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 _____	C 03/18/2022

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 and complaint investigation survey was conducted on 03/14/2022 through 03/18/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RT9R11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/14/2022 through 03/18/2022. Event ID#RT9R11 15 of the 15 complaint allegation were not substantiated. Intake numbers: NC00186157 and NC00186646.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other	F 583		4/8/22

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

Electronically Signed | 04/08/2022

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F 583	Continued From page 1 materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to protect private health information for 1 of 1 resident (Resident #10) by leaving confidential medical information unattended and exposed in an area visible and accessible to the public on 1 of 2 medication cart computers. The findings included: A continuous observation of an unattended medication cart in unit 1 hall was made on 3/16/22 from 8:27 AM to 8:30 AM. Nurse #1 left the medication cart with the computer screen visible outside of room 18 while she administered medications to Resident #10 who also resided on unit 1 hall. Resident #10's medical information was visible on the screen. Other residents, staff and visitors were present in the hallway. During an interview on 3/16/22 at 8:30 AM with Nurse #1, she indicated she had left the computer screen unattended in the hallway while	F 583	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. F583 Corrective Action for Affected Residents For resident #10 a corrective action was obtained on 03/16/22 by educating nurse #1 immediately on HIPAA and ensuring that all personal and medical records are kept secure and confidential. This corrective action was completed by the Administrator.	

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F 583	Continued From page 2 she went to administer medications to Resident #10. Nurse #1 explained she should have locked the screen and not left Resident #10's medical information in an area visible to others in the hallway. An interview was conducted on 3/16/22 at 9:35 AM with the Director of Nursing (DON). He indicated Nurse #1 should not have left the computer screen unlocked when she went into Resident #10's room to administer medications. He stated nurses were responsible for protecting Residents' medical information from others' visibility. During an interview on 3/16/22 at 9:40 AM with the facility Administrator, she indicated Nurse #1 should not have left the computer screen unattended while she went into residents' rooms. The Administrator further stated private health information should never be left on the computer screen where it is visible to the public.	F 583	Corrective Action for Potentially Affected Residents All residents have the potential to be affected by this alleged deficient practice. On 03/31/22, the Director of Nursing completed random medication observation of nursing staff to ensure steps were followed to protect the privacy of resident records. This was completed on 03/31/22. Audit Results: 0 of 2 concerns related to the privacy of resident records during observations. Systemic Changes On 03/17/22, the Director of Nursing began in-servicing all current employees. This in-service included the following topics: HIPPA and protecting privacy for all residents The Director of Nursing will ensure that any employee who has not received this training by 04/08/22 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all Licensed Nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing or designee will monitor this issue using the Quality Assurance Tool for Privacy and Confidentiality. The monitoring will include completing random medication observations to ensure steps are followed	

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F 583	Continued From page 3	F 583	to protect the privacy of resident□s records. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 04/08/22	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		4/15/22

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F 584	Continued From page 4 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain ceiling tiles and ceiling vents clean and in good repair. This was evident in 10 (Rooms 12, 14, 20, 22, 24, 26, 29, 32, 33, 34) of 27 rooms observed. Findings included: On 3/15/22 at 8:10 AM a tour of hallways and ceilings was conducted. Observations were made of the ceiling and the overhead ceiling vents in all rooms. -a. An observation in room 12 revealed the ceiling vent at the entrance of the room was heavily covered in dust. -b. An observation in room 14 revealed the ceiling vent at the entrance of the room was heavily covered in dust.	F 584	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. F584 Corrective Action for Affected Residents For room #12, 14, 20, 22, 24 a corrective action was obtained on 03/17/22 by cleaning vents. This was completed by the	

