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	345191	A. BUILDING _____ B. WING _____	05/04/2012

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

(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 441 SS=E	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.	06-19-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Barrett Kramer	Administrator	6-15-12

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F 441	Continued From page 1 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.	F 441	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.	

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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		

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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.

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F 441	Continued From page 4	F 441		

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

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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

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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 know what protective equipment they would need to have before going into the resident's room."	F 441		

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K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. 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 (Cafe 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 from closing. 42 CFR 483.70(a)	K 018	**Preparation and or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because the provision of federal and state laws requires it.** K 018 SS = F **Criteria 1** 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 ensure that the gap at the bottom of the door was closed. The Maintenance Director was educated regarding self closing, fire-rated doors. **Criteria 2** All other facility fire-rated doors were inspected to ensure self-latching when closed. **Criteria 3** 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. **Criteria 4** The results from the monitoring will be brought to the QAA committee to monitor regulatory compliance monthly X 3 months or until no longer deemed necessary.	9-14-12
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Harriet Brewer	Administrator	8-10-12

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K 038 SS=D	Continued From page 1 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 038	K 038 SS = D **Criteria 1** Facility staff was in-serviced on the master override switch at the nurse station to unlock the magnetically locked doors. **Criteria 2** Facility staff will be educated and newly hired employees will be educated during their orientation period. **Criteria 3** The ED and/or DNS and/or DCE in the ED's absence 3 random staff members rotating shifts to ensure understanding and location of the override switch. **Criteria 4** The results from the monitoring will be brought to the QAA committee for 3 months to ensure regulatory compliance.	9-14-12
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 045	K 045 SS = D **Criteria 1** A light was placed outside of D-Hall to ensure adequate lighting from the D-Hall exit discharge leading to the parking lot **Criteria 2** All other areas outside of the building were assessed in order to adequate lighting. **Criteria 3** The Maintenance Director will monitor the exterior exits weekly to ensure adequate visual illumination. **Criteria 4** The results from the monitoring will be brought to the QAA committee for one month to ensure regulatory compliance.	9-14-12

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K 045	Continued From page 2 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. 42 CFR 483.70(a)	K 045		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 70 and 72. 9.6.1.4 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.	K 052	K 052 SS = F **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.	9-14-12
K 054 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD 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	K 054		

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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 054	K 054 SS = F **Criteria 1** Smoke duct detector in attic was cleaned immediately to ensure that the smoke duct detectors worked efficiently. **Criteria 2** All smoke duct detectors in attics will be cleaned to ensure that the smoke duct detectors function properly.	9-14-12
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 076	**Criteria 3** The Maintenance Director will monitor all smoke duct detectors weekly for two months and then monthly thereafter to ensure they are clean and functioning properly. **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.	
	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) 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 4-3.5.2.2b(2)) (oxygen storage near the nurses station)			

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GOLDEN LIVINGCENTER - SURRY COMMUNITY	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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
K 076	Continued From page 4 42 CFR 483.70(a)	K 076	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.	9-14-12
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 144	K 144 SS = D **Criteria 1** The generator enunciator 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.	9-14-12