PRINTED: 04/09/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345367	B. WING _				08/2018
	ROVIDER OR SUPPLIER YEARS NURSING HOMI	<u> </u>	•	73	REET ADDRESS, CITY, STATE, ZIP CODE 48 NORTH WEST STREET ALCON, NC 28342		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695 SS=E	S 483.25(i) Respirator tracheostomy care and tracheostomy care and tracheal surple care and tracheal surple care, consistent with practice, the compressive care plan, the reside and 483.65 of this surple care plan, the reside and 483.65 of this surple care plan, the reside and 483.65 of this surple care plan, the reside and 483.65 of this surple care plan, the reside and 483.65 of this surple care plan, the reside and 483.65 of this surple care plan, the reside and 483.65 of this surplies and interviews the facility three (Residents # 1, sampled residents which work the residents (#1, failed to assure a system to assure infection of the composition of the findings included to the findings included to the findings included to the findings included the findings	and tracheal suctioning. ure that a resident who re, including tracheostomy ctioning, is provided such professional standards of thensive person-centered ints' goals and preferences, abpart. To is not met as evidenced on, record review, and staff failed to provide services for at 2, and #3) of three with tracheostomies. For three #2, and #3), the facility stem was in place for nurses guidance related to costomy needs. For one we residents the facility failed control methods were tioning. d: ealed Resident # 1 was the facility on 11/8/17. The these of anoxic the history of tracheostomy the betructive lung disease, the services of gastrostomy seizure disorder, and	F6	695	Based on observation, record review, staff interviews the facility failed to prove services for three (Residents # 1, # 2, 2 # 3) of three sampled residents with tracheostomies. For three of the reside (#1, #2, and # 3), the facility failed to assure a system was in place for nurse to have supplies and guidance related individualized tracheostomy needs. Foone (Resident # 1) of three residents the facility failed to assure infection control methods were observed during suctioning. The plan for correcting the specific deficiency and the process that led to the alleged deficiency: On 3/7/18 the Director of Nurses revise the tracheostomy order set and care plated to the residents in cannula and revised the order set and care plans for each resident with a tracheostomy. On 3/9/18 The Director of Nurses and	vide and ents es to r ne he	4/5/18
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE

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

Electronically Signed

03/22/2018

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	PLE CONSTRUCTION G		E SURVEY IPLETED
		A. BOILDIN	<u> </u>		С
	345367	B. WING _) o:	3/08/2018
NAME OF PROVIDER OR SUPPLIE	3		STREET ADDRESS, CITY, STATE, ZIP CO		
OOL DEN VEADO MUDOINO L	OME		7348 NORTH WEST STREET		
GOLDEN YEARS NURSING H	OME		FALCON, NC 28342		
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 695 Continued From	page 1	F 6	95		
initial facility admethe record, the refacility between the facility bet	rission of 11/8/17. According to esident was readmitted to the he hospitalizations. His facility ed in length from less than 24 between his hospitalizations. The readmission date to the facility esident's most recent minimum ment, dated 11/8/17, revealed the communicate and was dependent trance. In the risk for complications. If the resident is for complications. If the resident is as follows. "Assist with ded. Ensure that trach ties are the ine. Give humidified oxygen as the reverse for and document for tration, confusion, increased the result of the resident is the resident is the resident in the resident in the resident is the resident in the	F 6	Nurse Consultant developed assure that each resident will tracheostomy will have trach supplies maintained at the beemergency cart and individuate central supply for each residitracheostomy. As well a product developed to assure that any admitted or re-admitted residitracheostomy will have the obtracheostomy equipment on their admission or readmissis facility. These processes will implemented as of 3/30/18. On 3/7/18 the Director of Nure-educated Nurse #1 and on Nurse# 2, on facility policy retracheostomy suctioning and return demonstration of Nurse Nurse #2's practice observed Director of Nurses. On 3/08/and #2 were additionally reset the Director of Nurses regard practice of having all needed the bedside prior to initiating care. The procedure for implement acceptable plan of correction specific deficiency cited: On 3/9/2018, the Director of began re-education, with obserturn demonstration, of all fit time and per-diem nurses. Ended to the trached the trached that the contraction is pecific deficiency of the trached that th	th a eostomy edside, on the ally labeled in ent with a cess was y newly dents with a ordered hand prior to on to the labe fully rses n 3/08/18 elated to la care with se #1 and d by the 18 Nurse #1 educated by ding the la supplies at resident ting the n for the Nursing servation by ull time, part ducation will process	

