	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION		ATE SURVEY OMPLETED
		345367	B. WING		04/04/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				7348 NORTH WEST STREET		
GOLDEN	YEARS NURSING HOM	AE		FALCON, NC 28342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE
E 000	Initial Comments		E 00	o		
	conducted on 03/37					
F 641	Accuracy of Assess		F 64	1		4/24/19
SS=D	CFR(s): 483.20(g)					
	resident's status. This REQUIREMEN by:	cy of Assessments. ust accurately reflect the NT is not met as evidenced eview and staff interviews the		The statements made on this F	Plan of	
	correctly for 1 of 2 s	urately code information sampled closed records se Minimum Data Set (MDS) reviewed.		Correction are not an admission not constitute an agreement with alleged deficiencies. To remain in compliance with a	th the	
	The findings include	ed:		and State Regulations the facili taken or will take the actions se this Plan of Correction. The Pla	ty has et forth in	
	09/11/18 and dischar Cumulative diagnos Type 2, Hypertensio	admitted to the facility on arged home on 03/29/19. ses included Diabetes Mellitus on, Chronic Obstructive e, Major Depressive Disorder		Correction constitutes the facili allegation of compliance such t alleged deficiencies cited have will be corrected by the date or indicated.	ty's hat all been or	
	and Dementia. Review of the Quar assessment dated section O (special t programs) was cod areas were check y chemotherapy, radi tracheostomy care, ventilator, IV medic	terly Minimum Data Set on 03/21/19 revealed that reatments, procedures and ed inaccurately. The following		<ul> <li>F641 Accuracy of Assessments</li> <li>For resident #46, a corrective a obtained on 04/01/19.</li> <li>The specific deficiency was on 04/01/19 by modifying the M Data Set assessment with an A Reference Date of 03/21/19 an correcting the answers for quest 00100A – 00100M (Special Trip Procedures and Programs) in corrections</li> </ul>	action was s corrected linimum sssessment d stions eatments,	

**Electronically Signed** 

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.

04/24/2019

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345367 B. WING 04/04/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7348 NORTH WEST STREET GOLDEN YEARS NURSING HOME FALCON, NC 28342 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 641 Continued From page 1 F 641 revealed that the resident had none of these accurately reflect the absence of any of these items for Resident #46 during the areas. 14 day lookback window for assessment During an interview with the MDS Licensed reference date. This was completed by Practical Nurse on 04/01/19 at 3:00 PM, stated the Minimum Data Set Nurse. Corrected that she was must have been distracted to make Minimum Data Set assessment was these errors and the resident did not have any of re-submitted to State Database in Batch those conditions. #898 and accepted on 04/02/19. During an interview with the MDS Consultant Corrective action for residents with the Nurse on 04/02/19 at 1:30 PM who signs off on potential to be affected by the alleged the MDS stated that she typically looks at section deficient practice. H, G, O & P. She further stated that it was an All residents have the potential to be oversight that she did not catch the errors and is affected by the alleged deficient practice. her expectation that the MDS be coded A 100 % audit of Minimum Data Set accurately. assessments that have been completed with Assessment Reference Dates for the During an interview with the Administrator on past 60 days (02/24/19 - 04/24/19) for 04/03/19 at 2:05 PM, she stated that it is her current residents will be completed in expectation that the MDS be coded accurately order to validate accurate coding of O0100A - O0100M (Special Treatments, according to the Resident Assessment Instrument (RAI) Manual. Procedures and Programs). Any coding errors that are identified during this audit will be corrected immediately. This audit will be conducted by the Minimum Data Set nurse and will be completed no later than 05/03/19. Systemic Changes On 04/24/19, the Regional Minimum Data Set Consultant completed an in service training for the facility Minimum Data Set Coordinator that included the importance of thoroughly reviewing the medical record prior to completion of Section O0100 (Special Treatments, Procedures and Programs) of the Minimum Data Set assessment. The education also

