		AND HUMAN SERVICES			FC	DRM	APPROVED
		& MEDICAID SERVICES					0938-0391
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		· · · · · · · · · · · · · · · · · · ·		E SURVEY PLETED
		345367	B. WING			01/3	30/2015
NAME OF PROVIDER OR SU	IPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN YEARS NUR		OME			POST OFFICE BOX 40		
				I	FALCON, NC 28342		
PREFIX (EACH DE	FICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	(X5) COMPLETION DATE
SS=D COMPRÉHE	ENSIVE	()(1) DEVELOP CARE PLANS he results of the assessment	F 2	279			2/13/15
to develop, r comprehens		and revise the resident's n of care.					
plan for each objectives an medical, nur	n reside nd time sing, a re iden	evelop a comprehensive care ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive					
to be furnish highest prac psychosocia §483.25; and be required due to the re	ed to a ticable I well-b d any s under § sident luding f	describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided s exercise of rights under the right to refuse treatment).					
by: Based on re interviews, th plan for 1 of urinary cathe failed to dev reviewed for #45). Finding 1. Resident i on 12/22/14. (excessive u Disease. The	ecord re ne facil 2 resid eters (F elop a o signific gs inclu #32 wa Diagn rination e entry	NT is not met as evidenced eview, observation and staff ity failed to develop a care ents reviewed for indwelling Resident #32). The facility also care plan for 1 of 2 residents cant weight loss (Resident ided: s admitted into the on facility oses included Polyuria n) and Chronic Kidney Minimum Data Set completed indicate an indwelling urinary			The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa 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 facilityKs allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated	al n	
		ER/SUPPLIER REPRESENTATIVE'S SIGN			TITLE		(X6) DATE

Electronically Signed

(X6) DATE

02/13/2015

PRINTED: 03/03/2015

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.

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	· · /	E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	СОМ	COMPLETED	
		345367	B. WING		01/3	30/2015	
NAME OF F	IAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
GOLDEN	I YEARS NURSING H	OME		POST OFFICE BOX 40 FALCON, NC 28342			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETIO DATE	
F 279	Continued From pa catheter.	ige 1	F 2	79			
	"3/4/15" did not refl indwelling urinary c On 1/29/15 at 2:00 Resident #32 had a with yellow urine in On 1/29/15 at 2:50 stated she was res plans were complet further indicated wh the facility the resid she missed the indi- did not know the re catheter since adm On 1/29/15 at 2:59 Director of Nursing to be a care plan for urinary catheter. On 1/30/15 at 7:45 (Nursing Assistant) catheter was obser	pm, during an observation, an indwelling urinary catheter the drainage bag. pm, in an interview, Nurse #1 ponsible for ensuring care ted for the residents. Nurse #1 nen a resident is admitted into lent is discussed; however, welling urinary catheter and sident had an indwelling		 F279 For the residents involved, co action has been accomplished 1. Resident #32: Catheter was removed. 2. Resident #45: Actual Weight loss was adde residentK's Comprehensive C Corrective action has been ad on all residents with the poter affected by the alleged deficien by: All residents were potentially this alleged deficient practice February 13, 2015, all residen Comprehensive Care Plans w reviewed for accuracy of Catt Weight Loss. Any changes in were made at that time. 	d by: d to the Care Plan ccomplished ntial to be ent practice affected by . By nt vere neters and		
	2. Resident #45 was readmitted to the facility on 12/13/12. His diagnoses included persistent vegetative state, anoxic brain injury, tracheostomy, chronic respiratory failure, gastrostomy and epilepsy. The most recent Minimum Data Set (MDS) a quarterly review dated 11/20/14 revealed Resident #45 was totally dependent for all			Measures put into place o changes made to ensure that practice does not occur: All RNs, LPNs, Medication Ai Certified Nursing Assistants v in-serviced on ensuring Phys capture a true picture of the r the order checking procedure admissions and readmissions	the deficient des and vere ician orders esident and for new		

