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 _____	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS NURSING HOME	POST OFFICE 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 record review and staff interviews the facility failed to develop an individualized care plan for 1 of 1 resident at high risk for developing pressure ulcers (Resident #5). Resident #5 developed a Stage 3 pressure ulcer. The findings include: Resident #5 was admitted to the facility on June 17, 2016 with diagnoses including hypertension. Review of the most recent Minimum Data Set (MDS) Assessment dated 6/24/2016 identified the resident as cognitively intact and having no pressure ulcers. Resident #5 was coded as being a risk for pressure ulcers and needed	F 279	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility ' s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	10/3/16

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

Electronically Signed | 10/04/2016

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 _____	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS NURSING HOME	POST OFFICE 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	Continued From page 1 extensive assistance with bed mobility, transfers, and personal hygiene. The functional limitation in range of motion was coded as impairment on both sides of lower extremities and impairment on one side of upper extremities. Resident #5 was also coded as having no bed or chair pressure relieving devices. The Pressure Ulcer Care Area Assessment (CAA) on 6/24/2016 MDS was checked and indicated a decision to be care planned, but there was no CAA summary. Review of the initial care plan dated 6/24/2016, revealed no care plan for pressure ulcers or for at risk for pressure ulcers with no interventions. Wound assessment notes were reviewed. The notes indicated that on 9/9/2016 a new ulcer was noted on the left gluteal fold. The ulcer was noted to be a stage III. The ulcer measured 7.5 centimeters (cm) x 7.5 cm x 0 cm in size. No exudate. Description of wound edges is defined. During an interview on 9/14/2016 at 2:35 PM, the MDS Coordinator acknowledged there was no care plan for being at risk for a pressure ulcer in the 10 pages of care planned items. She explained she was new and had not identified the information was missing. During an interview on 9/14/2016 at 4:50 PM, the Facility Administrator revealed her expectation was to have an accurate care plan for Resident #5 to include preventive measures and measures for care of the new pressure ulcer.	F 279	F279 For the residents involved, corrective action has been accomplished by: 1. The Care Plan for Pressure Ulcers was added to Resident #5 on September 14, 2016. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: All resident Care Plans were potentially affected by this alleged deficient practice and were reviewed on October 3, 2016. All resident Comprehensive Care Plans were reviewed to ensure that their Care Plan accurately reflects his/her risk for Pressure Ulcers or actual Pressure Ulcers that may be present. This was completed by the MDS Coordinator (Exhibit One). Measures put into place or systemic changes made to ensure that the deficient practice does not occur: The MDS Coordinator and Care Plan Team were in-serviced by the Corporate MDS Consultant on October 3, 2016. This in-service included re-education on items to be included on Interim and Comprehensive Care Plans, potential versus actual problems and resident	

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 _____	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS NURSING HOME	POST OFFICE 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	Continued From page 2	F 279	assessment needed to accurately complete the resident ' s Comprehensive Care Plan (Exhibit Two). The Daily Quality of Life Committee will review all new and readmitted residents the first business day after admission. They will evaluate the resident ' s Interim Care Plan to ensure it is an accurate reflection of the resident. This assessment will be recorded on the Daily Quality of Life Quality Assurance Worksheet (Admission and Readmission Checklist) for Admissions/Readmissions (Exhibit Three). The facility has implemented a quality assurance monitor: The Care Plan Quality Assurance Monitor will be completed monthly by the Director of Nursing or designee and reported to the Monthly Quality of Life Committee at the Monthly Quality of Life Meeting initially for three months (Exhibit Four). For any month that the monitor reveals less that 100% compliance, the monitor will be extended an additional month and corrective action will be implemented as deemed necessary by the Monthly Quality of Life Committee.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		10/5/16