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 923188

If continuation sheet Page 2 of 14

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/26/2019 MAPPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
		345367	B. WING			04/04/2019	
NAME OF P	ROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•	
	YEARS NURSING HOME			73	348 NORTH WEST STREET		
00151				F/	ALCON, NC 28342		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	OULD BE COMP	
F 641	Continued From page	≥ 2	F	641	emphasized the importance of checkin back over Minimum Data Set coding in order to catch possible errors prior to signing off on each section of the assessment. This information has been integrated in the standard orientation training for ne Minimum Data Set Coordinators. The monitoring procedure to ensure the the plan of correction is effective and t specific deficiency cited remains corre and/or in compliance with the regulato requirements. On 05/01/19, the Director of Nursing o Minimum Data Set Nurse will begin auditing the coding of Section O0100A-O0100M (Special Treatments Procedures and Programs) of the Minimum Data Set Assessment using quality assurance survey tool entitled "Accurate Coding of Section O0100 (Special Treatments, Procedures and Programs) Audit Tool" to ensure that the plan of correction is effective and that specific deficiency cited remains corre and in compliance with the regulatory requirements. This will be done weekly x 4 weeks are then monthly x 2 months. Reports will presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit	nto w hat cted ry r s, the cted hd be	

Event ID: 2IKG11

Facility ID: 923188

If continuation sheet Page 3 of 14

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/26/201 M APPROVE <u>D. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345367	B. WING			04/04/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	YEARS NURSING HOME				348 NORTH WEST STREET ALCON, NC 28342		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 641	Continued From page	æ 3	F	641	Manager, Support Nurse, Therapy, He Information Manager, Dietary Manage and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator. Date of Compliance: 05/02/19		
F 727 SS=E	§483.35(b) Registere §483.35(b)(1) Except paragraph (e) or (f) or must use the services least 8 consecutive h §483.35(b)(2) Except paragraph (e) or (f) or must designate a reg director of nursing on §483.35(b)(3) The dir as a charge nurse on average daily occupa	-(3) d nurse when waived under f this section, the facility s of a registered nurse for at ours a day, 7 days a week. when waived under f this section, the facility istered nurse to serve as the	F	727			4/24/19
	Based on record rev facility failed to scheo (RN) eight consecutiv during the weekends The findings included Review of the daily no May 2018 to April 20 days during the week	iew and staff interview the lule a Registered Nurse ve hours on 16 of 94 days , holidays and week days. : ursing staffing sheets from 19 revealed the following tend when there was no RN on the following days:			The statements made on this Plan of Correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all Fede and State Regulations the facility has taken or will take the actions set forth this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been of	d do ral in	

Event ID: 2IKG11

Facility ID: 923188

If continuation sheet Page 4 of 14

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345367 B. WING 04/04/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7348 NORTH WEST STREET GOLDEN YEARS NURSING HOME FALCON, NC 28342 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 727 Continued From page 4 F 727 September 16, 2018 - Sunday - census - 45; will be corrected by the date or dates September 22, 2018 - Saturday - census 48; indicated. September 23, 2018 - Sunday - census - 47; September 29, 2018 - Saturday - census - 47; F727: RN 8 HRS/7 Days /Week September 30, 2018 - Sunday - census - 47; Corrective Action for concern identified October 5, 2018 - Friday - census - 49: October DON and NHA educated on 4/4/19 of the 10, 2018 - Wednesday - census - 49; October 20, 2018 - Saturday - census 52; October 21, 2018 requirement for RN services for at least 8 Sunday - census - 51; November 03, 2018 consecutive hours a day, 7 days a week Sunday - census - 51; November 4, 2018 by the Nurse Consultant. Sunday - census - 51; November 22, 2018 -Thursday (Thanksgiving) - census - 49; December 15, 2018 - Saturday - census - 50; Corrective Action for potential concern December 16, 2018 - Sunday - census - 50; identified December 25, 2018 - Tuesday (Christmas) census - 48; March 24, 2019 - Sunday - census -On 4/30/19, DON, NHA and Nurse 48. Consultant reviewed upcoming clinical schedule to ensure 8 consecutive hours, 7 During an interview with the Administrator on days week RN coverage in place daily. 04/03/19 at 2:05 PM, she stated that it is her Also, reviewed succession plan in the expectation that RN coverage is in the building 8 event of schedule changes to ensure hours a day, 7 days a week. The Administrator compliance daily. stated that they have struggled in this remote area to employ RN's they have reached out Systemic Changes staffing agencies and offered a sign on bonus. The Administrator stated that she is an RN and On 4/4/19, the DON and NHA education have worked on the weekends when an RN has on requirement for RN services to include: called out and on the above weekends she may Requirement of 8 consecutive hours, been out of town and was not sure why the 7 days a week of RN coverage Director of Nursing was not in the building. She Succession plan for RN schedule further stated that on the two days during the changes week the DON had paid time off and the two holidays had no RN coverage. She further stated This information has been integrated into that sometimes the when an RN calls out at the the standard orientation DON and NHA last minute they could not cover the RN position. training and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2IKG11

