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	345367	A. BUILDING ______ B. WING ______	05/18/2018

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
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		6/15/18

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

Electronically Signed — 06/08/2018

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 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, resident interviews, and staff interviews the facility failed to ask permission from the resident and RP's to post information about the resident care needs in the resident's rooms for 7 of 20 sampled residents. (#12, #19, #20, #30, #35, #40, #41) Findings included: (1) A-Review of the quarterly Minimum Data Set dated 4/27/18, Resident #41 was admitted on 2/12/15 with diagnoses of multiple sclerosis, muscle weakness, overactive bladder, and convulsions was coded as severely cognitively impaired with extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene. Review of the current medical record revealed no consents and/or nursing notes asking permission for displaying posted signs for care. An observation on 05/16/18 at 11:58 AM revealed an 8 by 11 ½ inch white piece of paper with black typed letters posted at the head of Resident #41's bed. The sign stated, "swallow strategies ... sip for nectar liquids one at a time. Not multiple sips. Alternate liquid and solid make sure he has swallowed before giving another." During an interview by phone with the previous interim Director of Nursing (DON) on 05/16/18 at 11:26 AM, the DON stated she did not ask permission to post the signs on the residents' wall regarding his treatment.	F 550	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 550 Plan of Correcting the specific deficeincy and including what processes that lead to deficiency cited The specific deficiency was immediately corrected on 5/16/2018 by removing all posted information in resident rooms. 100% of all resident rooms were assessed by the Director of Nursing, Nurse Consultant and Regional Director of Operations and all posted information identified was removed from all resident rooms on 5/16/2018. The process identified that lead to this area of concern is that the facility staff failed to ask permission from resident and RP to post resident care information in the resident room. NHA and DON begin to	

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F 550	Continued From page 2 During an interview with the current DON on 05/16/18 at 12:09 PM, the DON stated there were no signed consents for any of the signs in residents' rooms. He also stated, he would expect the staff to have had consents from residents or Responsible Parties (RP) for the signage prior to posting the signs. An interview with the Administrator on 05/16/18 at 12:09 PM, revealed her expectation for posted signs was to get consent from residents or Responsible Parties before posting the signs displaying the residents care needs. B-Review of the quarterly Minimum Data Set dated 04/26/18 had Resident #40 admitted on 05/19/15 with diagnoses of emphysema, hemiplegia, hemiparesis, hypertensive heart disease, hyperlipidemia, and major depressive disorder and was coded as cognitively intact with extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene. Review of the current medical record revealed no consents and/or nursing notes asking permission for displaying posted signs for care. An observation on 05/15/18 at 11:57 AM revealed an 8 by 11 ½ inch white piece of paper with typed black letters on the side of resident #40's bed that stated, "I am a daily weight. Please weigh me daily before lunch." During an interview with Resident #40 on 05/15/18 at 3:54 PM, the resident stated he thought the sign had to be there and he was not asked beforehand to have the sign placed there.	F 550	provide education to all staff on 5/16/2018 to ask permission from resident and RP prior to posting any resident care information in resident rooms and documenting consent. Procedure for implementing the acceptable plan of correction for specific deficiency The Director of Nursing and Adminsitrator begin to in-service all staff on the posting of resident care information in the resident rooms. Information Provided on Education included: " Definition of Dignity " Identify key components of dignified/respectful resident care and resident rights " Identify how dignity may be breeched during care and/or with posting of care information in resident rooms " Identify ways in which lack of respect may be conveyed during care. " Importance of not posting resident care information in resident rooms without resident and responsible party consent.This education of all staff will be completed by June 15th 2018. This information has been integrated into the standard orientation training and in the required in-service refresher courses for staff with resident rights and will be reviewed by the Quality Assurance	

