

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

PRINTED: 05/23/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345367</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/26/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN YEARS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7348 NORTH WEST STREET</b> <b>FALCON, NC 28342</b>		
(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 000	INITIAL COMMENTS  A complaint investigation survey was conducted from 04/25/2022 through 04/27/2022. Event ID# LYVO11. The following intakes were investigated NC00187886.  1 of the 1 complaint allegation was substantiated resulting in a deficiency.	F 000			
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)  §483.45(f) Medication Errors. The facility must ensure that its-  §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to have a medication error rate of less than 5 percent as evidenced by 3 medication errors out of 26 opportunities, resulting in a medication error rate of 11.5 percent for 2 of 5 residents (Resident #4 and Resident #6) observed during medication pass.  The findings included:  1. On 4/26/2022 at 8:01 A.M., Medication Aide (MA) #1 was observed as she prepared and administered medication to Resident #4. The administered medications included one tablet of acetaminophen 650 milligrams (mg). The medication was obtained from a house stock bottle stored on the medication cart.  A review of Resident #4's Physician Orders	F 759	F759 Free of Medication Rate 5 % or More 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.  Corrective action for resident(s) affected by the alleged deficient practice:  On 04/26/2022 the Director of Nursing	4/28/22	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/09/2022

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 759	<p>Continued From page 1</p> <p>included a current medication order for acetaminophen 650 mg, give 2 tablets by mouth every 12 hours for pain.</p> <p>An interview was conducted on 4/26/2022 at 10:00 A.M. with MA #1. During the interview the stock bottle of acetaminophen was reviewed and compared with Physician Orders. MA #1 confirmed the order stated to give two tablets of acetaminophen and she had administered one tablet of acetaminophen to Resident #4. MA #1 stated the physician usually ordered acetaminophen 650 mg and she thought Resident #4's order was for a total dose of 650 mg.</p> <p>An interview conducted on 4/26/2022 at 10:24 A.M. with the Administrator and the Director of Nursing revealed during the medication administration pass, staff were responsible to follow the five rights of medication administrations to ensure the correct medication, correct dose and correct time were followed during medication administration.</p> <p>An interview conducted on 4/26/2022 at 12:26 P.M. with the Physician revealed staff needed to administer medications as ordered. The Physician stated Resident #4 was not harmed with the omission of one acetaminophen tablet.</p> <p>2. On 4/26/2022 at 8:25 A.M., Nurse #1 was observed as she prepared and administered medication to Resident #6. The administered medications included one capsule of Cranberry 500 mg. The medication was obtained from a house stock bottle stored on the medication cart. Nurse #1 removed bimatoprost 0.01% solution eye drops (used to reduce eye pressure in</p>	F 759	<p>assessed resident #4 and resident #6. Findings were no harm noted to resident #4 or resident #6. On 04/26/2022, resident #4 received appropriate medication per policy during medication administration. On 04/26/2022, resident #6 received order clarification for Cranberry 500 mg daily. On 04/26/2022, resident #6 received the appropriate eye medication. Additionally, the MD was notified of medication error 04/26/2022 by the Director of Nursing. On 04/26/2022, the Director of Nursing reeducated the Nurse #1 and Medication Aide #1 on Medication administration and following physician orders.</p> <p>Corrective action for residents with the potential to be affected by the deficient practice:</p> <p>All resident receiving medications have potential to be affected. On 04/26/2022, the Director of Nursing began Medication Pass Observation/Competencies on 100% of Licensed Nurses and Med aides including Agency staff utilizing the Medication Pass Observation tool provided by McNeill's Pharmacy. All current Licensed Nurses and Med Aides including Agency staff competencies were completed by 4/28/2022.</p> <p>Measures / Systemic changes to prevent reoccurrence of alleged deficient practice:</p> <p>On 04/26/2022 In-service education</p>		

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F 759	<p>Continued From page 2</p> <p>patient's with glaucoma) from the top drawer of the medication cart.</p> <p>A review of Resident #6's Physician Orders included a current medication order for cranberry 200mg capsule, give 2 capsules one time a day and bimatoprost 0.01% solution eye drops, instill 1 drop in each eye at bedtime.</p> <p>An interview was conducted on 4/26/2022 at 10:00 A.M. with Nurse #1. During the interview the stock bottle of cranberry capsules was reviewed and compared with Physician Orders. Nurse #1 confirmed the order stated to give two tablets of Cranberry 200 mg and Nurse #1 administered one tablet of Cranberry 500 mg to Resident #6. During the interview Nurse #1 stated Resident #6 had run out of her prescription cranberry tablets and Nurse #1 substituted the missing medication with house stock one cranberry tablet 500 mg. During the interview Nurse #1 confirmed the bimatoprost 0.01% solution eye drops were administered during the morning medication pass and the physician orders stated the medication was ordered to be given at bedtime.</p> <p>An interview conducted on 4/26/2022 at 10:24 A.M. with the Administrator and the Director of Nursing revealed during the medication administration pass, staff were responsible to follow the five rights of medication administrations to ensure the correct medication, correct dose and correct time were followed during medication administration.</p> <p>An interview conducted on 4/26/2022 at 12:26 P.M. with the Physician revealed staff needed to administer medications and eye drops as</p>	F 759	<p>began by the Director of Nursing and was provided to all full time, part time, and as needed Licensed Nurses, Med Aide's including agency staff. Topics included:</p> <ul style="list-style-type: none"> <li>• Medication administration process</li> <li>• Medications provided as ordered by MD</li> <li>• 6 rights of medication administration</li> </ul> <p>This information has been integrated into the standard orientation training and in the required in-service refresher courses for all new hire Licensed Nurses, Med Aides, and Agency staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Staff that have not received the education by 04/28/2022 will not be allowed to work until it has been completed. The Regional Staff Development Coordinator and Director of Nursing will be responsible for providing this ongoing education.</p> <p>Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements:</p> <p>The Director of Nurses or RN designee will monitor Compliance with the regulatory requirements utilizing Med Pass QA monitoring tool. Monitoring will include observing medication pass following the 6 rights of medication</p>		

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F 759	Continued From page 3 ordered. During the interview the Physician stated there was no harm to Resident #6 with the increase in the cranberry dose and the eye drops being received in the morning instead of at bedtime.	F 759	administration for 2 nurses and/or medication aides of various shifts including weekends. This monitoring will occur 2 x a week for 4 weeks, then monthly x 2 months. The findings will be reported in the weekly Quality assurance (QA) meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.		