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F 584	Continued From page 5 -c. An observation in room 20 revealed the ceiling vent at the entrance of the room was heavily covered in dust. -d. An observation in room 22 revealed the ceiling vent at the entrance of the room was heavily covered in dust. -e. An observation in room 24 revealed the ceiling vent at the entrance of the room was heavily covered in dust. -f. An observation in room 26 revealed the ceiling vent at the entrance of the room was heavily covered in dust. The ceiling also had darkened discolored areas near the bathroom door. -g. An observation in room 29 revealed the ceiling vent at the entrance of the room was heavily covered in dust. The ceiling also had a large darken area the ceiling vent. -h. An observation in room 32 revealed the ceiling vent at the entrance of the room was heavily covered in dust. The ceiling also had an irregular shaped discolored areas over the head of the resident ' s bed. -i. An observation in room 33 revealed the ceiling vent at the entrance of the room was heavily covered in dust. The ceiling also had discolorations along the back corner of the room. -j. An observation in room 34 revealed the ceiling vent at the entrance of the room was heavily covered in dust. The ceiling also had large discoloration of irregular shapes in the center of the room. On 3/15/22 at 1:59 PM an interview was conducted with the Housekeeping/Maintenance Supervisor. He acknowledged the dust and stated it was the responsibility of housekeeping to dust and clean the ceiling vents. He explained he was planning to clean the vents and complete some facility repairs in the near future. He	F 584	Maintenance Director. For room #26, 29, 32, 33, 34 a corrective action obtained on 4/15/22 by cleaning vents and repairing/repainting ceiling. Corrective Action for Potentially Affected Residents All residents have the potential to be affected by this alleged deficient practice. On 04/08/22 a comprehensive audit of all resident rooms and common areas of the physical plant was initiated by the Administrator to identify areas in need of cleaning and repair. This process was completed on 04/08/22. Systemic Changes On 03/17/22, the Administrator began in-servicing all environmental services staff regarding proper steps to deep clean resident rooms and general cleaning techniques for all common areas. The Administrator will ensure that any employee who has not received this training by 04/08/22 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all Licensed Nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Administrator or designee will monitor this issue using the Quality Assurance Tool for Homelike Environment. The monitoring will include reviewing resident rooms and common areas to ensure vents are clean and ceiling in good repair.	

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F 584	Continued From page 6 discussed having a new filter system to help improve the air circulation. He also stated painting repairs were to be done soon. On 3/15/22 at 5:30 PM a tour of the rooms was conducted with the Administrator. She acknowledged the dust hanging from the overhead vents as soon as you enter each room. The Administrator stated there had been a plan from the corporate office for future improvements. Upon sharing the plan of Golden Year EVS (environmental services) Site Visit dated 3/03/22 listed life safety priority items, general maintenance/housekeeping tasks and projects. The list included vent cleaning, filter changes, and ceiling repairs and paint. The Administrator admitted the list had not been started prior to the survey for vent cleaning or ceiling repairs. Observations of Rooms 12, 14, 20, 22, 24, 26, 29, 32, 33, and 34 on 3/16/22 at 9:00 AM was conducted. The overhead vents at the room entry had been dusted. Some of the dust had been removed from the first grid; but there was dust still hanging on the second grid. On 3/18/22 at 8:13 AM a telephone interview was conducted with the Administrator. The Administrator stated that the facility had completed the dusting of the identified rooms on 3/15/22 and housekeeping/maintenance would be doing a deep cleaning according to the proposed corporate schedule. The Administrator acknowledged her expectation was the facility environment would be maintained in a healthy, clean, and safe manner.	F 584	This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 04/15/22	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		4/8/22

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F 623	Continued From page 7	F 623		

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or

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(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.

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F 623	Continued From page 9 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide written notification of discharge or transfer to the resident representative of the reason for discharge to the hospital for 1 of 1 sampled resident (Resident #25) reviewed for hospitalization. This deficient practice had the potential to affect other residents. The findings included: Resident #25 was initially admitted to the facility on 6/13/19 with the last readmission on 3/10/22. The most recent quarterly Minimum Data Set (MDS) dated 1/17/22 indicated Resident #25 was cognitively impaired. Resident #25's medical records revealed hospital stays from 11/27/21 through 12/4/21, 1/3/22 through 1/10/22 and 3/5/22 through 3/10/22.	F 623	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. F623 Corrective Action for Affected Residents For resident #25, readmitted to facility on 03/10/22. Resident admitted back to previous room. Corrective Action for Potentially Affected Residents:	