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F 550	Continued From page 3 During an interview by phone with the previous interim Director of Nursing (DON) on 05/16/18 at 11:26 AM, the DON stated she did not ask permission to post the signs on the residents' wall regarding his treatment and care. During an interview with the current DON on 05/16/18 at 12:09 PM, the DON stated there were no signed consents for any of the signs in residents' rooms. He also stated, he would expect the staff to have had consents from residents or Responsible Parties (RP) for the signage prior to posting the signs. An interview with the Administrator on 05/16/18 at 12:09 PM, revealed her expectation for posted signs was to get consent from residents or Responsible Parties before posting the signs displaying the residents care needs. (2) C-Review of the quarterly Minimum Data Set dated 02/23/18 has Resident #12 admitted on 05/16/07 with diagnoses of Anemia, Hypertension, Non-Alzheimer's Dementia, and Aphasia and was coded as cognitively impaired with total dependence in bed mobility, transfer, dressing, eating, toilet use and personal hygiene. An observation on 05/15/18 at 10:57 A.M. revealed an 8 by 11 ½ inch white piece of paper with typed black letters at the head of resident #12's bed that stated, "Please keep head of bed at least 30 degrees thank you".	F 550	process to verify that the change has been sustained. Monitoring procedure to ensure the plan of correction is effective and specific deficieny remains corrected and/or in compliance with the regulatory requirements The Department Managers will perform Quality Assurance Rounds 5 days per week, including occassional Saturday and Sundays to ensure compliance that there are no resident care information posted without consent from resident and RP. The quality assurance audit will start on 6/6/2018 This audit will be performed for 4 weeks and then monthly for 2 months. The Administrator will monitor completion of the Quality Assurance Rounds worksheet to ensure regulatory compliance weekly. Any negative findings will immediately be addressed. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager.	

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F 550	Continued From page 4 D -Review of the quarterly Minimum Data Set dated 4/16/18 has Resident #19 admitted on 11/21/08 with diagnoses of Hypertension, Benign Prostatic Hyperplasia, DM, Aphasia and Non-Alzheimer's Dementia coded as cognitively impaired with total dependence with bed mobility, transfer, dressing, eating, and personal hygiene. An observation on 5/16/18 at 10:06 A.M. revealed an 8 by 11 ½ inch white piece of paper with typed black letters posted over Resident #20's bed that stated, " ....splint schedule ...". E-Review of the quarterly Minimum Data Set dated 3/16/18 has Resident #20 admitted on 06/21/07 with diagnoses of Anemia, Hypertension, Seizure Disorder, and Traumatic Brain Injury has resident coded as cognitively impaired with total dependency with transfer, bed mobility, dressing, eating, toilet use, and personal hygiene. An observation on 05/15/18 at 10:58 A.M. revealed three 8 by 11 ½ inch white pieces of paper with typed black letters posted at the head of Resident #20's bed that stated, "please keep head of bed at least 30 degrees thank you", "heels need to be floated at all times while in bed", and "Charlean McDougald's splint schedule". F-Review of the quarterly Minimum Data Set dated 04/25/18 Resident #35 was admitted on 10/03/16 with diagnoses of Anemia, Hypotension, Seizures and Cerebral Palsy coded as cognitively impaired with extensive assistance for bed mobility, transfer, dressing, toilet use and personal hygiene and total dependence with	F 550	Title of person responsible for implementing the acceptable plan of correction The Administrator is responsible for implementation and completion of the acceptable plan of correction. Compliance Date June 15, 2018.	

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F 550	Continued From page 5	F 550		

eating.

An observation on 05/16/18 at 10:06 A.M. revealed an 8 by 11 ½ inch white piece of paper with black typed letters posted at the head of Resident #35's bed. The sign stated, "swallow strategies ... must be alert to take any food liquid sit him straight up.... check mouth after meals". Review of the quarterly Minimum Data Set dated 3/23/18 has Resident #30 admitted on 2/20/18 with Diagnoses of A-Fib, Coronary Artery Disease, and Heart Failure is coded as cognitively intact with extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene

An observation on 05/15/18 at 10:06 A.M. revealed (2) 8 by 11 ½ inch white pieces of paper with typed black letters posted on the wall in Resident #30's side of the room concerning fluid restriction. The signs stated, "resident is on fluid restrictions please see nurse before giving fluids".

During an interview with Resident #30 on 05/15/18 at 10:06 A.M., the resident stated when he returned from the hospital the signs were up and was not asked beforehand to have them placed there. Resident #30 also stated he didn't have any issues with the signs.

G-During an interview by phone with the previous interim Director of Nursing (DON) on 05/16/18 at 11:26 A.M., the DON stated she did not ask permission to post the signs on the resident's wall regarding his/her treatment. Surveyor explained dignity issues were the concern for this phone call.

