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 _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS NURSING HOME	7348 NORTH WEST STREET 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
E 000	Initial Comments An unannounced Recertification survey was conducted on 03/31/19 through 04/03/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 2IKG11.	E 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code information correctly for 1 of 2 sampled closed records (Resident #46) whose Minimum Data Set (MDS) assessments were reviewed. The findings included: Resident #46 was admitted to the facility on 09/11/18 and discharged home on 03/29/19. Cumulative diagnoses included Diabetes Mellitus Type 2, Hypertension, Chronic Obstructive Pulmonary Disease, Major Depressive Disorder and Dementia. Review of the Quarterly Minimum Data Set assessment dated on 03/21/19 revealed that section O (special treatments, procedures and programs) was coded inaccurately. The following areas were check yes while a resident chemotherapy, radiation, oxygen, suctioning, tracheostomy care, invasive mechanical ventilator, IV medications, transfusions, dialysis, hospice and isolate/quarantine. Record review	F 641	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 date or dates indicated. F641 Accuracy of Assessments For resident #46, a corrective action was obtained on 04/01/19. • The specific deficiency was corrected on 04/01/19 by modifying the Minimum Data Set assessment with an Assessment Reference Date of 03/21/19 and correcting the answers for questions O0100A – O0100M (Special Treatments, Procedures and Programs) in order to	4/24/19

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

Electronically Signed | 04/24/2019

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F 641	Continued From page 1 revealed that the resident had none of these areas. During an interview with the MDS Licensed Practical Nurse on 04/01/19 at 3:00 PM, stated that she was must have been distracted to make these errors and the resident did not have any of those conditions. During an interview with the MDS Consultant Nurse on 04/02/19 at 1:30 PM who signs off on the MDS stated that she typically looks at section H, G, O & P. She further stated that it was an oversight that she did not catch the errors and is her expectation that the MDS be coded accurately. During an interview with the Administrator on 04/03/19 at 2:05 PM, she stated that it is her expectation that the MDS be coded accurately according to the Resident Assessment Instrument (RAI) Manual.	F 641	accurately reflect the absence of any of these items for Resident #46 during the 14 day lookback window for assessment reference date. This was completed by the Minimum Data Set Nurse. Corrected Minimum Data Set assessment was re-submitted to State Database in Batch #898 and accepted on 04/02/19. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of Minimum Data Set assessments that have been completed with Assessment Reference Dates for the past 60 days (02/24/19 – 04/24/19) for current residents will be completed in order to validate accurate coding of O0100A – O0100M (Special Treatments, Procedures and Programs). Any coding errors that are identified during this audit will be corrected immediately. This audit will be conducted by the Minimum Data Set nurse and will be completed no later than 05/03/19. Systemic Changes On 04/24/19, the Regional Minimum Data Set Consultant completed an in service training for the facility Minimum Data Set Coordinator that included the importance of thoroughly reviewing the medical record prior to completion of Section O0100 (Special Treatments, Procedures and Programs) of the Minimum Data Set assessment. The education also	

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F 641	Continued From page 2	F 641		

emphasized the importance of checking back over Minimum Data Set coding in order to catch possible errors prior to signing off on each section of the assessment.

This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.
On 05/01/19, the Director of Nursing or Minimum Data Set Nurse will begin auditing the coding of Section O0100A-O0100M (Special Treatments, Procedures and Programs) of the Minimum Data Set Assessment using the quality assurance survey tool entitled "Accurate Coding of Section O0100 (Special Treatments, Procedures and Programs) Audit Tool" to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements.
This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit

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F 641	Continued From page 3	F 641	Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator. Date of Compliance: 05/02/19	
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to schedule a Registered Nurse (RN) eight consecutive hours on 16 of 94 days during the weekends, holidays and week days. The findings included: Review of the daily nursing staffing sheets from May 2018 to April 2019 revealed the following days during the weekend when there was no RN coverage as working on the following days:	F 727	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	4/24/19

