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 _____	07/13/2017

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 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to follow the care plan by not providing adaptive equipment at meals for 1 of 18 residents (Resident #46) sampled. Findings included: Resident was admitted to the facility on 1/15/16 with diagnosis including Epilepsy, Cerebrovascular Accident and Dementia Review of Annual MDS (Minimum Data Set) dated 1/22/17 revealed the resident was independent with eating after set-up and required a mechanically altered diet. MDS also revealed Resident #46 had moderately impaired cognition. Review of Nutrition Care Area Assessment Worksheet dated 1/22/17 revealed Nutritional Status would be addressed in care plan to maintain residents' current functional level by providing foamed (built up) silverware. Review of Care Plan dated 2/25/16 revealed Nutritional or potential Nutritional problem with	F 282	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. F282 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: 1. The original foam was lost from the spoon. The Dietary Manager was on vacation and neither the Nursing Assistant nor the Dietary Aide made anyone aware at the time that it occurred. Foam was	7/27/17

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

Electronically Signed | 07/27/2017

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F 282	Continued From page 1 interventions for foam silverware (built up utensils) at all meals. Review of OT daily treatment notes beginning 2/4/16 revealed training in self-feeding by using adaptive equipment (built up utensils) Observation of Resident #46 on 07/11/2017 12:07 PM revealed tray ticket noting "built up fork and spoon". Resident # 46 did not have a built up spoon on tray and was eating using a regular spoon. Observation of Resident #46 07/12/2017 8:07 AM, Resident #46 was observed eating breakfast without a built up spoon. Interview with CNA #2 on 07/12/2017 3:08 PM revealed if a resident didn't have items on tray ticket, she would go to the kitchen and request the item. Interview with Nurse #1 on 07/12/2017 3:11 PM revealed she would notify dietary if a resident didn't have what was noted on tray ticket. Nurse #1 also revealed that the MDS nurse communicated with staff verbally regarding resident needs and information can also be found on the care card on computerized chart. Interview with OT (Occupational Therapist) on 07/12/2017 4:20 PM revealed she made recommendation for built up utensils for Resident #46 in February 2016. She revealed she would pass recommendations for adaptive equipment to	F 282	added to Resident #46's spoon on July 12, 2017 by the Dietary Manager to make it compliant with the OT recommendations. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On July 12, 2017, the Rehabilitation Director and MDS Coordinator reviewed all Care Plans, Therapy recommendations and kitchen devices to ensure each resident is getting the appropriate adaptive equipment as recommended by therapy and outlined on their Care Plan (Exhibit One). Zero of the six patients required corrections by the MDS Coordinator, Dietary Manager or Rehabilitation Director. All Dietary, Nursing and Rehabilitation Staff, part-time, full-time and PRN were in-serviced on the importance of adaptive equipment, where to determine if a patient has adaptive equipment and what to do if the appropriate adaptive equipment is not provided at any meal (Exhibit Two). Education was provided by the MDS Coordinator and Rehabilitation Director on July 13, 2017 or by phone. The specifics of the adaptive equipment were set to "fire" the Nursing Assistant tasks for those residents as a reminder of the specific adaptive equipment needed.	

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F 282	Continued From page 2 Dietary Manager and MDS nurse for implementation. Interview with MDS nurse on 07/12/2017 2:39 PM revealed that Dietary Manager is responsible for getting information on tray tickets and completing nutritional status assessments of all residents. MDS nurse also demonstrated area in computerized chart where staff can locate Resident #46's care needs. Interview with Dietary Manager on 07/12/2017 2:53 PM revealed that she was unaware that Resident #46 wasn't receiving a built up spoon on his meal trays. Interview with acting Director of Nursing/MDS nurse on 07/12/2017 4:23 PM revealed that she would expect the care plan be followed. Interview with Administrator on 07/13/2017 10:3 AM revealed that the Dietary Manager was on vacation and wasn't notified that Resident #46 wasn't receiving a built up spoon. She also revealed her expectation was that the care plan be followed.	F 282	The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Adaptive Equipment Quality Assurance Monitor will be completed monthly by the Rehabilitation Director or designee and reported to the Monthly Quality of Life Committee at the Monthly Quality of Life Meeting initially for three months (Exhibit Three). 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. The title of the person responsible for implementing the acceptable plan of correction: The Dietary Manager and the Director of Nursing are responsible for the implementation of this Plan of Correction. The date when the corrective action will be completed: In compliance as of July 27, 2017.	
F 431 SS=F	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 431		7/27/17