During an interview with the current DON on

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F 550	Continued From page 6 05/16/18 at 12:09 P.M., the DON stated he would expect the staff would have consent from residents or Responsible Party (RP). During an interview with the Administrator on 05/16/18 at 12:09 P.M., the Administrator stated her expectation for posted signs were to get consent from residents or RP before posting the signs showing the residents care, the Administrator also stated they have started 100% in service on all employees regarding the policy for posting signs.	F 550		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to assess a resident using the quarterly review instrument once every 3 months for 1 of 1 residents sampled for assessments. Resident #21. Findings included: According to the quarterly Minimum Data Set (MDS) dated 03/13/18, Resident #21 was admitted on 02/03/12 coded with diagnoses of Anemia, Hypertension, DM, Quadriplegia, and Seizure Disorder, cognitively impaired, total dependency with bed mobility, transfer, toilet use, personal hygiene, dressing and eating with restraint to limb used daily.	F 638	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.	6/15/18

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F 638 Continued From page 7

Review of the Comprehensive Care Plan dated 04/06/18 showed a focus of hand mitt use due to previously pulling out trach tube unknowingly with increased risk for associated complications/injuries.

During an observation on 05/15/18 at 11:07 A.M., resident #21 in bed eyes closed, even labored breathes, clean neat appearance, covered with a white sheet and right arm resting on top of body with a clean white hand mitt covering right hand. Review of the Device and Bed Rail Review dated 11/07/17 indicated resident #21 had the hand mitt, is the least restrictive and determined to be necessary at the time due to pulling and previously removing trach. This was the only quarterly assessment review for this device that initiated on 11/07/17.

During an interview with the Director of Nursing (DON) on 05/18/18 at 12:14 P.M., the DON stated the Nurse's notes are documented detailing her trying to pull at her trach when her hand is removed from mitt but there is not a quarterly assessment after the initial review. The DON also stated going forward he would assure resident #21 is assessed using the quarterly review instrument every 3 months.

During an interview with the Administrator on 05/18/18 12:14 P.M., the Administrator stated she expects her staff to assess the residents quarterly using the review instrument every 3 months.

F 638

F 638

Plan of correcting the specific deficiency and including what processes that lead to deficiency cited

The specific deficiency was immediately corrected on 5/17/18 by the completion of a Device Assessment by the MDS Support nurse.
The process identified that lead to this area of concern is that the facility process was to complete the Device Assessment every 6 months versus quarterly. This process has been revised to include completing the Device assessments quarterly. NHA and DON begin to provide education to licensed nurses on 5/17/18 to perform Device assessments quarterly.

Procedure for implementing the acceptable plan of correction for specific deficiency

The Director of Nursing and Administrator begin to in-service licensed nurses on completing Device assessments on a quarterly basis on 5/17/18.

Information Provided on Education included:

" Device evaluation forms must be completed on all patients on admission, readmission, every 3 months and with significant changes. A device evaluation form should be completed in Point Click

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F 638	Continued From page 8	F 638	Care to document this review in the medical record. The device evaluations should look at all devices that the patient uses that may meet the definition of a restraint listed above. If the device is considered a restraint then the medical necessity of the device is reviewed. If the device is medically necessary then the interdisciplinary care plan team should review the device to try and reduce or eliminate the use of the restraint. All possible alternatives to any device should be utilized and documented. Care plan and kardex should be updated accordingly. This information has been integrated into the standard orientation training and in the required in-service refresher courses for staff with resident rights and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Monitoring procedure to ensure the plan of correction is effective and specific deficiency remains corrected and/or in compliance with the regulatory requirements The Department Managers will perform Quality Assurance Device assessment Audit to ensure compliance with quarterly	

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F 638	Continued From page 9	F 638	Device assessments. The quality assurance audit will start on 5/21/18.This audit will be performed weekly for 4 weeks and then monthly for 2 months. The Administrator will monitor completion of the Quality Assurance Device Assessment Audit worksheet to ensure regulatory compliance. Any negative findings will immediately be addressed. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Title of person responsible for implementing the acceptable plan of correction The Administrator is responsible for implementation and completion of the acceptable plan of correction. Compliance Date June 15, 2018	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		6/15/18