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F 727	Continued From page 4 September 16, 2018 - Sunday - census - 45; September 22, 2018 - Saturday - census 48; September 23, 2018 - Sunday - census - 47; September 29, 2018 - Saturday - census - 47; September 30, 2018 - Sunday - census - 47; October 5, 2018 - Friday - census - 49; October 10, 2018 - Wednesday - census - 49; October 20, 2018 - Saturday - census 52; October 21, 2018 - Sunday - census - 51; November 03, 2018 - Sunday - census - 51; November 4, 2018 - Sunday - census - 51; November 22, 2018 - Thursday (Thanksgiving) - census - 49; December 15, 2018 - Saturday - census - 50; December 16, 2018 - Sunday - census - 50; December 25, 2018 - Tuesday (Christmas) - census - 48; March 24, 2019 - Sunday - census - 48. During an interview with the Administrator on 04/03/19 at 2:05 PM, she stated that it is her expectation that RN coverage is in the building 8 hours a day, 7 days a week. The Administrator stated that they have struggled in this remote area to employ RN's they have reached out staffing agencies and offered a sign on bonus. The Administrator stated that she is an RN and have worked on the weekends when an RN has called out and on the above weekends she may been out of town and was not sure why the Director of Nursing was not in the building. She further stated that on the two days during the week the DON had paid time off and the two holidays had no RN coverage. She further stated that sometimes the when an RN calls out at the last minute they could not cover the RN position.	F 727	will be corrected by the date or dates indicated. F727: RN 8 HRS/7 Days /Week Corrective Action for concern identified DON and NHA educated on 4/4/19 of the requirement for RN services for at least 8 consecutive hours a day, 7 days a week by the Nurse Consultant. Corrective Action for potential concern identified On 4/30/19, DON, NHA and Nurse Consultant reviewed upcoming clinical schedule to ensure 8 consecutive hours, 7 days week RN coverage in place daily. Also, reviewed succession plan in the event of schedule changes to ensure compliance daily. Systemic Changes On 4/4/19, the DON and NHA education on requirement for RN services to include: • Requirement of 8 consecutive hours, 7 days a week of RN coverage • Succession plan for RN schedule changes This information has been integrated into the standard orientation DON and NHA training and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance	

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F 727	Continued From page 5	F 727	The DON/NHA will monitor this issue using the QA RN Services Survey Tool monitoring RN coverage daily. Any issues will be reported to the Administrator. This will be done weekly for 2 weeks and then monthly x 2 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator/ whoever to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Therapy, HIM, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator Compliance date: 5/2/2019	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.	F 865		4/24/19

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F 865	Continued From page 6 §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's Quality Assessment and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the recertification survey of 05/18/18. This was for the deficiency originally cited in May 2018 and subsequently recited on the current recertification survey of 04/03/19 in the area of Accuracy of Assessments (F641). The continued failure of the facility during two federal surveys of records show a pattern of the facility's inability to sustain an effective Quality Assurance (QA Program. The findings included: This tag is crossed-reference to: F641 Accuracy of Assessments - Based on record review and staff interviews the facility failed to accurately code information correctly for 1 of 2 sampled closed records (Resident #46) whose Minimum Data Set (MDS) assessments were reviewed. During the previous recertification survey of 05/18/18, the facility failed to accurately code MDS assessment for active diagnoses of anxiety and depression for 1 of 5 sampled residents reviewed for MDS accuracy. During an interview with the Administrator on 04/03/19 at 3:34 PM, she stated that it is her	F 865	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 date or dates indicated. F865: QAPI Program The facility was unable to sustain continued quality assessment and assurance implemented procedures and monitoring of interventions for F 641Accuaracy of Assessments after cited deficiency and plan of correction from the recertification survey of 5/18/18 resulting in a repeat deficiency. • The specific deficiency during the current recertification survey on 04/01/19 was corrected by modifying the Minimum Data Set assessment with an Assessment Reference Date of 03/21/19 and	

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F 865	Continued From page 7 expectation that the MDS assessments are accurately completed by conducting QAA to follow up on any failure to code the MDS accurately. The Administrator further stated moving forward Director of Nursing will be signing off all the Minimum Data Set (MDS) to make sure they were coded accurately.	F 865	correcting the answers for questions O0100A – O0100M (Special Treatments, Procedures and Programs) in order to accurately reflect the absence of any of these items for Resident #46 during the 14 day lookback window for assessment reference date. This was completed by the Minimum Data Set Nurse. Corrected Minimum Data Set assessment was re-submitted to State Database in Batch #898 and accepted on 04/02/19. • All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of Minimum Data Set assessments that have been completed with Assessment Reference Dates for the past 60 days (02/24/19 – 04/24/19) for current residents will be completed in order to validate accurate coding of O0100A – O0100M (Special Treatments, Procedures and Programs). Any coding errors that are identified during this audit will be corrected immediately. This audit will be conducted by the Minimum Data Set nurse and will be completed no later than 05/02/19. • On 04/24/19, the Regional Minimum Data Set Consultant completed an in service training for the facility Minimum Data Set Coordinator that included the importance of thoroughly reviewing the medical record prior to completion of Section O0100 (Special Treatments, Procedures and Programs) of the Minimum Data Set assessment. The education also emphasized the importance of checking back over Minimum Data Set coding in order to	

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F 865	Continued From page 8	F 865		

catch possible errors prior to signing off on each section of the assessment.