Facility ID: 923188

If continuation sheet Page 2 of 10

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COM	COMPLETED	
		345367	B. WING _		01/	30/2015	
AME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE			
GOLDEN	I YEARS NURSING H	ОМЕ		POST OFFICE BOX 40 FALCON, NC 28342			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE	
F 279	Continued From pa	age 2	F 27	79			
	 Continued From page 2 tube feeding with a risk for complications including aspiration and infection. It was initiated on 5/5/13 and revised on 11/19/14. One of the goals listed was to maintain adequate nutritional and hydration as evidenced by stable weight. A new focus/care plan problem was initiated on 1/20/15 which revealed he required tube feeding to assist in maintaining or improving nutritional status. There was no focus related to preventing or correcting weight loss. A medical record review revealed Resident #45's current weight dated 1/19/15 was listed as 109 pounds (lbs.). His weight on 12/01/14 was 125 lbs. which represented a 16 lb. weight loss or a 12.8% weight loss. An interview was conducted with the Dietary Manager on 1/29/15 at 2:55 PM. She stated Resident #45 was discussed in the daily Quality of Life (QOL), a daily meeting during which resident concerns are discussed. She stated she emailed the Registered Dietitian (RD) and 			Corporate MDS Consultant 13, 2015. This in-service in re-education on items to be Comprehensive Care Plans versus actual problems and assessment needed to accur complete the residentK's Cor Care Plan. The Daily Quali Committee will review all ne readmitted residents the first after admission. They will p assess that patient to ensur devices are accounted for t and that the Comprehensive an accurate reflection of the assessment will be recorde Quality of Life Quality Assur Worksheet for Admissions/I	cluded included on a, potential resident urately omprehensive ty of Life ew and at business day ohysically re that all hrough orders e Care Plan is e resident. This d on the Daily rance		
	Dietary Manager st was added to see i A telephone intervie on 1/29/15 at 3:05 completed a nutritio 2014 which reveale kilocalories per kilo only 30-31 kcal/kg per day. The RD ad the feeding formula Glucerna 1.5, 1 car 1.2 at the same rat provided 1838 kcal kcals/kg. She then	ew was conducted with the RD PM. She stated she on assessment in September ed Resident #45 was getting 38 gram (kcals/kg) but needed which was equal to 1800kcals dded that in September 2014 a was decreased from n every 4 hours to Glucerna e. She stated the new formula s per day which was 31 stated the resident had a oticed in November 2014 so		The facility has implemented assurance monitor: The Care Plan Quality Assu- will be completed monthly be of Nursing and reported to the Quality of Life Committee and Quality of Life Meeting initian month. For any month that reveals less that 100% commonitor will be extended and month and corrective action implemented as deemed need the Monthly Quality of Life Commonitor will be as of Februa	rance Monitor by the Director he Monthly t the Monthly lly for three the monitor pliance, the additional will be ecessary by Committee.		

Facility ID: 923188

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		345367			01/30/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/30/2013
GOLDEN	YEARS NURSING H	OME		POST OFFICE BOX 40 FALCON, NC 28342	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 279 F 315 SS=D	 ² 279 Continued From page 3 1.5. On 1/29/15 at 3:40 PM Nurse #3 stated Resident #45 received Glucerna 1.5 every 4 hours for total of 6 cans per day. On 1/30/15 at 8:35 AM, during an interview, the MDS nurse, who was also responsible for developing care plans, stated she attended the daily QOL meetings and that Resident #45 was discussed numerous times and his weight loss was discussed. She stated the weight loss was not in the care plan and that she was not aware the concern needed to be put in the care plan. On 1/30/15 at 9:37 AM the Administrated stated Resident #45's weight loss had been discussed in the QOL meeting and she expected it to be included on the resident's care plan. F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a 		F 27		2/13/15
	indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servi	the facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder e.			
	by: Based on record re interviews, the facili urinary catheters fo	NT is not met as evidenced eview, observations and staff ity failed to secure indwelling r 2 of 2 residents reviewed for esident #32, #37). Findings		The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies.	do