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F 623	Continued From page 10 Review of the Resident's medical record revealed that written notification of discharge was not provided to the resident representative for the hospitalizations on 11/27/21, 1/3/22 and 3/5/22. An interview was conducted on 03/18/22 at 1:16 PM with facility Social Worker (SW). The SW stated she was not aware she was supposed to provide a written notice of the reason for transfer to resident/ resident representative (RR). She indicated going forward she would send a written notice of the reason for transfer to RR. During an interview on 03/18/22 at 11:05 AM with the facility Administrator, she stated nursing staff usually notified RR of resident's transfer by telephone call and documented in resident's record. She indicated the facility had not been providing RR with written notifications of the reason for transfers. She explained going forward she would ensure Social Worker sent a written notice of the reason for transfer to RR.	F 623	All residents sent to hospital have the potential to be affected by this alleged deficient practice. On 04/01/22, the Administrator audited the last 48hrs of discharges/transfers to hospitals. Administrator ensured all resident identified in audit received written noticed. Audit Results: 2 of 2 residents received written notice. This was completed on 3/22/22. Systemic Changes On 03/21/22, the Administrator began in-servicing all Department Managers. On 03/21/22, The Director of Nursing began in-servicing all Licensed Nurses. This in-service included the following topics: Transfer Discharge to Hospital written notification The Director of Nursing will ensure that any staff who has not received this training by 4/8/22 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all Licensed Nurses and Department Managers, will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing or designee will monitor this issue using the Quality Assurance Tool for Monitoring Hospital Written Transfer Notice. The monitoring will include reviewing PCC documents to verify that notice was sent. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved	

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F 623	Continued From page 11	F 623	by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 04/08/22	
F 641 SS=E	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 the Minimum Data Set (MDS) to reflect the Preadmission Screening and Resident Review (PASRR) Level II status for 3 of 4 residents (Resident #16, #19, and #29) and to correctly code a resident's personal hygiene on a quarterly minimum data set assessent (Resident #23) for 4 of 4 residents reviewed for MDS accuracy. Finding included: 1. The North Carolina Department of Health and Human Services PASRR Level II determination notification dated 08/10/2021 revealed the nursing facility placement was appropriate.	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 Corrective Action for Affected Residents For resident #16 a corrective action was obtained on 03/17/22 by modifying and	4/8/22

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F 641	Continued From page 12 Resident #16 was admitted to the facility on 05/02/2019 with diagnosis of type 2 diabetes mellitus. The quarterly Minimum Data Set (MDS) dated 01/09/2022 had Resident #16 coded as cognitively intact and needed extensive assistance with activities of daily living (ADL). The MDS was also coded 7 days for antidepressant use during the 7-day look back period. Resident #16's MDS was coded, "No" for having been considered by the state PASRR Level II process to have serious mental illness and/or intellectual disability or a related condition. The care plan dated 01/05/2022 had focus' of having had episodes of displaying the following inappropriate behaviors: cursing, yelling at staff, wandering, & violence/aggression towards staff/other residents, and a focus of having a PASRR Level II related to severe mental illness, use anti-anxiety medications with risk for adverse side effects. The diagnosis list revealed Resident #16 was diagnosed with bipolar disorder 05/02/2019, and anxiety disorder 05/02/2019. An interview with the MDS nurse was conducted on 03/15/2022 at 3:47 PM. The nurse stated she was responsible for coding the resident's MDS and the annual MDS was coded as no when it asked if Resident #16 was considered for a PASRR Level II, and it should have been checked, "Yes". The nurse also stated the wrong coding was due to human error. An interview with the Administrator was conducted on 03/15/2022 at 3:52 PM. The Administrator stated the MDS nurse is responsible for coding the screening for the	F 641	correcting MDS assessment for assessment reference date of 01/09/22. Coding of question A1500 (Level II PASARR) was corrected to accurately reflect that resident was considered to be a Level II PASARR according to their most recent review by reviewer from North Carolina PASARR authority. Correction was completed by MDS Coordinator on 3/17/22. Corrected MDS was re-submitted and accepted into state database on 03/18/22 in MDS Batch #1276. For resident #19 a corrective action was obtained on 03/15/22 by modifying and correcting MDS assessment for assessment reference date of 06/06/21. Coding of question A1500 (Level II PASARR) was corrected to accurately reflect that resident was considered to be a Level II PASARR according to their most recent review by reviewer from North Carolina PASARR authority. Correction was completed MDS Coordinator on 03/15/22. Corrected MDS was re-submitted and accepted into state database on 03/16/22 in MDS Batch #1275. For resident #29 a corrective action was obtained on 03/15/22 by modifying and correcting MDS assessment for assessment reference date of 11/08/21. Coding of question A1500 (Level II PASARR) was corrected to accurately reflect that resident was considered to be a Level II PASARR according to their most recent review by reviewer from North Carolina PASARR authority. Correction was completed by MDS Coordinator on	

