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 _____	C 10/05/2011

OCT 16 2011
OCT 19 2011

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted on 10/05/11. Event ID #Z2NS11.	F 000		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to implement a decrease in a dose of a medication for 1 of 10 sample residents	F 329	**F329** **For the residents involved, corrective action has been accomplished by:** 1. Resident #49: The physician was notified on October 6, 2011 of the medication error. An order was received to obtain a Dilantin level and fax to the physician. Dilantin level drawn on October 7, 2011 and faxed to the physician on October 8, 2011. Dilantin was discontinued and the level was checked again on October 10, 2011. New order received on October 10, 2011 to recheck the Dilantin level on October 13, 2011. New order received on October 14, 2011 to restart Dilantin at 200mg via G-tube daily. **Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:** All residents with anti-psychotic medications were potentially affected by this alleged deficient practice.	10/17/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Hobbs	Administrator	10.17.11

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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	345367	A. BUILDING _____ B. WING _____	C 10/05/2011

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 329	Continued From page 1 (#49). The findings include: Resident #49 was admitted to the facility on 08/29/09 and readmitted on 06/24/11 with cumulative diagnoses that included Intracranial injury, H/O Pressure Ulcers, Diabetes Mellitus, Epilepsy and requiring a Gastrostomy Tube. The resident was coded on the most recent MDS (minimum data set) dated 08/03/11 as having short and long term memory problems and as being severely impaired in the decision making process. A review of the medical record for the resident revealed a laboratory report dated 07/26/11. According to the report the resident's Dilantin level (anti seizure medication) was "23.2" . (According to the report the normal level is 10.0 - 20.0) On the report is typed "Patient drug level exceeds published reference range. Evaluate clinically for signs of potential toxicity." Written on the report is "currently on Dilantin 125 mg (milligrams) /5 ml (milliliters) 10 ml (250 mg) Q (every) PM (evening)." Below that is written "Dilantin with an arrow down (lower) 7 ml daily." During an interview with Nurse #1 on 10/05/11 at 10:15 AM it was revealed "that is the handwriting of (name of physician) who wrote the change. He will do that and then we would write an interim order and make the change on the MAR (medication administration record). " A review of the medical record revealed that the order had not been changed and that the order had remained as 250 mg. for the months of July, August and September. A review of the MAR revealed that the nurses were signing for a 250	F 329	On October 14, 2011 a complete audit of all residents receiving anti-psychotic medications was completed by the Administrator and assigned. The orders were verified as correct on the MAR **(Exhibit One)**. All residents with psychotropic medications were audited for reduction attempts/documentation for a period of one year using the Anti-psychotic Medication Audit Tool **(Exhibit Two)**. **Measures put into place or systemic changes made to ensure that the deficient practice does not occur:** Each month the nurses will provide written documentation to the physician on all residents receiving anti-psychotic medications using the Anti-psychotic Medication List **(Exhibit Three)**. This documentation will identify the residents receiving the medication, their current behaviors and if there are any Pharmacy Recommendations.	

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	345367	A. BUILDING _____ B. WING _____	C 10/05/2011

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 329	Continued From page 2 mg dose on the October MAR and had signed for a 250 mg . dose on the July, August and September MAR ' s. Nurse #1 could not give any reason why the dose had not been changed. During an interview with the Director of Nursing (DON) on 10/05/11 at 11:00 AM it was revealed "I would consider what was written on the lab report to be an order and would expect that the nursing staff would make the change and carry out the order. I cannot tell you what happened here."	F 329	The facility has also implemented the use of the Lab Work Log which is being used to track the process of Lab Work from the time the specimen is drawn until the results are placed on the chart **(Exhibit Four)**. **The facility has implemented a quality assurance monitor:**	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the pharmacist failed to alert the facility that a medication dose that had been ordered to be decreased for 1 of 10 sampled residents (#49) had not been carried out. The findings include: Resident #49 was admitted to the facility on 08/29/09 and readmitted on 06/24/11 with cumulative diagnoses that included Intracranial injury, H/O Pressure Ulcers, Diabetes Mellitus,	F 428	The Anti-psychotic Medication Quality Assurance Monitor will be completed each month for three months by the Staff Development Coordinator **(Exhibit Five)** and 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 a threshold of 100% the monitor will be extended for an additional month and corrective action taken as necessary under the direction of the Monthly Quality of Life Committee.	