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F 431	Continued From page 3	F 431		

law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. 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.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of

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F 431	Continued From page 4 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to: 1) Dispose of 5 boxes of expired Influenza vaccine and 2 vials of expired Tuberculin PPD (purified protein derivative) Injectable in 1 of 1 medication room refrigerators and, the facility failed to: 2) dispose of expired medications on 1 of 2 medication carts. Findings included: Review of med storage facility policy provided by the Director of Nursing on 07/13/2017 11:02 AM, the policy revealed in part, in item 1, Section m, Outdated medications are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. The policy also revealed in item 3, Discontinued Medications and Expired Medications, that "when medications are discontinued by physician order, medications are expired, a resident is transferred or discharged and does not take medications with him/her, or in the event of resident's death, the medications are marked as "discontinued" and sent to provider pharmacy to be destroyed, and in Item 3b, policy revealed that medications awaiting disposal or return are stored in a locked secure area designated for that purpose until destroyed or picked up by pharmacy.	F 431	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. F431 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility policy of discarding expired medication had not been continually implemented, resulting in the occurrences below. 1. The unopened Tuberculin PPD was removed from the active medication refrigerator on July 13, 2017 by the MDS Coordinator. The opened vial of Tuberculin PPD, opened June 5, 2017 was discarded on July 13, 2017 by Nurse	

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F 431	Continued From page 5 Review of manufacture's product information revealed opened vials of Tuberculin PPD injectable should be discarded 30 days after opening. 1.Observation of medication room refrigerator on 07/13/2017 9:34 AM revealed three full boxes with ten vials and two boxes with three vials remaining of Influenza vaccine expired on 6/30/17 and two opened vials of Tuberculin PPD injectable (used as skin test in the diagnosis of Tuberculosis) dated 6/5/17. 7/13/17 9:45 AM Interview with Nurse #1 revealed she was aware that the Influenza Vaccine was expired, but they were waiting for them to be returned to pharmacy. Nurse # 1 also revealed she was aware the PPD injectable was expired and she removed them from the refrigerator. 2.Observation of 1 of 2 medication carts (long hall) on 07/13/2017 9:51 AM revealed one bottle of Aspirin with an expiration date of 6/17/17, and one vial of Novolin NPH (neutral protamine Hagedorn) insulin vial opened and not dated. 7/13/17 9:53 AM Interview with Nurse #1, who was present at medication cart, revealed she couldn't be sure when vial of NPH insulin was opened, so it would need to be disposed of and that nurses should remove expired medications from med carts. 07/13/2017 at approximately 1030 AM Interview with Administrator revealed the expired influenza vaccine was in refrigerator waiting to be sent back to pharmacy for facility credit, but that she would expect expired meds to be removed from	F 431	One. 2. Both the Aspirin and the Novolin NPH (neutral protamine Hagedorn) were discarded on July 13, 2017 by Nurse One. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On July 27, 2017, the Administrator or designee examined all areas in the facility storing resident medication. This includes the Medication Room, Medication Room refrigerator and both nursing carts. (Exhibit Four). Any expired medications noted were discarded at that time. All RNs, LPNs and Medication Aides, full-time, part-time and PRN were in-serviced on proper storage, discarding (pending expiration or open status) and return to pharmacy procedures on July 13, 2017 or by phone by the MDS Coordinator or DON (Exhibit Five). The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Expired Medication Quality Assurance Monitor will be completed monthly by the DON or designee and reported to the Monthly Quality of Life Committee at the Monthly Quality of Life Meeting initially for three months (Exhibit	

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F 431	Continued From page 6 med carts and med room.	F 431	Six). For any month that the monitor reveals less than 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. The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing is responsible for the implementation of this Plan of Correction. The date when the corrective action will be completed: In compliance as of July 27, 2017	