Facility ID: 923188

CENTER	O I OIL WEDICAILE &	WEDICAID SERVICES				CIVID IVC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY
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		345367	B. WING _			l	08/2018
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S1	FREET ADDRESS, CITY, STATE, ZIP CODE		
		_		73	348 NORTH WEST STREET		
GOLDEN	YEARS NURSING HOME			F	ALCON, NC 28342		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	×	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 695	Continued From page	e 2	F 6	195			
		neostomy suctioning for			ordered supplies at the bedside prior to)	
		the provision of suctioning,			initiating care.		
		erved to have large amounts			3		
	of thick tannish colore				On 3/8/2018, the Director of Nursing		
	secretions covered a	pproximately half of the			began re-education with return		
	resident's tracheosto				demonstration observation of all full time	•	
		to a washcloth lying below			part time and per-diem nurses related t		
	_	suctioning the resident,			facility policy on tracheostomy suctioning	ng	
		had last suctioned Resident			and care.		
	# 1 about 1.5 hours b	As of 3/19/18 all full time, part time and per diem nurses will be educated by the					
	_	amounts of secretions. e, the nurse was observed to			Contracted Respiratory	E	
		on catheter, which was			Consultant/Director of Nurses and the		
	· ·	n machine, to perform			Contracted Respiratory		
	-	ning. Upon completion of the			Consultant/Director of Nurses will obse	rve	
	-	fied with the nurse that this			a return demonstration of tracheostomy	/	
	suction catheter was	the same suction catheter			care and suctioning by 04/05/18.		
		ion the resident earlier that					
	-	stated she did not always			The Director of Nurses will educate all		
	_	atheter, and she routinely			department managers as to the proces	S	
		nes before discarding the			changes made to the		
		ne suctioning procedure, would also do the resident's			admission/readmission process and supply process for all residents with		
		hile she was in the room.			tracheostomies via the daily clinical		
	1	ved to prepare her supplies			meeting by 3/22/18.		
		The nurse attempted to					
		s inner cannula, but could			The monitoring procedure to ensure that	at	
	not remove it. The nu	irse stated she would need			the plan of correction is effective and th	nat	
	to get assistance fror	n another nurse.			specific deficiency cited remains correct	ted	
					and/or in compliance with the regulator	у	
		M, Nurse # 2 was observed			requirements:		
		ssist Nurse # 1 with the			The Director of Nurses will randomly		
		my care. According to Nurse			observe nurse practice for adherence to		
		ely work with Resident # 1, st Nurse # 2. The following			tracheostomy process revisions. This was		
		ade. Nurse # 1 set up a			tracheostomy process revisions. This was done on all shifts including weekens		
		t in preparation to clean the			The supply manager's adherence to	13.	
		ula. After donning gloves,			maintaining tracheostomy supplies will	be	
		ne resident's inner cannula			directly observed by the Director of	- -	