Facility ID: 923188

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	-	AND HUMAN SERVICES					APPROVEI 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		345367	B. WING			01/3	30/2015
NAME OF I	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOLDEN	GOLDEN YEARS NURSING HOME				OST OFFICE BOX 40 ALCON, NC 28342		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 315 Continued From page 4 1. Resident #32 was admitted into the facility on 12/22/14. Diagnoses included Chronic Kidney Disease and Polyuria (excessive urination). The entry Minimum Data Set completed on 12/22/14 did not indicate an indwelling urinary catheter. On 1/29/15 at 2:59 pm, in an interview, the Director of Nursing indicated she expected indwelling urinary catheters to be secured, unless otherwise specified on the resident's care plan. On 1/30/15 at 7:45 am, in an observation, accompanied by NA (Nursing Assistant) #1, Resident #32's urinary catheter was observed unsecured and positioned underneath the resident's right leg with tension. NA#1 indicated she had never seen the resident urinary catheter secured. On 1/30/15 at 8:24 am, in an interview, Nurse #2 stated she does not secure the resident's urinary catheter because the resident probably would not allow her to. Nurse #2 did not indicate if she had discussed this matter with the resident. On 1/30/15 at 8:38 am, in an interview, the Director of Nursing stated "Nurses and NAs should be checking to ensure urinary catheters are secured." 2. Resident #37 was admitted into the facility on 8/27/14. Diagnoses included Chronic Kidney Disease and History of Urinary Tract Infection. The quarterly Minimum Data Set completed on 12/19/14 did not indicate an indwelling urinary catheter.		F 3	15	To remain in compliance with all fer and state regulations, the facility has taken or will take the actions set fo this plan of correction. The plan of correction constitutes the facilityKs allegation of compliance such that alleged deficiencies cited have bee will be corrected by the dates indica F315 For the residents involved, correcti action has been accomplished by: 1. Resident #32: Catheter was removed. 2. Resident #37: Catheter securing device was place patient agreed. Resident refuses of securing device as times was adde Comprehensive Care Plan. The resident was educated on the purpose/impo of catheter being secured at the tim the device was applied.	ed as catheter ed to sident ortance	
					Corrective action has been accomp on all residents with the potential to affected by the alleged deficient pra- by: All residents were potentially affect this alleged deficient practice. By February 13, 2015, residents with catheters were assessed for Cather Securing Device compliance and c explanation on the Comprehensive Plan. Any changes indicated were at that time.	ed by eter orrect care	

Facility ID: 923188

If continuation sheet Page 5 of 10

	-	AND HUMAN SERVICES			PRINTED: 03/0 FORM APP OMB NO. 093	ROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345367	B. WING		01/30/2	015
	NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP COE POST OFFICE BOX 40 FALCON, NC 28342		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI	HOULD BE CON	(X5) /IPLETION DATE
F 315	3/11/15 directed "Le No rejection of care On 1/30/15 at 7:50 accompanied by N/ Resident 37's urina secured and positic leg. On 1/30/15 at 8:24 stated she does no catheter because th allow her to. Nurse discussed this matt On 1/30/15 at 8:38 Director of Nursing should be checking are secured. If a re catheter secured, I	eg band to secure catheter."	F 3	 Measures put into place or changes made to ensure that practice does not occur: All RNs, LPNs, Medication Aid Certified Nursing Assistants win-serviced on utilizing a cathed device and notifying Nurse an Coordinator in the event of ref self-removal. The Daily Qua Committee will review all new readmitted residents the first thafter admission. They will phy assess that patient to ensure a devices are accounted for through and application and that the Comprehensive Care Plan is a reflection of the resident. This assessment will be recorded of Quality of Life Quality Assurar Worksheet for Admissions/Reflection generations. The Quality Assurance Monitor: The facility has implemented assurance monitor: The Quality Assurance Monitor Securing the Catheter will be condinated to the Monthly Qualit Committee at the Monthly Qualit 00% compliance, the monito extended an additional month corrective action will be implemented and that the monitor reveals 100% compliance, the monito extended an additional month corrective action will be implemented and that the monitor reveals 100% compliance, the monito extended an additional month corrective action will be implemented and the monitor reveals 100% compliance, the monito extended an additional month corrective action will be implemented and the committee. 	the deficient les and ere eter securing d MDS usal or lity of Life and ousiness day vsically that all ough orders an accurate on the Daily ice admission. a quality or for completed tor and y of Life ality of Life ths. For any s less than r will be and mented as	