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F 641	Continued From page 13 PASRR's and they are expected to be coded accurately. 2. Resident #19 was initially admitted to the facility on 5/30/2018 with the last readmission on 1/5/2022. Her diagnoses included vascular dementia, bipolar disorder, and anxiety. The North Carolina Department of Health and Human Services PASRR level II determination notification dated 4/23/20 revealed a Level II PASRR for Resident #19. Nursing facility placement was appropriate. The most recent comprehensive Minimum Data Set (MDS) assessment dated 6/6/21 indicated Resident #19 did not currently have a Level II PASRR. An interview was conducted on 03/16/22 at 08:50 AM with the MDS Nurse. She indicated it was an error and Resident # 19's MDS should have been coded as having a Level II PSARR screening since a Level II PSARR had been submitted to the state agency and received back. An interview was conducted on 03/16/22 at 09:44 AM with the facility Administrator. The Administrator stated the annual MDS should have been coded to indicated Resident #19 had a Level II PSARR. 3. Resident #29 was initially admitted to the facility on 11/17/2014 with the last readmission on 6/26/2020. His diagnoses included unspecified dementia with behavioral disturbance, adjustment disorder with depressed mood, unspecified mood affective disorder, impulse disorder, and major depressive disorder.	F 641	03/15/22. Corrected MDS was re-submitted and accepted into state database on 03/16/22 in MDS Batch #1275. For resident #23 a corrective action was obtained on 03/16/22 by modifying and correcting MDS assessment for assessment reference date of 10/01/21. Coding of Personal Hygiene in Section G was corrected to accurately reflect that resident did require full/total staff assistance for this task during the specified lookback timeframe. Correction was completed by MDS Coordinator on 03/16/22. Corrected MDS was re-submitted and accepted into state database on 03/18/22 in MDS Batch #1276. 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 all current residents most recently completed Comprehensive Minimum Data Set assessment in order to determine if question A1500-Level II PASARR was accurately coded. This audit was conducted by the facility Administrator on 03/21/22. Audit Results: 33 of 47 residents were accurately coded for question A1500-Level II PASARR. 14 of 47 residents were inaccurately coded for question A1500-Level II PASARR. All residents who were identified to have inaccurate coding of A1500-Level II	

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F 641	Continued From page 14 The North Carolina Department of Health and Human Services PASRR level II determination notification dated 9/2/21 revealed a Level II PASRR for Resident #29. Nursing facility placement was appropriate. The most recent comprehensive Minimum Data Set (MDS) assessment dated 11/8/21 indicated Resident #29 did not currently have a Level II PASRR. An interview was conducted on 03/16/22 at 08:50 AM with the MDS Nurse. She indicated it was an error and Resident # 29's MDS should have been coded as having Level II PSARR screening since a Level II PSARR had been submitted to the state agency and received back. An interview was conducted on 03/16/22 at 09:44 AM with the facility Administrator. The administrator stated the annual MDS should have been coded to indicated Resident #29 had a Level II PSARR. 4. Resident #23 was admitted to the facility on 3/02/20 with most recent readmission on 12/23/21. Her active diagnoses included aphasia, cerebral edema, and convulsions. Review of Resident #23 quarterly minimum data set (MDS) assessment dated 10/01/21 revealed in section G - personal hygiene was coded as total dependence. A review of her most recent MDS assessment dated 1/14/22 revealed in section G - personal hygiene was coded as needing supervision. The care plan dated 1/17/22 had focus area to include having activities of daily living self-care	F 641	PASARR had the affected MDS modified and corrected by the facility MDS Coordinator on 04/05/22. Corrected MDSs were re-submitted and accepted into state database on 04/05/22 in MDS Batch #1280. A 100% audit was completed of all current residents most recently completed OBRA Minimum Data Set assessment (Admission, Quarterly, Annual or Significant Change) in order to determine if question G0110J-Personal Hygiene was accurately coded. This audit was completed by MDS Coordinator on 04/22/22. Audit Results: 45 of 47 residents reviewed were noted with accurate coding of question G0110J-Personal Hygiene. 2 of 47 residents reviewed were identified as having inaccurate coding of question G0110J-Personal Hygiene. All residents identified with inaccurate coding of G0110J had a modification of the affected assessment and the coding was corrected. Modification and corrections completed by MDS Coordinator on 04/05/22. Corrected MDS was re-submitted on 04/05/22 in MDS Batch #1280. Systemic Changes On 04/05/22, the Regional Minimum Data Set Nurse Consultant completed an in-service training for the facility Minimum Data Set Coordinator that included the importance of thoroughly reviewing the medical record during the assessment	