Facility ID: 923188

If continuation sheet Page 5 of 14

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/26/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° <i>î</i>	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345367	B. WING		04/04/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	YEARS NURSING HOME			7348 NORTH WEST STREET	
				FALCON, NC 28342	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 727	Continued From page	9 5	F 72	7	
F 865 SS=D	CFR(s): 483.75(a)(2) §483.75(a) Quality as improvement (QAPI) §483.75(a)(2) Preser Survey Agency no lat promulgation of this r §483.75(h) Disclosur A State or the Secret disclosure of the reco except in so far as su	ssurance and performance program. It its QAPI plan to the State er than 1 year after the egulation; e of information. ary may not require ords of such committee uch disclosure is related to ch committee with the	F 86	The DON/NHA will monitor this issue using the QA RN Services Survey Too monitoring RN coverage daily. Any issues will be reported to the Administrator. This will be done week for 2 weeks and then monthly x 2 mon or until resolved by Quality Assurance Committee. Reports will be presented the weekly QA committee by the Administrator/ whoever to ensure corrective action initiated as appropria Compliance will be monitored and ongoing auditing program reviewed at weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Therapy, HIM, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator Compliance date: 5/2/2019	ly ths to te. the

Facility ID: 923188

If continuation sheet Page 6 of 14

		MEDICAID SERVICES	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345367	B. WING		04/04/2019
NAME OF PF	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	
				7348 NORTH WEST STREET	
GOLDEN	EARS NURSING HOME			FALCON, NC 28342	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	
F 865	Continued From page	9 6	F 865	5	
	§483.75(i) Sanctions.				
		by the committee to identify			
		eficiencies will not be used as			
	a basis for sanctions.				
	This REQUIREMENT	is not met as evidenced			
	by:				
		iew and staff interviews the		The statements made on this Plan of	
	• •	ssment and Performance		Correction are not an admission to a	
	Improvement (QAPI)			not constitute an agreement with the	•
	•	d procedures and monitor		alleged deficiencies.	lanal
		at the committee put into certification survey of		To remain in compliance with all Fed and State Regulations the facility ha	
		or the deficiency originally		taken or will take the actions set fort	
		d subsequently recited on		this Plan of Correction. The Plan of	
	-	tion survey of 04/03/19 in		Correction constitutes the facility's	
		of Assessments (F641).		allegation of compliance such that a	II
	-	of the facility during two		alleged deficiencies cited have been	
		cords show a pattern of the		will be corrected by the date or date	
	facility's inability to su	stain an effective Quality		indicated.	
	Assurance (QA Progr	ram.			
	The findings included	:		F865: QAPI Program	
	This tag is crossed-re	eference to: F641 Accuracy			
	-	sed on record review and		The facility was unable to sustain	
	staff interviews the fa	cility failed to accurately		continued quality assessment and	
		ectly for 1 of 2 sampled		assurance implemented procedures	and
		dent #46) whose Minimum		monitoring of interventions for F	
	Data Set (MDS) asse	essments were reviewed.		641Accuaracy of Assessments after	
				deficiency and plan of correction from	
	<b>e</b> .	ecertification survey of		recertification survey of 5/18/18 resu	llting
		failed to accurately code		in a repeat deficiency.	
		active diagnoses of anxiety			
		of 5 sampled residents		The specific deficiency during the surrout reportification surrout on 04/6	
	reviewed for MDS ac	curacy.		current recertification survey on 04/0	
	During an interview w	vith the Administrator on		was corrected by modifying the Mini Data Set assessment with an Assess	