Facility ID: 923188

If continuation sheet Page 6 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FOR	PRINTED: 03/03/2015 FORM APPROVED OMB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY		
		345367	B. WING		0 [,]	/30/2015		
NAME OF F	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	YEARS NURSING H	ОМЕ			OST OFFICE BOX 40 ALCON, NC 28342			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 315	Continued From pa	ige 6	F 3	15				
F 520 SS=D	483.75(0)(1) QAA COMMITTEE-MEN QUARTERLY/PLAN		F 5	20	In compliance as of February 13, 2015	2/13/15		
	assurance committ nursing services; a	tain a quality assessment and ee consisting of the director of physician designated by the 3 other members of the						
	committee meets a issues with respect and assurance acti develops and imple	ment and assurance t least quarterly to identify to which quality assessment vities are necessary; and ements appropriate plans of entified quality deficiencies.						
	disclosure of the re except insofar as s	retary may not require cords of such committee uch disclosure is related to the committee with the s section.						
		s by the committee to identify deficiencies will not be used as is.						
	by: Based on record re facility's Quality Ass Committee failed to procedures and mo	NT is not met as evidenced eview and staff interviews, the sessment and Assurance o maintain implemented onitor these interventions that ace December 2013. This was			The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.			

Facility ID: 923188

If continuation sheet Page 7 of 10

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU	TIPLE CONSTRUCTION	OMB NO.	E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		ING	· · ·	PLETED
		345367	B. WING			30/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
GOLDEN	I YEARS NURSING H	ОМЕ		POST OFFICE BOX 40 FALCON, NC 28342		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 520	Continued From pa	ige 7	F 5	20		
	for one federal deficited on in Decemb survey and recited survey of January 3 recited in the area of (Comprehensive Ca failure of the facility of record show the effective Quality As include: This tag is cross re F 279 - D: Compre- the recertification s facility was cited: B review and staff into develop a care plan residents reviewed #28). The facility al plan for 1 of 3 resid urinary drainage de The facility on January	ciency which was originally ber 2013 on a recertification on a current recertification 30, 2015. The deficiency was of Resident Assessment are Plans). The continued of during a recertification survey facility's inability to sustain an surance program. Findings ferenced to: whensive Care Plans - During urvey of December 2013 the ased on observations, record erviews, the facility failed to a for pressure ulcers for 1 of 3 for pressure ulcers (Resident so failed to develop a care lents reviewed for indwelling evices (Resident #64). ary 30, 2015 during a		 To remain in compliance wi and state regulations, the fa taken or will take the action this plan of correction. The correction constitutes the fa allegation of compliance su alleged deficiencies cited ha will be corrected by the date F520 For the residents involved, action has been accomplish 1. Resident #32: Catheter was removed. 2. Resident #45: Actual Weight loss was add residentKs Comprehensive 	acility has s set forth in plan of icilityKs ch that all ave been or es indicated. corrective hed by:	
	recertification surve failure to develop a reviewed for indwel (Resident #32) and for 1 of 2 residents loss (Resident #45) CMS-2567 (statem investigative details December 12, 2013 survey. On 1/29/15 at 2:50 stated she was resi plans were complet further indicated wh the facility the resid she missed the induced	ey was recited for F 279 for care plan for 1 of 2 residents ling urinary catheters failure to develop a care plan reviewed for significant weight) - see F 279 per the ent of deficiency) for s, F 279 was originally cited 3 during a recertification pm, in an interview, Nurse #1 ponsible for ensuring care ted for the residents. Nurse #1 nen a resident is admitted into lent is discussed; however, welling urinary catheter for did not know the resident had		Corrective action has been on all residents with the pot affected by the alleged defic by: All residents were potential this alleged deficient practic February 13, 2015, all resid Comprehensive Care Plans reviewed for accuracy of Co Care Plans regarding Weig Catheters, Catheter Securit Wounds.	ential to be cient practice ly affected by ce. By ent were omprehensive ht Loss and	