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F 641	Continued From page 15 performance deficit related to encephalopathy. Interventions included tasks to assist with total dependence for dressing and requiring staff assistance with grooming and personal hygiene. During an interview on 3/14/22 at 4:00 PM Nurse Aide #1 stated that Resident #23 required total dependence with personal hygiene and with one-person physical assist. She further stated Resident #23 had always been total dependent to her knowledge. An interview was conducted on 3/16/22 at 3:05 PM with the MDS Nurse. She stated she was responsible for coding Resident #23 activities of daily living. She continued and stated Resident #23 should not have been coded as supervision. An interview was conducted on 3/18/22 at 8:13 AM with the Administrator. She explained Resident #23 coding for the quarterly MDS dated 1/14/22 was coded incorrectly. She also stated Minimum Data Set assessments should be entered correctly on each assessment.	F 641	process and before coding the MDS assessment. Special emphasis was highlighted on: " Question A1500-Level II PASARR coding. When completing a comprehensive Minimum Data Set assessment for a resident, it is very important that the assessor complete a thorough review of the resident□s medical record in order to be able to accurately code the assessment. In order to code question A1500-Level II PASARR correctly, the resident□s most recent Level I PASRR form must be reviewed to determine whether a Level II PASRR was required. The assessor must also be sure to review the PASRR report provided by the State if Level II screening was required in order to find out if there are special recommendations that have been made pertaining to the resident□s care. When completion A1500 on the assessment, Code 0, no: and skip to A1550, Conditions Related to ID/DD Status, if any of the following apply: □ PASRR Level I screening did not result in a referral for Level II screening, or □ Level II screening determined that the resident does not have a serious MI and/or ID/DD or related conditions, or □ PASRR screening is not required because the resident was admitted from a hospital after requiring acute inpatient care, is receiving services for the condition for which he or she received care in the hospital, and the attending physician has certified before admission that the resident is likely to require less than 30 days of nursing home care. Code 1, yes: if	

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F 641	Continued From page 16	F 641	PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. " Question G0110J-Personal Hygiene: Personal hygiene: how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers). In order to be able to accurately code a resident□s functional level of Personal Hygiene in Section G, the assessor must review the documentation in the medical record for the 7-day look-back period. They must also talk with direct care staff from each shift that has cared for the resident to learn what the resident does for themselves during each episode of each ADL activity definition as well as the type and level of staff assistance provided. Remind staff that the focus is on the 7-day lookback period only. Consider all episodes of the activity that occur over a 24-hour period during each day of the 7-day look-back period, as a resident□s ADL self-performance and the support required may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations to occur, including but not limited to, mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and	

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F 641	Continued From page 17	F 641		

medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident□s ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well). 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 the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.
The Director of Nursing or designee will begin auditing the most recently completed comprehensive Minimum Data Set assessment in order to determine coding accuracy of MDS items: A1500-Level II PASARR and G0110J-Personal Hygiene using the quality assurance audit tool entitled Accurate Minimum Data Set Coding Audit Tool-Level II PASARR and Section G Personal Hygiene.
"This audit 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