Facility ID: 923188

	S FOR MEDICARE &		(X2) MULTIPLE CONSTRUCTION			<u>10. 0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		345367	B. WING		0	4/04/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOLDEN	YEARS NURSING HOMI	E		7348 NORTH WEST STREET FALCON, NC 28342		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 865	expectation that the accurately completed follow up on any failu accurately. The Adm moving forward Dired	MDS assessments are d by conducting QAA to ure to code the MDS inistrator further stated ctor of Nursing will be signing Data Set (MDS) to make sure	F 86	<ul> <li>5</li> <li>correcting the answers for que O0100A – O0100M (Special Procedures and Programs) is accurately reflect the absence these items for Resident #46 14 day lookback window for reference date. This was conthe Minimum Data Set Assessmere-submitted to State Database #898 and accepted on 04/02</li> <li>All residents have the preaffected by the alleged deficit A 100 % audit of Minimum Data Setsessments that have beer with Assessment Reference past 60 days (02/24/19 – 04/2 current residents will be comorder to validate accurate control of the validate accurate control of the validate accurate control of the control of the dimediately will be control of the Minimum Data Set Nurse and Programs).</li> <li>errors that are identified duri will be control of the facility Data Set Consultant completion that and importance of thoroughly revimedical record prior to complex for O0100 (Special Treat Procedures and Programs) of Minimum Data Set assessment and will be completed than 05/02/19.</li> <li>On 04/24/19, the Region Data Set Coordinator that indimportance of thoroughly revimedical record prior to complex for O0100 (Special Treat Procedures and Programs) of Minimum Data Set assessment and programs) of Minimum Data Set assessment and programs).</li> </ul>	Treatments, n order to ce of any of during the assessment impleted by e. Corrected ent was ase in Batch 2/19. otential to be ient practice. bata Set n completed Dates for the /24/19) for impleted in oding of Treatments, Any coding ng this audit y. This audit imum Data eted no later nal Minimum cluded the viewing the oletion of atments, of the ent. The the	

Event ID: 2IKG11

Facility ID: 923188

If continuation sheet Page 8 of 14

CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/26/2019 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	UPPLIER/CLIA (X2) MULTIPLE CONSTR			(X3) DATE	E SURVEY PLETED
		345367	B. WING			04/04/2019	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	YEARS NURSING HOME			7348 NORTH WEST STREET			
				F/	ALCON, NC 28342		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 865	Continued From page	e 8	F	865	catch possible errors prior to signing	off	
					on each section of the assessment.		
					This information has been integr into the standard orientation training new Minimum Data Set Coordinators	for	
					<ul> <li>On 05/01/19, the Director of Nur- or Minimum Data Set Nurse will begin auditing the coding of Section O0100A-O0100M (Special Treatment Procedures and Programs) of the Minimum Data Set Assessment using quality assurance survey tool entitled "Accurate Coding of Section O0100 (Special Treatments, Procedures and Programs) Audit Tool" to ensure that plan of correction is effective and that specific deficiency cited remains corr and in compliance with the regulatory requirements.</li> <li>This will be done weekly x 4 we and then monthly x 2 months. Report be presented to the weekly Quality Assurance committee by the Director Nursing to ensure corrective action for trends or ongoing concerns is initiate appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, H Information Manager, Dietary Manag and the Activity Director.</li> </ul>	n ts, g the the t ected c s will c of or d as e ealth	

Facility ID: 923188

If continuation sheet Page 9 of 14

	S FOR MEDICARE &						ORM APPROV NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		OATE SURVEY OMPLETED
		345367	B. WING			04/04/2019	
AME OF PI	ROVIDER OR SUPPLIER	L		STR	EET ADDRESS, CITY, STATE, ZIP CODE	04/04/2013	
	YEARS NURSING HOME				8 NORTH WEST STREET		
				FAL	LCON, NC 28342		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 865	Continued From page	9	F 86	65			
					Audit reports and findings will be presented to the Quality Assurance Performance Improvement Commi weekly for 4 weeks and then mont months. Minimum Data Set Nurse Nursing Home Administrator to ens corrective action is sustained. Con through ongoing auditing program monitored by the Administrator and Quality Assurance and Performance Improvement Committee. The weekly and monthly Quality Assurance and Performance Improvement Committee are atten the Administrator, Director of Nursi Minimum Data Set Nurse, Rehab I Health Information Manager, Dieta Manager, Social Worker and Activi Director. The Administrator is responsible for implementing the acceptable plan correction.	ittee hly for 2 and sure npliance will be d the ce ded by ing, Director, iry ity	
F 880 SS=D	Infection Prevention & CFR(s): 483.80(a)(1)		F 88		Date of Compliance: 5/2/19		4/24/19
		blish and maintain an Ind control program I safe, sanitary and Inent and to help prevent the Insmission of communicable					

Facility ID: 923188

If continuation sheet Page 10 of 14

	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	): 06/26/2019 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ECONSTRUCTION		(X3) DATE	
		345367	B. WING			_	04/	04/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
GOLDEN	YEARS NURSING HOME				348 NORTH WEST STRE	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	§483.80(a) Infection p program. The facility must estal and control program ( a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable dis staff, volunteers, visito providing services und arrangement based u conducted according accepted national stat §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whom communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including but (A) The type and dura depending upon the ir involved, and (B) A requirement tha least restrictive possible circumstances. (v) The circumstances	brevention and control blish an infection prevention IPCP) that must include, at ing elements: m for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify le diseases or can spread to other in possible incidents of e or infections should be smission-based precautions ent spread of infections; lation should be used for a t not limited to: tion of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the is under which the facility we with a communicable	F	880				