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 _____	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS NURSING HOME	POST OFFICE 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 323	Continued From page 3 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff and physician interviews and record review: the facility left a resident sitting alone on the side of the bed resulting in a fall with left tibia/fibula fracture, failed to determine cause of the fall and the facility failed to have two staff present during a full sling transfer for 1 (Resident #11) of 4 reviewed for accidents. Findings included Resident #11 was admitted 5/15/15 with cumulative diagnoses of schizoaffective disorder, low back pain, osteoarthritis, encephalopathy and a spinal and neck fusion. A review of Resident #11 ' s quarterly Minimum Data Set (MDS) assessment dated 2/23/16 indicated he was cognitively intact with no behaviors, required extensive assistance of one person for bed mobility, and extensive assistance of two staff for transfers. The MDS also indicated impairment of mobility to both lower extremities and one upper extremity. His annual MDS assessment dated 5/23/16 indicated Resident #11 remained cognitively intact with verbal behaviors toward staff, extensive assistance of two staff for bed mobility and total dependence of two staff for transfers. The 5/23/16 MDS also indicated impairment mobility to both lower extremities and one upper extremity. His annual MDS assessment was also coded for one fall with major injury. A review of the Care Area Assessment (CAA) dated 5/31/16 indicated	F 323	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F323 For the residents involved, corrective action has been accomplished by: 1. The Care Plan for Resident #11 was updated to include to not leave him sitting on side of bed unsupervised at any time, as well as his noncompliance with care provided. This was completed by the MDS Coordinator on or before October 5, 2016 (Exhibit Five). The local Ombudsman was contacted on September 15, 2016 for assistance with resident. In addition, the resident was added to Q Shift charting for behaviors and non-compliance. Resident was cleared by Orthopedics on September 15, 2016 to return to Physical Therapy. On	

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 _____	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS NURSING HOME	POST OFFICE 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 323	Continued From page 4 Resident #11 triggered for activities of daily living (ADLs), behaviors and falls. The CAA read Resident #11 was alert and oriented and able to make his needs known. He required extensive assistance from staff for his activities of daily living (ADLs), non-ambulatory and currently required to use of a full sling lift for transfers due to a left tibia/fibula fracture requiring a soft cast. He displayed periods of agitation and verbally abusive toward staff. Resident #11 ' s most recent MDS assessment dated 8/23/16 indicated he was cognitively intact with verbal behaviors towards staff. He required extensive assistance of two staff with bed mobility and total assistance of two staff for transfers. . A review of Resident #11 ' s quarterly care plan dated 2/23/16 did not include a care concern related to his falls risk, actual falls or transfer needs until 4/18/16 when those areas were added to Resident #11 ' s care plan. The care plan dated 4/18/16 included the following intervention: Resident #11 was to be transferred using the full sling lift with two staff assistance. Resident #11 was receiving therapy services starting on 4/6/16 due to expressed desire to increase his independence with transfers and ambulation. The physical therapy plan of care dated 4/6/16 indicated Resident #11 had not ambulated in two years but had a strong desire to stand and ambulate. The long term goals indicated Resident #11 would complete a basic transfer from sit to stand to chair safely requiring contact guard assist (contact with resident due to unsteadiness.) The goal date was set for 5/3/16. A review of the last daily note dated 4/13/16 indicated Resident #11 was moderate to maximum assistance to perform a stand pivot	F 323	October 3, 2016, all RNs, LPNs, and Nursing Assistants, full time and part time were in-serviced on accident prevention which included: the requirement of having two person assists for all total transfers and the importance of not leaving residents who are unable to transfer independently sitting on the side of the bed for therapy or anything else, regardless of the orientation status or directive from therapy (Exhibit Seven). This education was conducted by the Director of Nursing. Any nursing staff member who has not received this education by October 3, 2016 will not be permitted to work until he/she has received it. This education has been incorporated into the general orientation for all new nurses and nursing assistants. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: All residents who are not independent with transfers were potentially affected by this alleged deficient practice. On October 3, 2016, all residents requiring assistance with transfers were reviewed for an accurate Comprehensive Care Plan that reflects their current transfer needs and flows through to the Kardex, including but not limited to full transfers requiring two people. This was conducted by the MDS Coordinator (Exhibit Six). Any changes	