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F 641	Continued From page 18	F 641	Information Manager, Dietary Manager and the Activity Director. Date of Compliance: 04/08/22	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to obtain a Preadmission Screening and Resident Review (PASRR) Level II for a resident with an active diagnosis of a serious mental illness for 1 of 4 residents reviewed for PASRR. (Resident #4) The findings included: The North Carolina Department of Health and	F 644	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	4/8/22

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F 644	Continued From page 19 Human Services PASRR screening tool dated 03/14/2022 at 2:32 PM revealed a PASRR Level II screening was completed for Resident #4. Resident #4 was admitted to the facility on 09/17/2020 with diagnosis including essential (primary) hypertension. The quarterly Minimum Data Set (MDS) dated 12/18/21 had Resident #4 coded as cognitively intact and needing total dependence on staff with activities of daily living (ADL). The MDS was also coded for an anxiety disorder and schizophrenia and used an antipsychotic and an antidepressant for 7 days of the 7-day look back period. The annual MDS dated 07/22/2021 had Resident #4 coded as, "No" for having been considered by the state PASRR Level II process to have serious mental illness and/or intellectual disability or a related condition. The comprehensive care plan dated 01/17/2022 had focus' of have episodes of displaying the following inappropriate behaviors: cursing, yelling at staff, potential to demonstrate verbally abusive behaviors related to (r/t) ineffective coping skills, mental/emotional illness, poor impulse control. The diagnosis list revealed a diagnosis of anxiety disorder 09/17/2020 and schizophrenia 05/11/2021. An interview with the Social Worker (SW) was conducted on 03/15/2022 at 3:49 PM. The SW stated she was familiar with the resident. He was submitted for a PASRR level II on 03/14/2022. He had a new diagnosis in May, and it should have been submitted then. The SW also stated she had been going through the charts in August to get PASRR screening up to date and will continue to update all residents.	F 644	deficiencies cited have been or will be corrected by the date or dates indicated. F644 Coordination of PASARR and Assessments Corrective actions for Resident #4 Specific deficiency for Resident #4 was resolved on 03/14/22 by the facility Social Services Director who submitted a request for review via NCMUST. 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 all current residents who have a diagnosis of a severe mental illness or intellectual disability was completed in order to determine if the following items: " The State Mental Health Authority was notified and a new resident review request was sent through the NCMUST system for any resident who: " Received a new diagnosis of Severe Mental Illness or Intellectual Disability/Mental Retardation. " Who has a diagnosis of Severe Mental Illness and/or Intellectual Disability/Mental Retardation and has had a significant change in condition, onset or worsening behavioral symptoms, newly initiated psychotropic medication(s) and/or significant change in condition Minimum Data Set assessment. Any resident who is identified as having one of the above conditions and has not	

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F 644	Continued From page 20 An interview with the Administrator was conducted on 03/16/2022 at 11:34 AM. The Administrator stated she was new to PASRR's, but she and the social worker was working on the PASRR screening. The Administrator also stated residents with a new mental health diagnosis should have a PASRR Level II screening.	F 644	had a new request for PASRR review sent to the State Mental Health Authority via NCMUST will have this completed immediately. This audit was completed by the facility Social Services Director and was completed on 04/04/22. Audit results are: " 31 of 47 residents reviewed were noted to have had new diagnosis of severe mental illness or intellectual disability/mental retardation and are a Level II PASARR. All residents who were identified as having a new diagnosis of Severe Mental Illness and/or Intellectual Disability/Mental Retardation, new onset or worsening of behaviors, newly initiated psychotropic medication(s), significant change in condition and/or significant change Minimum Data Set assessment completed and DID NOT have evidence of having been referred to state mental health authority for a new PASARR screening had new request for PASARR level review sent via NCMUST. This was completed by the facility Social Services Director on 04/04/22. Systemic Changes All residents who receive a diagnosis of a Serious Mental Illness or Intellectual Disabilities/Mental Retardation have the potential to be impacted. On 04/05/22, the Regional Minimum Data Set Consultant completed an in-service training for the facility Social Services Director and Minimum Data Set Nurse that included the importance of thoroughly reviewing each resident□s medical record	