Facility ID: 923188

If continuation sheet Page 11 of 14

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345367	B. WING		04/04/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	YEARS NURSING HOME			7348 NORTH WEST STREET FALCON, NC 28342		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION	
F 880	contact will transmit th (vi)The hand hygiene by staff involved in din §483.80(a)(4) A syste identified under the fa corrective actions tak §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update thei This REQUIREMENT by: Based on record revi interviews, the facility infection control guide changing gloves while provided for 1 of 1 res a nurse failed to perfo contaminated and ste Findings Included: A review of the facility Procedures, last revis it was the policy of the be regarded as the si of preventing the spre-	s or their food, if direct he disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the en by the facility. en by the facility. le, store, process, and to prevent the spread of <i>view.</i> tot an annual review of its ir program, as necessary. ' is not met as evidenced iew, observation, and staff failed to follow established elines for hand hygiene and e tracheostomy care was sidents (Resident #31) when orm hand hygiene between erile procedures.	F 880		ederal has orth in of all en or	
	indicated if gloves we	re worn for a procedure, be completed before putting		F 880: Infection Prevention and co Corrective Action for Resident Affe		

Facility ID: 923188

If continuation sheet Page 12 of 14

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345367 B. WING 04/04/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7348 NORTH WEST STREET GOLDEN YEARS NURSING HOME FALCON, NC 28342 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 880 Continued From page 12 F 880 Resident #31 on 04/03/19 at 11:13 a.m., Nurse was provided trach care following the #1 was observed to wash her hands, apply facility's Infection Control policy on Hand non-sterile gloves and suction tracheal secretions Hygiene and sterile field by the Director of (mucous) from the resident's tracheostomy site. Nursing. Nurse #1 removed her gloves and did not wash her hands. Nurse #1 then opened the Nurse #1 was provided 1:1 education by tracheostomy care kit and removed the sterile the Director of Nursing on 4/3/19 with drape and placed it on the over-bed table. When return demonstration of compliance. asked if she had washed her hands after she had performed suctioning and had removed her non-sterile gloves, Nurse #1 stated she had not. Corrective Action for Resident Potentially Nurse #1 stated she had been nervous and Affected over-thinking the procedure and had forgotten to wash her hands. Immediately on 4/3/19, the Director of Nursing ensured that all residents During an interview with the Director of Nursing requiring trach care received trach care (DON) on 04/03/19 at 11:52 a.m., the DON stated following the facility's Infection Control it was her expectation nursing staff follow the policies for Hand Hygiene and sterile field. facility's infection control policy. During an interview with the Administrator on Systemic Changes 04/03/19 at 2:00 p.m., the Administrator stated it was her expectation nursing staff follow infection All licensed nurses (Full Time, Part Time, control policies and procedures. and PRN) will attend an in service on Trach Care, including Hand Hygiene, Sterile Field and facility's infection Control policy on 5/2/19. Nurses not attending the in-services will not work until in-service is completed. **Quality Assurance** The Director of Nursing/Designee will monitor infection control procedures during trach care, including hand hygiene and sterile field. Any issues will be reported to the Administrator. This will be

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: 2IKG11

Facility ID: 923188

If continuation sheet Page 13 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       345367       B. WING       04/04/2019         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       04/04/2019         GOLDEN YEARS NURSING HOME       STREET ADDRESS, CITY, STATE, ZIP CODE       7348 NORTH WEST STREET FALCON, NC 28342         (X4) ID PREFIX       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL       ID PREFIX       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE       (X5) COMPLET	TORMATTROVED	EALTH AND HUMAN SERVICES CARE & MEDICAID SERVICES	
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NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         GOLDEN YEARS NURSING HOME       7348 NORTH WEST STREET         (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)       Continued From page 13       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Continued From page 13       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLET DATE         F 880       Continued From page 13       F 880       done weekly for 2 weeks and then monthly for 2 months. Reports will be presented to the weekly QA committee by the Administrator/ whoever to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS	B. WING 04/04/2019	345367	
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Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator Compliance date: 5/2/2019	F 880 done weekly for 2 weeks and then monthly for 2 months. Reports will be presented to the weekly QA committee by the Administrator/ whoever to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Therapy, HIM, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator	From page 13	F 880 (

Event ID: 2IKG11

Facility ID: 923188

If continuation sheet Page 14 of 14