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 _____	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS NURSING HOME	POST OFFICE 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 323	Continued From page 5 transfer from the edge of the bed to the wheelchair to the mat table with the physical therapy assistant. (PTA). The PTA documented Resident #11 did not have postural control to stand completely upright. He was discharged from services on 4/13/16 due to a fall resulting in a left tibia/fibula fracture. In an interview on 9/12/16 at 4:15 PM, Resident #11 recalled being left on the side of bed unattended by an aide about four months ago. He stated he slipped off the edge of the bed and fell to the floor breaking his left tibia/fibula. He stated it sounded like a "gunshot went off when it popped." A review of a nursing note dated 4/14/16 and timed 4:45 PM read the aide reported Resident #11 was sitting on the side of the and slid off. He complained of left knee pain and was sent to the hospital for an evaluation. A review of the incident report dated 4/14/16 indicated at 4:35 PM, Resident #11 was sitting on the side of his bed and his knees gave away and fell to the floor hurting his left knee and hip. The report indicated nursing assistant (NA #1) was present at the time of the fall and tried to prevent him from sliding off the side of the bed. NA #1 stated Resident #11 was sitting on the side of the bed waiting to be transferred to the wheelchair. The aide stated she put his shoes on and his feet were planted on the floor and the bed was low and that Resident #11 raised the bed. A review of the emergency room record dated 4/14/16 indicated Resident #11 presented with left knee and hip pain after falling out of a full sling lift at the nursing home. He was diagnosed with a non-displaced fracture of the proximal tibia and	F 323	indicated were made at that time. Measures put into place or systemic changes made to ensure that the deficient practice does not occur: On October 3, 2016, all RNs, LPNs, and Nursing Assistants, full time and part time were in-serviced on accident prevention which included: the requirement of having two person assists for all total transfers and the importance of not leaving residents who are unable to transfer independently sitting on the side of the bed for therapy or anything else, regardless of the orientation status or directive from therapy (Exhibit Seven). This education was conducted by the Director of Nursing. Any nursing staff member who has not received this education by October 3, 2016 will not be permitted to work until he/she has received it. This education has been incorporated into the general orientation for all new nurses and nursing assistants. The facility has implemented a quality assurance monitor: The Quality Assurance Monitor for Safety will be completed monthly by the Director of Nursing or designee and reported to the Monthly Quality of Life Committee at the Monthly Quality of Life Meeting initially for three months (Exhibit Eight). For any month that the monitor reveals less than 100% compliance, the monitor will be extended an additional month and	

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 _____	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS NURSING HOME	POST OFFICE 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 323	Continued From page 6 fibula placed in an immobilizer and returned to the facility on 4/15/16 with orders to follow up with an orthopedic 5/10/16. An orthopedic follow up 5/10/16 indicated Resident #11 was non-ambulatory from severe myopathy and ordered the continued use of the immobilizer for six to eight more weeks for healing. In an interview on 9/13/16 at 9:55 AM, NA #2 stated before Resident #11 ' s fall, staff were using the sit to stand lift to get him up out of the bed. She stated Resident #11 was no longer able to get himself up to the side of the bed without staff assistance and he was not steady to be left unattended at the bedside. She stated she had not known Resident #11 to adjust his bed height because he rarely got up out of the bed. NA #2 stated the Kardex (quick reference guide) was what the aides followed to know how much assistance a resident needed and the facility put a picture in a resident ' s room of what type of lift they needed for transfers. A review of an undated Kardex indicated Resident #11 required two staff for assistance with transfers using the full sling lift and he was totally dependent on staff for repositioning and turning in bed. A Kardex indicating the previous staff instructions was requested on 9/13/16. The Administrator stated that due to the computer limitations, she could not provide a Kardex with previous staff instructions since only the date the Kardex was printed would populate on the copy. In another interview with Resident #11 on 9/13/16 at 3:50 PM, he stated he was working with therapy and the PTA came to his room to get him every day around 4:00 PM. He stated NA #1 got him up in preparation for therapy and NA #1 left him sitting on the side of the bed while she did	F 323	corrective action will be implemented as deemed necessary by the Monthly Quality of Life Committee.	