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F 644	Continued From page 21	F 644	in order to identify whether or not the resident has a diagnosis of a severe mental illness or intellectual disability/mental retardation. The education also included the importance of ensuring that the state mental health authority is notified in order to request a new review of PASARR level via NCMUST of all residents who have newly received these diagnoses and/or if these residents have a significant change in status. A status change is defined by the presence of newly emerging or changing conditions or needs. These should always be reported to NC Medicaid PASRR department by submitting a Level I screen and may occur in one of three ways: 1. If the individual's physical status changes significantly, such that his/her Intellectual or Developmental Disabilities needs are more likely to respond to treatment, the facility should report such changes to NC Medicaid for an screening of need for further assessment (Level II) 2. If a serious mental illness or Intellectual or Developmental Disabilities/ related condition was not discovered at the preadmission screen, and that condition later emerged or was discovered, the facility should report those symptoms, diagnoses, etc., to the NC Medicaid PASRR department to assess for further screening needs. The facility should monitor data on the MDS to identify any issues which might be positive indicators of a mental disability 3. If an individual has been previously screened for the PASRR population, begins to exhibit increased symptoms or	

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F 644	Continued From page 22	F 644	behavioral problems, these should be reported to NC Medicaid to assess for further screening needs. This information has been integrated into the standard orientation training for new Social Services Directors and 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. The Administrator or designee will begin auditing residents who have a diagnoses of a severe mental illness and/or intellectual disabilities/mental retardation to ensure that state mental health authority is notified via NCMUST system anytime that they have a significant change in status or are newly diagnosed with above diagnoses, using the quality assurance survey tool entitled PASARR Screening 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	

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	345367	A. BUILDING _____ B. WING _____	C 03/18/2022

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F 644	Continued From page 23	F 644	Information Manager, Dietary Manager and the Activity Director. Date of Compliance: 04/08/22	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and physician interviews, the facility failed to administer oxygen at the prescribed rate for 1 of 1 resident (Resident #34) reviewed for respiratory care. The findings included: Resident #34 was admitted to the facility on 12/18/21 with diagnoses that included chronic obstructive pulmonary disease (COPD), chronic respiratory failure and heart failure. Physician order dated 1/3/22 indicated administer oxygen at 2 liters/minute via nasal cannula continuously. The most recent Minimum Data Set (MDS) assessment dated 1/25/22 indicated Resident #34 was moderately impaired and received	F 695	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. F695 Corrective Action for Affected Residents For resident #10 a corrective action was obtained on 03/15/22 by adjusting oxygen flow to the prescribed rate. The corrective action was completed by the MDS	4/8/22

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F 695	Continued From page 24 oxygen therapy. Diagnoses included heart failure and respiratory failure. Resident #34's care plan revised 2/8/22 indicated focus areas of chronic heart failure, shortness of breath and continuous oxygen therapy. Interventions included administer oxygen per physician orders. Observation on 03/14/22 at 12:50 PM revealed Resident #34's oxygen regulator on the concentrator was set at 3.5 liters/minute when viewed horizontally at eye level. Observation on 03/15/22 at 9:36 AM revealed Resident #34's oxygen regulator on the concentrator was set at 3.5 liters/minute when viewed horizontally at eye level. Observation on 03/15/22 at 3:00 PM revealed Resident #34's oxygen regulator on the concentrator was set at 3.5 liters/minute when viewed horizontally at eye level. During an interview on 03/15/22 3:02 PM with Medication Aide #1, she stated Resident #34 had a physician order for oxygen at 2 liters/minute via nasal cannula continuously. Resident #34's oxygen regulator was verified with Medication Aide #1 to be set at 3.5 liters/minute. Medication Aide #1 stated she had not adjusted the oxygen levels during her shift and probably the night shift nurse had adjusted the settings. During an interview on 3/15/22 at 3:08 PM with Medication Aide #2, she revealed she had cared for Resident #34 on 3/14/21 night shift. Medication Aide #2 indicated she had noticed Resident #34's oxygen regulator was set at 3.5	F 695	Coordinator. Corrective Action for Potentially Affected Residents All residents have the potential to be affected by this alleged deficient practice. On 03/16/22, the MDS Coordinator audited all residents receiving oxygen therapy to ensure the oxygen currently administrated was set at the prescribed rate. This was completed on 03/16/22. Audit Results: 9 of 9 residents were receiving oxygen at the prescribed rate. Systemic Changes On 03/15/22, the Director of Nursing began in-servicing all current Licenses Nurses. This in-service included the following topics: Oxygen Administration Procedure The Director of Nursing will ensure that any Licensed Nurse who has not received this training by 04/08/22 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all Licensed Nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing or designee will monitor this issue using the Quality Assurance Tool for Monitoring Respiratory Care. The monitoring will include reviewing residents currently receiving oxygen therapy to ensure oxygen is administered at the prescribed rate. This	