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	345367	A. BUILDING _____ B. WING _____	C 10/05/2011

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GOLDEN YEARS NURSING HOME	P O BOX 40 FALCON, NC 28342

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F 428	Continued From page 3 Epilepsy and requiring a Gastrostomy Tube. The resident was coded on the most recent MDS (minimum data set) dated 08/03/11 as having short and long term memory problems and as being severely impaired in the decision making process. A review of the medical record for the resident revealed a laboratory report dated 07/26/11. According to the report the resident's Dilantin level (anti seizure medication) was "23.2". (According to the report the normal level is 10.0 - 20.0) On the report is typed "Patient drug level exceeds published reference range. Evaluate clinically for signs of potential toxicity." Written on the report is "currently on Dilantin 125 mg (milligrams) /5 ml (milliliters) 10 ml (250 mg) Q (every) PM (evening). " Below that is written "Dilantin with an arrow down (lower) 7 ml daily." A review of the "Consulting Pharmacy Notes" revealed a note dated 07/29/11 that read in part "(07/26) Dil (dilantin) = 23.2 arrow up (elevated). per nn (nurse notes) labs were collected @ (at) 10:30 am, okay as dosed." The Consulting Pharmacy Notes dated 08/31/11 and 09/28/11 did not include any documentation regarding the change in the dose of the medication that had been written on the lab. report. During an interview with Nurse #1 on 10/05/11 at 10:15 AM it was revealed "that is the handwriting of (name of physician) who wrote the change. He will do that and then we would write an interim order and make the change on the MAR (medication administration record)."	F 428	**F428** **For the residents involved, corrective action has been accomplished by:** 1. Resident #49: The physician was notified on October 6, 2011 of the medication error. An order was received to obtain a Dilantin level and fax to the physician. Dilantin level drawn on October 7, 2011 and faxed to the physician on October 8, 2011. Dilantin was discontinued and the level was checked again on October 10, 2011., New order received on October 10, 2011 to recheck the Dilantin level on October 13, 2011. New order received on October 14, 2011 to restart Dilantin at 200mg via G-tube daily. On October 14, 2011, John Watson, Pharmd re-educated Tiffany Simmons, Pharmacy Consultant on the proper procedure for reporting Medication Errors in the Long Term Care facility **(Exhibit Six).**	10/7/11

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F 428	Continued From page 4 A review of the medical record revealed that the order had not been changed and that the order had remained as 250 mg. for the months of July, August and September. A review of the MAR revealed that the nurses were signing for a 250 mg dose on the October MAR and had signed for a 250 mg . dose on the July, August and September MAR ' s. Nurse #1 could not give any reason why the dose had not been changed. During an interview with the Director of Nursing (DON) on 10/05/11 at 11:00 AM it was revealed "I would consider what was written on the lab report to be an order and would expect that the nursing staff would make the change and carry out the order. I cannot tell you what happened here. " During an interview with the Pharmacy Consultant on 10/05/11 at 12:15 PM it was revealed "I was not concerned that the level (Dilantin) was elevated. The prior level was 12.3. I was fine with the dose (250 mg.) When asked about the physician writing on the lab slip, the pharmacist replied "if that was an order the nurses did not carry it out. I don't know what to say about that."	F 428	**Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:** All residents with Lab Work and subsequent Physician Orders were potentially affected by this alleged deficient practice. On October 14, 2011 a complete audit of all residents receiving lab work was completed by the Administrator and assigned. Any orders noted on the lab work were verified as transcribed correctly on the Telephone Orders and the MARS using the Lab Work/Physician Order Audit Tool **(Exhibit Seven).** **Measures put into place or systemic changes made to ensure that the deficient practice does not occur:** All Lab Work will be entered on to the Lab Work Log **(Exhibit Four).** The Support Nurse has been educated and participated in the development of the form as a tool for monitoring Lab Work from specimen through filing on the chart after the Physician has reviewed the results.	

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	345367	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 10/20/2011 the facility has a heater in the sprinkler riser room located outside on the front porch area to protect the sprinkler riser from freezing in cold weather. This heater is not currently plugged into an emergency power source. CFR#: 42 CFR 483.70 (a)	K 062	K062 **Corrective action will be taken by the facility to correct the alleged deficient practice by:** On November 3, 2011 Parnell Electrical Service inspected the Riser Room and found an outlet on the left wall that is connected to the emergency generator. The heater was plugged into this outlet and the outlet was tested to ensure that it was on the emergency generator. **Other Life Safety issues having the potential to affect residents by the same alleged deficient practice will be corrected by:** The Environmental Service Director examined the facility for further issues to determine compliance with NFPA 101 Life Safety Code Standard K062 on October 20, 2011. Any areas of concern were addressed at that time. **Measures put into place or systemic changes made to ensure that the alleged deficient practice does not incur:** The Riser Room will continuously have a space heater plugged into an emergency outlet.	11.3.11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Hobbs	Administrator	11.3.11

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The facility has implemented a quality assurance monitor:

The Environmental Service Director will complete the Electrical and Emergency Power Log Quality Assurance Monitor **(Exhibit One)** 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 system problems will be addressed and changes made to the system as indicated in the Monthly Quality of Life Meeting.