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 _____	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS NURSING HOME	POST OFFICE 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 323	Continued From page 7	F 323		

something another resident. Resident #11 stated he recalled he had the urge to urinate so he yelled out to NA #1 and she went to get the sit to stand lift since therapy had not arrived yet. When NA #1 got to the room with the sit to stand lift, she tried to stop the fall by grabbing his pants but she was not able to hold him up (weight at time of the 5/23/16 MDS assessment was 259 pounds). Resident #11 stated he preferred his bed up in the high position while in bed but NA #1 lowered his bed so his feet would be flat on the floor while he waited on the PTA to come get him for therapy the day of the fall. There was a picture of a full sling lift taped to the outside of Resident #11 ' s closet door observed.

In an interview on 9/13/16 at 4:50 PM, the PTA stated Resident #11 had been non-ambulatory since his admission but he had expressed a desire to attempt ambulation so he was being treated by physical therapy in April 2016. The PTA stated he was not present on 4/14/16 at the time of the fall. He recalled the medication aide (MA) came and got him because Resident #11 raised his bed too high. The PTA stated Resident #11 was able to sit unsupported on the mat table during therapy while supervised and he was working on transfers with Resident #11 using the standing and pivot method.

In an interview on 9/14/16 at 8:30 AM, Nurse #1 stated Resident #11 only had the one fall in April since his admission and that he was unable to move himself from the lying position to sitting up on the side of the bed unassisted. Nurse #1 stated she had never known Resident #11 to sit on the side of his bed unsupervised and he preferred to stay in bed and watch television or play on his phone.

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 _____	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS NURSING HOME	POST OFFICE 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 323	Continued From page 8	F 323		

In an interview on 9/14//16 at 9:10 AM, the Administrator stated she did not do an investigation regarding the fall on Resident #11 because she was under the impression that Resident #11 adjusted the bed height resulting in his fall. The Administrator stated she was aware therapy was working with Resident #11 and therapy informed her that he was able to support himself sitting on the side of his bed unattended.

In a telephone interview on 9/14/16 at 9: 40 AM, medication aide (MA) #1 stated she was working on 4/14/16 and NA #1 was assigned to Resident #11. MA #1 recalled Resident #11 wanting to urinate before going to therapy. MA #1 stated she was told Resident #11 raised his bed while NA #1 was in the room with the sit to stand lift. MA #1 stated staff were instructed that one person can use a sit to stand for transfers of a resident and two staff must be present to use the full sling lift. She stated NA #1 must have assisted Resident #11 to the side of the bed because next she heard NA #1 yelling for help. She ran to the room and saw NA #1 holding onto Resident #11 ' s pants trying to prevent him from falling off the side of the bed. MA#1 stated she did not stop to assist NA #1 but rather went and got the PTA to assist since he was strong and Resident #11 was so large. MA #1 stated when they got to the room, Resident #11 was on the floor complaining of left leg pain. MA #1 stated the Administrator questioned her about the fall after it happened.

In a telephone interview on 9/14/16 at 9:50 AM NA #1 stated she was assigned Resident #11 on 4/14/16 but she had never gotten him up out of the bed before. She assisted Resident #11 in getting his pants and ready for therapy. She

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 _____	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS NURSING HOME	POST OFFICE 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 323	Continued From page 9	F 323		

stated she always had trouble getting Resident #11 shoes on so she asked NA #3 to help her put his shoes on and left him sitting on the side of the bed. NA #1 stated his feet were flat on the floor. She stated she left the room and went into another resident ' s room to " work with another resident. " NA #1 stated she was not aware that Resident #1 " could not use his legs. " NA #1 stated she left Resident #11 sitting there waiting on the PTA to come get him for therapy. She stated she heard Resident #11 yelling for help so she ran and got the sit to stand lift but when she got to the room, Resident #11 was already sliding from the side of the bed so she grabbed him by his pants. She stated she called for help but Resident #11 fell to the floor.