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F 695	Continued From page 25 liters/minute during her shift but forgot to adjust the setting to the ordered flow rate. She verbalized Resident #34 had a physician order for oxygen at 2 liters/minute via nasal cannula continuously. An interview was conducted 03/15/22 3:15 PM with the Director of nursing (DON). He stated Resident #34 had a physician order for oxygen at 2 liters/minute via nasal cannula continuously and he expected nursing staff to administer oxygen per physician orders. He further stated nurses were to call the physician if they needed to titrate the oxygen rate. During an interview on 03/15/22 at 3:32 PM with the facility Administrator, she indicated Medication Aide #1 should have ensured Resident #34's oxygen regulator was set at the physician ordered rate. The Administrator explained she expected nursing staff to follow physician orders and to request an updated order if there was a need to titrate the oxygen. An interview was conducted on 03/16/22 at 2:49 PM with the facility Physician. He stated he expected nursing staff to follow physician orders as given.	F 695	will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 04/08/22	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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.	F 761		4/8/22

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F 761	Continued From page 26 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of 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 observation and staff interviews, the facility failed to secure 1 of 2 medication carts (unit 1 medication cart) when left unattended in the hallway. The findings included: A continuous observation of an unattended medication cart on the Unit 1 hall was made on 3/16/22 from 8:27 AM to 8:30 AM. The medication cart was noted to be unlocked with the push in lock in the out position. The medication cart was outside room 18 and was not visible to Nurse #1 when she was in room 20. Other residents, staff and visitors were present in the hallway. The medication cart was verified to be unlocked with Nurse #1 at 8:30 AM. During an interview on 3/16/22 at 8:30 AM with	F 761	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. F761 Corrective Action for Affected Residents For Unit #1 medication cart corrective action was obtained on 03/16/22 by educating nurse #1 immediately on	

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F 761	Continued From page 27 Nurse #1, she indicated she had left the medication cart unlocked in the hallway while she went into room 20 to administer medications. Nurse #1 explained she should have locked the medication cart when she walked away from the cart. An interview was conducted on 3/16/22 at 9:35 AM with the Director of Nursing (DON). He indicated Nurse #1 should not have left the medication cart unlocked while unattended. He stated nurses were responsible for securing the contents of the carts they were assigned. During an interview on 3/16/22 at 9:40 AM with the facility Administrator, she indicated Nurse #1 should not have left the medication cart unlocked and unattended.	F 761	ensuring all drugs and biologicals are stored and secured in locked cart when unattended. This corrective action was completed by the Administrator. Corrective Action for Potentially Affected Residents All residents have the potential to be affected by this alleged deficient practice. On 03/31/22, the Director of Nursing completed random medication observation of nursing staff to observe for any concerns related to proper storage of drugs and biologicals. This was completed on 03/31/22. Audit Results: 1 of 2 concerns identified during observation related to proper storage of drug. Nurse was observed leaving cart unlocked after shift count □ nurse remained in view of the cart during time. The nurse was immediately re-educated by the Director of Nursing on ensuring cart locked at all times when not in use. Systemic Changes On 03/17/22, the Director of Nursing began in-servicing all current employees. This in-service included the following topics: " Proper Storage of Medications The Director of Nursing will ensure that any employee who has not received this training by 04/08/22 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all Licensed Nurses and will be reviewed by the Quality Assurance Process to verify	

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F 761	Continued From page 28	F 761	that the change has been sustained. Quality Assurance The Director of Nursing or designee will monitor this issue using the Quality Assurance Tool for Privacy and Confidentiality. The monitoring will include completing random medication observations to observe for any concerns related to proper storage of drugs and biologicals. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 04/08/22	