DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

JUL 16 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345195	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TARBORO	1000 WESTERN BLVD TARBORO, NC 27886

(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 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to reconcile narcotics for 2 residents (#35 and #69) and failed to develop policies and procedures with direction of frequency for narcotic reconciliation for 2 of 36 sampled residents. Findings include: The facility policy dated 10/07 indicated current controlled medication accountability records are kept in Medication Administration Record (MAR) or narcotic book. When completed,	F 425	"Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statements of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state laws. F 425 As is our practice, the facility will assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. As per our facility policy, current controlled medication accountability records are kept on the floor in a narcotic book until completed. These MARs were for a current resident and not complete; thus not turned into the DON for reconciliation. These current sheets in the Narcotic Book are counted off by two nurses every shift. Nurse #4 was inserviced regarding borrowing and PRN documentation on. A hard script was obtained from Medical Director to replace borrowed doses and was billed to facility. The Emergency Drug kit was reviewed and updated by Medical Director, DON and Pharmacy Consultant to include Hydrocondone - Acetominaphen and to assure adequate amounts of all the drugs.	7/19/12 6/22/12 6/22/12 7/9/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Effie Webb | TITLE: Executive Director | (X6) DATE: 7-12-12

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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F 425	Continued From page 1 accountability records are submitted to the director of nursing and maintained on file at the nursing care center. The policy and procedure also indicated if a discrepancy or pattern of discrepancies are identified, the DON investigates and makes every reasonable effort to reconcile all reported discrepancies and the DON notifies the Administrator, pharmacy consultant and pharmacy manager. An observation of the medication cart and narcotic count books on June 21, 2012 at 10:40 AM revealed resident #35 had a narcotic count sheet that indicated a total of 14 doses of Hyrocodone-Acetaminophen 5-500 milligrams (mg) were borrowed for resident #69 on 2/17/12, 2/28/12, 2/21/12, 2/23/12, 2/26/12, 2/27/12, 3/1/12, 3/2/12, 3/6/12, 3/7/12, 3/8/12, 3/9/12, 3/13/12, and 3/15/12. An interview with Nurse #4 on 6/21/12 at 1:40 AM indicated she did not know why the Hydrocodone-Acetominaphen was borrowed from resident #35 and signed out as borrowed for resident #69 on those dates. An interview with the DON on 6/21/12 at 1:00 PM revealed she was not aware the Hydrocodone-Acetaminophen 5-500 mg was signed out from resident #35 for resident #69 for almost a month. The DON also revealed reconciliation was not done until the narcotic supply was finished and the narcotics count sheet was completed by the nurses and turned in to her. If a resident is discharged the medications are listed on a return form and sent in a sealed tote back to the pharmacy.	F 425	Narcotic books were reviewed for all current residents for any discrepancies. A Nursing Memo was issued to all nurses concerning borrowing of meds. A Medication Borrow Report was developed to help identify root cause. All staff inservice done on survey results. Nursing staff to be further inserviced on survey results. Wing Managers will monitor the narcotic books on a daily basis to ensure compliance. The results of the monitoring will be discussed monthly at our QAPI (QAA) meetings for any recommendations and continued education. The DNS/ADNS will be responsible for overall compliance.	6/27/12 6/26/12 6/27/12 6/22/12 7/19/12

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F 425	Continued From page 2 During an interview on 6/21/12 at 2:00PM with Nurse #6 it was revealed she borrowed and gave resident #69 the Hydrocodone-Acetaminophen on multiple occasions during her shift (11:00 PM to 7:00 AM) because resident #69 was very agitated and she wanted resident #69 to be comfortable. Nurse #6 also revealed she was unsure why she had not documented in the MAR and in the nurses notes for resident #69 any agitated behavior or the effectiveness of the Hydrocodone-Acetominaphen for resident #69. On 7/5/12 at 10:30 AM an interview with the consulting pharmacist revealed reconciliation was done when the narcotic supply was depleted and the form was completed and sent to the DON. The consulting pharmacist does 2 random audits of the narcotics books (2 of the 7 books) during his monthly visits. The audits include checking the counts and the narcotic sheets align and reconcile. The consulting pharmacist indicated he had not checked resident #35 or #69 as part of his recent audits and he was not aware of any problems with narcotics being signed out as borrowed for another resident and no documentation to support the other resident would have received the narcotics.	F 425		
F 441 SS=D	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	F 441	F441 As is our practice, the facility will 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.	7/19/12