- This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators.

- On 05/01/19, the Director of Nursing or Minimum Data Set Nurse will begin auditing the coding of Section O0100A-O0100M (Special Treatments, Procedures and Programs) of the Minimum Data Set Assessment using the quality assurance survey tool entitled "Accurate Coding of Section O0100 (Special Treatments, Procedures and Programs) Audit Tool" to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements.
- This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director.

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F 865	Continued From page 9	F 865	Audit reports and findings will be presented to the Quality Assurance and Performance Improvement Committee weekly for 4 weeks and then monthly for 2 months. Minimum Data Set Nurse and Nursing Home Administrator to ensure corrective action is sustained. Compliance through ongoing auditing program will be monitored by the Administrator and the Quality Assurance and Performance Improvement Committee. The weekly and monthly Quality Assurance and Performance Improvement Committee are attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Rehab Director, Health Information Manager, Dietary Manager, Social Worker and Activity Director. The Administrator is responsible for the implementing the acceptable plan of correction. Date of Compliance: 5/2/19	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		4/24/19

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F 880	Continued From page 10 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 11 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to follow established infection control guidelines for hand hygiene and changing gloves while tracheostomy care was provided for 1 of 1 residents (Resident #31) when a nurse failed to perform hand hygiene between contaminated and sterile procedures. Findings Included: A review of the facility's Hand Hygiene Policy and Procedures, last revised January 2010, indicated it was the policy of the facility that hand hygiene be regarded as the single most important means of preventing the spread of infections. The policy indicated if gloves were worn for a procedure, hand hygiene was to be completed before putting on gloves and after the removal of gloves. During an observation of tracheostomy care for	F 880	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 date or dates indicated. F 880: Infection Prevention and control. Corrective Action for Resident Affected Immediately on 4/3/2019, Resident #31	

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F 880	Continued From page 12 Resident #31 on 04/03/19 at 11:13 a.m., Nurse #1 was observed to wash her hands, apply non-sterile gloves and suction tracheal secretions (mucous) from the resident's tracheostomy site. Nurse #1 removed her gloves and did not wash her hands. Nurse #1 then opened the tracheostomy care kit and removed the sterile drape and placed it on the over-bed table. When asked if she had washed her hands after she had performed suctioning and had removed her non-sterile gloves, Nurse #1 stated she had not. Nurse #1 stated she had been nervous and over-thinking the procedure and had forgotten to wash her hands. During an interview with the Director of Nursing (DON) on 04/03/19 at 11:52 a.m., the DON stated it was her expectation nursing staff follow the facility's infection control policy. During an interview with the Administrator on 04/03/19 at 2:00 p.m., the Administrator stated it was her expectation nursing staff follow infection control policies and procedures.	F 880	was provided trach care following the facility's Infection Control policy on Hand Hygiene and sterile field by the Director of Nursing. Nurse #1 was provided 1:1 education by the Director of Nursing on 4/3/19 with return demonstration of compliance. Corrective Action for Resident Potentially Affected Immediately on 4/3/19, the Director of Nursing ensured that all residents requiring trach care received trach care following the facility's Infection Control policies for Hand Hygiene and sterile field. Systemic Changes All licensed nurses (Full Time, Part Time, and PRN) will attend an in service on Trach Care, including Hand Hygiene, Sterile Field and facility's infection Control policy on 5/2/19. Nurses not attending the in-services will not work until in-service is completed. Quality Assurance The Director of Nursing/Designee will monitor infection control procedures during trach care, including hand hygiene and sterile field. Any issues will be reported to the Administrator. This will be	

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 _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 13	F 880	done weekly for 2 weeks and then monthly for 2 months. Reports will be presented to the weekly QA committee by the Administrator/ whoever to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Therapy, HIM, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator Compliance date: 5/2/2019	