Facility ID: 923188

If continuation sheet Page 8 of 10

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE CONSTRUCTION	OMB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED
		345367	B. WING		01/3	30/2015
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP (CODE	
GOLDEN	I YEARS NURSING H	OME		POST OFFICE BOX 40 FALCON, NC 28342		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 520	Continued From pa	ge 8	F 5	320		
	indicated she exped	rector of Nursing (DON) cted there to be a care plan for dwelling urinary catheter. She		changes made to ensure the practice does not occur:	nat the deficient	
	also added that Nur On 1/30/15 at 8:35 Nurse #1, stated sh (QOL) meeting and discussed numerou was discussed. Sh not in the care plan the concern needed On 1/30/15 at 9:37 Administrator stated had been discussed expected it to be im- plan. On 1/30/15 at 10:29 administrator, acco administrator, acco administrator ackno Assurance Assess monthly and further a QAAC in place th required quality ass activities. No prior of	AM, during an interview, ne attended the Quality of Life I that Resident #45 was us times and his weight loss the stated the weight loss was and that she was not aware d to be put on the care plan. AM, in an interview, the d Resident #45's weight loss d in the QOL meeting and she cluded on the resident's care 5 am, in an interview, the mpanied by the DON; the pwledged the Quality ment Committee (QAAC) met acknowledged the facility had at identified issues that sessment and assurance or current quality assurance of related to failure to care plan		The MDS Coordinator was the Corporate MDS Consul February 13, 2015. This in included re-education on ite included on Comprehensive potential versus actual prot resident assessment neede complete the residentKs Ce Care Plan. The Daily Quality Committee will review all ne readmitted residents the fir after admission. They will p assess that patient to ensu devices are accounted for t and application and that the Comprehensive Care Plan reflection of the resident. T assessment will be recorde Quality of Life Quality Assu Worksheet for Admissions/	Itant on -service ems to be e Care Plans, olems and ed to accurately omprehensive y of Life ew and st business day physically re that all through orders e is an accurate his ed on the Daily rance	
	indwelling urinary c	atheters was provided.		The facility has implement assurance monitor: The Quality Assurance Mor Securing the Catheter, the Weight Quality Assurance I Care Plan Quality Assurance be completed monthly by th Coordinator and/or DON ar the Monthly Quality of Life	nitor for Care Plan Monitor and the ce Monitor will ne MDS nd reported to	

Facility ID: 923188

If continuation sheet Page 9 of 10

		AND HUMAN SERVICES				FORM	03/03/2015 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVE COMPLETED	
		345367	B. WING			01/:	30/2015
NAME OF	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	YEARS NURSING H	ОМЕ			OST OFFICE BOX 40 ALCON, NC 28342		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From pa		F 5		used to complete the Comprehensic Care Plan Quality Assurance Monit will be reported quarterly at the Qua Quality of Life Committee Meeting. Comprehensive Care Plan Quality Assurance Monitor will be reviewed Quarterly Quality of Life Committee including the Medical Director and b y signature. For any quarter that a monitor reveals less than 100% compliance, the monitor will be extra an additional quarter and corrective will be implemented as deemed necessary by the Quarterly Quality Team. In compliance as of February 13, 2	or and arterly The I by the verified the ended e action of Life 015	Page 10 of 10

Facility ID: 923188

If continuation sheet Page 10 of 10