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F 441	Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure staff disinfected a glucometer after resident use for 1 (Resident #15) of 2 residents observed for glucose monitoring. Findings include:	F 441	Nurse #1 was immediately inserviced regarding the cleaning of the blood glucose machine. A Nursing Memo was issued to all nurses regarding proper cleaning of the blood glucose machine. All staff inservice was done on survey results. Nursing staff to be further inserviced on survey results. Wing Managers will monitor proper cleaning of the blood glucose machine on a daily basis and assist with education to ensure compliance. The results of the monitoring will be discussed monthly at our QAPI (QAA) meeting for any recommendation and continued education. The DNS/ADNS will be responsible for overall compliance.	6/19/12 6/26/12 6/22/12 7/19/12

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F 441	Continued From page 4	F 441		

Review of the undated manufacturer ' s information regarding cleaning of the Blood Glucose Monitoring System for healthcare professionals read in part: " Acceptable cleaning solutions include 10% bleach, 70% alcohol, or 10% ammonia. "

The Center for Disease Control (CDC) " Recommended Infection Control and Safe Injection Practices to Prevent Patient-to Patient Transmission of Bloodborne Pathogens " reads in part: " If a glucometer that has been used for one patient must be reused for another patient, the device must be cleaned and disinfected. " Additional information included 70% alcohol is not effective against blood borne pathogens.

On 06/19/12 at 4:11 PM, an observation was made of Nurse #1 preparing to obtain a finger stick blood sugar (FSBS) for Resident #151. She removed the glucometer from a drawer in the medication cart; inserted a test strip; and proceeded to the resident ' s room. The nurse donned gloves; used a lancet to prick the resident ' s finger; and, placed the test strip against the resident ' s finger to obtain the blood sample for testing. Upon obtaining the blood sugar result, she pulled out the test strip, holding it in one hand removed the gloves, wrapped the test strip and lancet into the removed gloves, and disposed of the items in the biohazard box on the side of the medication cart. The nurse then cleaned the glucometer using a 70% disposable alcohol wipe. She placed the glucometer on top of the medication cart. When asked what the facility policy was regarding cleaning the glucometer, she replied the facility used the alcohol wipe to clean the glucometer.

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F 441	Continued From page 5	F 441		

On 06/19/12 at 4:20 PM, an observation was made of Nurse #1 obtaining a FSBS for Resident # 1. The nurse donned gloves; used a lancet to prick the resident ' s finger; and, placed the test strip against the resident ' s finger to obtain the blood sample for testing. Upon obtaining the blood sugar result, she pulled out the test strip, holding it in one hand removed the gloves, wrapped the test strip and lancet into the removed gloves, and disposed of the items in the biohazard box on the side of the medication cart. The nurse cleaned the glucometer using a 70% disposable alcohol wipe.

On 06/19/12 at 4:40 PM, Nurse #1 and the Director of Clinical Services (DCS) approached and indicated the nurse wanted to clarify some information. The nurse stated the facility used antimicrobial wipes to clean the glucometers. She indicated she did not have them on the medication cart, had failed to obtain the wipes to put on her cart, was nervous, and had used the disposable alcohol wipe to clean the glucometer.

An interview, on 06/20/12 at 4:00 PM, was conducted with the Director of Nursing (DON). The DON stated she had reviewed the manufacturer ' s instruction for the glucometers the facility used and she shared the manufacturer information indicated that 70% alcohol wipes were listed for cleaning the glucometer. The DON continued that the facility preferred nurses use the antimicrobial wipes, but the manufacturer indicated 70% alcohol was listed. She shared the company on a nationwide call this morning relayed to all facilities the company would be implementing nationwide the use of dedicated

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F 441	Continued From page 6 glucometers. An interview, on 06/21/12 at 1:30 PM, was conducted with the DCS. The DCS indicated during orientation the nurses are instructed to use antimicrobial wipes to clean the glucometers and she completed the competency testing during the orientation period. She confirmed the antimicrobial wipes are stored in the medication room for the nurses to access as needed for the medication cart.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to maintain emergency call lights at the commode areas in 2 (north wing) of 4 common resident bathing areas. During an observation of the North Wing Whirlpool room on with NA #5 on 6/20/12 at 10:15 AM, the emergency call light in the commode area was tested and found to not work. The NA stated she was surprised and did not know why the light would not turn on. There was no sound made when the cord for the light was pulled During an observation of the Therapy Room, a	F 463	F 463 As is our practice, the facility will assure the nurses' station is equipped to receive resident calls through a communication system from residents; and toilet and bathing facilities. 7/19/12 Both call lights were fixed immediately and are located behind a locked corridor door with a code or key for entering. 6/20/12 All call bell stations in the entire facility was checked to ensure compliance. 6/22/12 All staff inserviced on survey results. 6/22/12 As stated, the emergency call lights in the common bath areas were last checked 3/20/2012 per the facility's "Quarterly Preventative" Maintenance System. The next scheduled check was due between 6/19/2012 and 6/22/2012 which was within the facility's 5 day projected completion period.	