In an observation on 9/14/16 at 10:30 AM, NA #4 performed a transfer on Resident #11. NA #4 had to physically roll Resident #11 over onto his sides to get the lift pad underneath him then was able to hold himself onto each side using the side rail and roll back onto his back. He had no range of motion in his legs. Prior to the transfer, Nurse #1 asked NA #4 if she needed any assistance performing the transfer. NA #4 stated she did not. Using the full sling lift to transfer Resident #11 from the bed to the shower chair, NA #4 did not employ a second staff member for assistance. When asked if it was the facility ' s practice to only use one person during a full sling lift transfer, she stated it was not. NA #4 stated two staff should be present during full sling lift transfers. When questioned as to why she did no employ the offered assistance of Nurse #1, NA #4 stated she thought the surveyors presence counted as the second person. Once he was sitting up into the shower chair, Resident #11 was asked to demonstrate any range of motion he had in his

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 _____	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS NURSING HOME	POST OFFICE 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 323	Continued From page 10	F 323		

legs. He was unable to bend his left leg and his right knee only was able to bend approximately 10 degrees. NA #4 stated she had been working at the facility for about 8 months and she had never knew Resident #11 to have any falls and he always needed assistance of a lift for transfers. She stated she would not leave Resident #11 unsupervised to sit on the side of bed because he was not steady and he could not hold himself upright without help.

In an interview on 9/14/16 at 10:42 AM, the Administrator stated Resident #11 ' s fall occurred at a time when several nurses were out of work and she had to work on the halls. The Administrator stated it was the facility policy and her expectation for two staff members to be present during a full sling lift transfer. A review of Resident #11 current weight as of 9/1/16 was 287 pounds.

In a second transfer observation on 9/14/16 at 11:00 AM, NA #4 and Nurse #1 were both present during the transfer from the shower chair back to the bed using the full sling lift.

In an interview on 9/14/16 at 11:17 AM, Nurse #2 stated she was summoned to Resident #11 ' s room and NA #1 was standing outside his room complaining of back pain. Nurse #2 entered the room to see Resident #11 lying on the floor. The previous MDS nurse was assessing Resident #11 for injuries and she could not remember if the sit to stand lift was in the room at the time she entered. Nurse #2 stated she had never known Resident #11 to sit on the side of the bed unsupervised and it was unsafe to leave him that way because of poor judgment and advanced deconditioning.

In another interview on 9/14/16 at 2:00 PM, the PTA stated he had been working with Resident #11 on his upright sitting posture because his

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 _____	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS NURSING HOME	POST OFFICE 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 323	Continued From page 11	F 323		

abdominal muscles were weak and that made it difficult for him to lean in preparation for transfers. The PTA stated Resident #11 was not able to sit on the side of the bed unassisted and it was not safe to leave Resident #11 alone sitting on the side of the bed. He stated he did not instruct the staff to leave him sitting on the side of the bed in an effort to strengthen his abdominal muscles or to leave him sitting on the side of the bed while Resident #11 waited for him to come and get him for therapy.

In an interview on 9/14 at 2:28 PM, NA #3 stated when he entered the room to help NA #1 put Resident #11 ' s shoes on, he was already dressed and sitting on the side of the bed with his legs extended outward touching the floor. NA #3 stated he would have never left Resident #11 alone sitting on the side of the bed to wait for therapy to come get him. He stated if therapy wasn ' t there after he got Resident #11 ready, he would have laid him back down and engaged his side rail.

In a telephone interview with the Medical Director (MD) on 9/14/16 at 2:40 PM, he stated he thought he had an old tibia/fibula fracture and he recalled ordering him to see an orthopedic. The Medical Director stated it was his expectation Resident #11 not be left alone sitting on side of bed unattended due to Resident #11 ' s inability to ambulate, inability to his move legs and due to his obesity. He stated it was not safe.