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F 641	Continued From page 10 §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 Admission Minimum Data Set (MDS) assessment for active diagnoses of depression and anxiety for 1 of 5 sampled residents reviewed for MDS accuracy. (Resident # 25) Findings included: Resident # 25 was admitted to the facility on 4/18/2018 with multiple diagnoses that included anxiety and depression. The Admission Minimum Data Set (MDS) assessment dated 4/25/2018 indicated that Resident # 25 had severe cognitive impairment. Further review of the MDS revealed Resident # 25 was not coded for the diagnoses of anxiety and depression. Review of Resident # 25 Medication Administration Record (MAR) for the month of April 2018 revealed that the resident had diagnoses of anxiety and depression. It further revealed the resident was taking the medication Celexa 20 (ml) milligram 1 tablet a day for depression and Buspirone 7.5 ml 3 times a day for anxiety during the assessment period 4//12/2018 through 4/18/2018. On 5/16/ 2018 at 10:38 AM, the Admission director was interviewed. She indicated that Resident # 25 was admitted to the facility with diagnoses of anxiety and depression but she forgot to add the diagnoses in the medical records in the computer which should have auto	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. F 641 Plan for correcting the specific deficiency and including what processes that lead to deficiency cited The specific deficiency was corrected on 6/7/18 by modifying the Admission MDS with an ARD of 3/9/18 and adding the diagnosis of Depression and Anxiety to Section I. This was completed by the MDS Nurse. Corrected MDS was re-submitted to State Database on 6/7/18 in Batch #803. The process identified that lead to this area of concern is that the facility staff	

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F 641	Continued From page 11 populated into the MDS. She indicated that next time she would be careful to make sure she add all the residents' diagnoses into the MDS after their admission. On 5/16/ 2018 at 12:10 PM, the MDS Nurse was interviewed. She verified that Resident # 25 had the diagnoses of anxiety and depression upon admission and the MDS assessment should have been coded with the diagnoses. She further indicated that the admission director was responsible for entering the diagnoses into Resident # 25's medical records in the computer system which should have auto populated into the MDS. MDS Nurse also stated that moving forward she review all the MDS carefully for the accuracy in the residents' diagnoses. On 5/16/ 2018 at 12:35 PM, the Administrator was interviewed. She stated that she expected the MDS assessments to be accurate. She added the admission's director was expected to add the diagnoses of depression and anxiety in the resident's record in the computer system. The system was set up to populate the diagnoses into the MDS. The Administrator further stated she also expected the MDS nurse to check for the accuracy of the MDS.	F 641	failed to include the diagnosis of Depression and Anxiety on the admission MDS. The facility process is the Admissions Coordinator enter the active diagnosis into the electronic medical record. The diagnosis populate into the MDS assessments and the MDS Coordinator validate that the diagnosis is accurate. Procedure for implementing the acceptable plan of correction for specific deficiency The MDS Consultant provided education to the MDS Nurse and Director of Nursing on 5/23/18. Information Provided on Education included: (See Attached Education Packet) • Explanation of the intent of Section I on the MDS. Items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status. • It also included steps for accurately assessing and coding Section I. This information has been integrated into the standard orientation training for MDS Nurses.	

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	345367	A. BUILDING ______ B. WING ______	05/18/2018

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
F 641	Continued From page 12	F 641	Monitoring procedure to ensure the plan of correction is effective and specific deficiency remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will perform Quality Assurance Audits by using the tool entitled “Accurate Diagnosis Coding on Admission MDS (Anxiety & Depression) – Admission MDS Audit Tool.” This audit will be completed weekly for 4 weeks and then monthly for 2 months. This audit will monitor all residents who have been admitted to the facility within the past 30 days and who have diagnoses of either or both anxiety and depression to ensure compliance in accurately coding these active diagnoses on the admission MDS. The quality assurance audit will start on 6/8/18. The Administrator will monitor completion of the Quality Assurance audit to ensure regulatory compliance. Any negative findings will immediately be addressed. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality	

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F 641	Continued From page 13	F 641	Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, Activity Director, Admissions Coordinator and the Dietary Manager. Title of person responsible for implementing the acceptable plan of correction The Administrator is responsible for implementation and completion of the acceptable plan of correction. Compliance Date June 15, 2018	