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F 463	Continued From page 7 common shower area, on 6/20/12 at 10:05 AM, the emergency call bell at the commode did not alarm when pulled. An observation with NA #5 was made on 6/20/12 at 10:20 of the commode area emergency light. The light did not light when pulled. The NA stated she was surprised and did not know why it wouldn't ring. There was no sound made when the cord for the light was pulled During an observation of the commode area call lights in both common bathing areas with the Administrator on 6/20/12 at 10:35 AM, the Administrator observed the lights did not light or make a sound when the cord was pulled and stated they were expected to be in working order. The Maintenance Director was present during the demonstration and reported he checked the lights and if they didn't work, they were repaired. The Maintenance Director did not remember any problems with the call lights on the past inspection. Review of a statement provided by the Director of Nursing dated 6/25/12, the statement revealed the emergency call lights in the common bathing areas were last checked 3/20/12 per the facility ' s " Quarterly Preventive Maintenance System " . The statement revealed the next scheduled " Preventive Maintenance System " check was due between 6/19/12 and 6/22/12 which was within the facility ' s 5 day projected completion period	F 463	Maintenance Department Head will monitor the call light system in the facility. The results of the monitoring will be discussed monthly at our QAPI (QAA) meetings for any recommendations and continued education. Maintenance Department Head will be responsible for overall compliance.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345195	MULTIPLE CONSTRUCTION A. BUILDING B. WING	DATE SURVEY COMPLETE: 6/21/2012
NAME OF PROVIDER OR SUPPLIER: GOLDEN LIVINGCENTER - TARBORO	STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 WESTERN BLVD TARBORO, NC		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 253	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store medications in clean medication carts in 2 of 7 medication carts Findings include: 1. During an observation with Nurse #1 on 6/21/12 at 10:45 AM in the 900 hall medication cart the third drawer of the cart had a spilled sticky substance covering ¼ of the bottom of the drawer and coating 3 of the bottles of medication kept in the drawer. During an interview on 6/21/12 at 10:50 AM with Nurse #1, she identified the spilled substance as a medication called Miralax and indicated she was not sure how long it had been spilled in the cart. Nurse #1 indicated housekeeping had been cleaning the carts and it had not been done in a while. 2. During an observation with Nurse #3 on 6/21/12 at 11:30 AM the 400 hall medication cart had loose pills spilled on the bottom of the first drawer of the medication cart. There were 58 loose pills spilled on the bottom of the second drawer and 6 loose pills mixed in with spilled loose powder on the bottom of the third drawer. In addition, the third drawer also had a white cloth which had multiple red stains and there were multiples bottles of medicine that sat on it. An interview on 6/21/12 at 11:40AM with Nurse #3 revealed the wing managers check the cart regularly for cleanliness and the nurses are responsible to clean up spills if they occur. An interview with the DON on 6/21/12 at 2:15PM revealed her expectations would be the medication carts would be kept clean and spilled substances would be immediately wiped up. The DON also revealed she would expect spilled or loose pills to be cleaned up immediately. The DON indicated the housekeeping department had been cleaning the medication carts on a regularly scheduled basis and that had not occurred in a few months.

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The above isolated deficiencies pose no actual harm to the residents

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FORM APPROVED
OMB NO. 0938-0391

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	345195	A. BUILDING 01 - MAIN BUILDING 01 NOV 27 2012 B. WING _____	11/09/2012

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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 This STANDARD is not met as evidenced by: A. Based on observation on 11/09/2012 there were full and empty 02 cylinders mixed in the 02 storage out side the service hall entrance. 42 CFR 483.70 (a)	K 076	"Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statements of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state laws. *Note date of Survey was 11/8/2012. The full and empty O2 cylinders were separated immediately. Signage regarding separation of full and empty tanks was physically audited and noted proper signage was and is in place. Two new oxygen racks were ordered, received and placed into service upon arrival. All staff education sessions were held on 11/8/12, 11/12/12, 11/15/12, 11/16/12 to include all shifts to keep full and empty O2 cylinders separated. The Regular Oxygen delivery man was re-educated on 11/8/12 and back up man re-educated on 11/15/12 regarding separation of full and empty tanks.	11/8/2012 11/8/2012 11/15/2012 11/16/2012 11/15/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Effie St. White | TITLE: Executive Director | (X6) DATE: 11-26-2012

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