observed dof 26 medication oppa 15.38 % medication #32). The findings incomplete the findings in the finding	less than 5% for 2 of 5 uring a medication pass, out ortunities, which resulted in n error rate (Resident #13, cluded:		F332 For the residents involved, corrective action has been accomplished by: 1. Resident #13 The Medication Aide was transferred temporarily to a Patient Care Technicia position where she was not responsible for medication administration. 2. Resident #32 The Medication Aide was transferred temporarily to a Patient Care Technicia position where she was not responsible	e In	

AND PLAN OF CORRECTION IDENTIFICATION I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345367	B. WING			2/12/2013	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
OOL DEN	VE 4 DO MUDOINO 110			P O BOX 40			
GOLDEN	YEARS NURSING HO	VIE.		FALCON, NC 28342			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 332	Continued From pa	age 4	F 3	32			
	12/5/13 in part read (mg) twice daily.	d "seroquel 100 milligrams		for medication administration	n.		
	A review of the me for December 2013	dication administration record B revealed seroquel 100 mg administered between		Corrective action has been accomplished on all residen potential to be affected by the deficient practice by: Both Medication Aides were	ne alleged		
	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.			temporarily to a Patient Care position where they were no for medication administration education and evaluation of	e Technician ot responsible n pending		
	#1 stated that that seroquel 100 mg b medication accordi	12/10/13 at 9:15 am, med aide she did not administer ecause she administered the ng to the medication card nister two 25 mg tablets and		Measures put into place or s changes made to ensure the practice does not occur:	-		
	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.			Both Medication Aides were the proper procedure for Me Administration using the Me Administration Clinical Skills (DHSR/AC 4605) by the SD Consulting Pharmacist on on December 18, 2013. After the	dication dication Checklist C and the r before		
				was completed, a Med Pass completed with each Medica either the SDC or the Consu Pharmacist using the Medic Administration Clinical Skills	review was ation Aide by ulting ation		
	5/23/11. Diagnoses obstruction.	was admitted into the facility on sincluded chronic airway		or before December 18, 201 compliance of 95% or better Four). In addition, all nurses Medication Aides were in-se	(Exhibit and both erviced by the		
	the physician on D "symbicort aerosol	thly physician orders signed by ecember 11, 2013 in part read 160-4.5 micrograms (mcg) ally two times daily, rinse se."		Consulting Pharmacist on D 2014. The extensive in-serv both broad medication admi topics as well as the step by of medication administration	vice reviewed nistration v step process		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345367	B. WING _			12	2/12/2013	
	NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE P O BOX 40 FALCON, NC 28342				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 332	8:40 am, med aide # aerosol 160-4.5 mcg Resident #13, follower med pass (a nutrition resident's mouth was inhaler. In an interview on 12, #1 when questioned Resident #13's mouth administering the synstated that she forgot that she was trained after administering in In an interview on 12 director of nursing incomedications to be adaphysician. 2. Resident #32 was 3/13/12. Diagnoses in Conjunctivitis. According to the Nati Clinical Center, page put in your eye drops the eye drop (medical pocket (conjuntival saleyes closed and gent then gently press on thirty seconds, this we contact with the eye I minutes between put.	observation on 12/10/13 at administered symbicort two puffs by mouth to ed by the resident drinking all supplement). The not rinsed following the 10/13 at 9:15 am, med aide why she did not rinse as ordered, after abicort aerosol inhaler, she who had aide #1 concluded to rinse the resident's mouth halant medications.	F3	332	Five). The facility has implemented a quality assurance monitor: The DON or designee will monitor for compliance with Medication Adminstrat weekly for twelve weeks using the Medication Administration Clinical Skill Checklist and the Medication Pass Observation Report (Exhibit Six). Each week one nurse or Medication Aide will audited for proper medication administration. The results of each weekly medication pass observation where the Monthly Quality of Meeting using the Medication Administration Quality Assurance Monfor three months (Exhibit Seven). For month where an over all compliance is less than 95%, the audits will be extend for an additional month.	h Il be rill Life itor any		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345367	B. WING		1	2/12/2013	
	ROVIDER OR SUPPLIER YEARS NURSING HON	E		STREET ADDRESS, CITY, STATE, ZIP CODE P O BOX 40 FALCON, NC 28342		12.12.10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 332	read "1) pataday so both eyes one time solution 0.6 % instill times a day." During an observati med aide #1 adminidirectly onto the cereye, then immediate eye drops directly o left and right eye. Mote between the different administering the new linear and interview on 1 #1 stated that she for administer eye drop (conjunctival sac) of between the two different linear interview on 1 director of nursing in	Jution 0.2 % instill one drop in a day. 2) systane balance one drop in both eyes two on on 12/10/13 at 8:47 am, stered pataday eye drops atter aspect of the left and right ely administered systane ultrainto the center aspect of the ed aide #1 did not wait at eye drops prior to	F 33				