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245267 B	3. WING		С
343307			03/08/2018
		, , ,	
		7348 NORTH WEST STREET	
		FALCON, NC 28342	
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	F 695	5	
the inner e. While e # 1 a was different viously before oked at the inner nat according to a, this inner id needed to be ould go and find sident. After Nurse # 2 a which was to Nurse # 2, 7 mm nula. or of Nursing facility system to n correct ostomy care. eferenced the rmed nurses neters after ng, and they time a Regarding pital was regarding the eded for each n. This ne supply clerk, eded oly room. The	F 695	Nursing weekly. Compliance with the revised admission/readmission process for residents with tracheostomies will be monitored via the Daily Clinical Meeting the Director of Nurses. The Director of Nurses will complete the Quality Assurance audit tool for adherence to facility policy and process weekly x 4 then monthly x 3. The Director of Nursing will present reports to the Administrator weekly, that in turn will be shared with the Quality Assurance Committee to ensure that corrective action for any identified trends or ongo concerns are initiated and monitored a appropriate. The Director of Nursing, Minimum Data Set Coordinator, Support Nurse, Therapy Manager, Health Information Manager, Dietary Manager Administrator and Medical Director attention weekly Quality Assurance Meeting	e g by e s stor e ing s rt
er the second of	as a state of the	EFICIENCIES ECCEDED BY FULL INGINFORMATION) F 695 for Nurse # 1 to the inner le. While le # 1 a was different leviously before loked at the inner led needed to be lead to be lead to lead	STREET ADDRESS, CITY, STATE, ZIP CODE 7348 NORTH WEST STREET FALCON, NC 28342 ID PREVIOUS (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRY DEFICIENCY) F 695 for Nurse # 1 to the inner e. While bar # 1 a was different wiously before oked at the inner hat according to la, this inner do ladden as a could go and find sident. After Nurse # 2 a which was to Nurse # 2, 7 mm nula. Nurse # 2 a which was to Nurse # 2, 7 mm nula. Nurse # 2 a which was to Nurse # 2, 7 mm nula. PROVIDER'S PLAN OF CORRECTIVN Nursing weekly. Compliance with the revised admission/readmission process weekly x 4 then paily Clinical Meeting the Director of Nurses will complete the Quality Assurance audit tool for adherence to facility policy and process weekly x 4 then monthly x 3. The Director of Nursing will present reports to the Administrator weekly, that in turn will be shared with the Quality Assurance Committee to ensure that corrective action for any identified trends or ongo concerns are initiated and monitored as appropriate. The Director of Nursing, Minimum Data Set Coordinator, Support Nurse, Therapy Manager, Health Information Manager, Dietary Manager Administrator and Medical Director atte the weekly Quality Assurance Meeting. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing The Director of Nursing Administrator and Medical Director atte the weekly Quality Assurance Meeting. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing A/05/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345367	B. WING			1	08/2018
	ROVIDER OR SUPPLIER YEARS NURSING HOME			7:	TREET ADDRESS, CITY, STATE, ZIP CODE 348 NORTH WEST STREET ALCON, NC 28342		00,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	was accompanied to were no inner cannularoom for Resident #1 would review the resit in noted the individual Resident #1's trache On 3/7/18 at 1 PM, thagain. She stated she directions in the residother parts of the medinner cannula he need nurses should have to actual tracheostomy aright supplies when the constant of inner cannula it was nurse stated she had and found one like it, labeled for the reside According to the nurse cannula was not routing care plan. An interview on 3/8/1 supply clerk revealed The hospital had initian 11/15/17 without any type of inner cannula picture of the tracheo she had not understo tracheostomy replace.	the supply room. There as labeled in the supply . The DON stated she dent's record to determine if ized instructions for ostomy supplies and care. The DON was interviewed was unable to find ent's orders, care plan, or dical record for the type of ded. The DON stated the tooked at the resident's and been prepared with the ney entered the room. Nurse #2 was interviewed ed when she had assisted to sinner cannula on 3/7/18 at to been able to tell what type is until she removed it. The gone to the supply room but there had been nothing int in the supply room. e, the size and type of inner nely written on the orders or as at 10:30 AM with the the following information. Sally sent the resident on instructions regarding the he needed. They had sent a stomy replacement kit, but od from the picture of the ement kit which type of inner ne resident. According to the	F	695			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345367	B. WING _			C 03/08/2018	
	ROVIDER OR SUPPLIER YEARS NURSING HOM	ΛΕ		STREET ADDRESS, CITY, STATE, ZIP CODE 7348 NORTH WEST STREET FALCON, NC 28342	E	33/33/2313	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 695	the hospital had secannula for her to ordischarged followin periods of only a fer 3/5/18, she had not information again a supplies he needed his individualized so the supply clerk cowhich had last beer an 8 mm inner canrusing a 7 mm inner was not sure if the orbeen changed at somm inner cannula at An interview with a 3/8/18 at 9:45 AM rinformation. The nut supplies by looking and coincide the intracheostomy with sinformation in the result of the information	e to assist her. On 11/16/17, at a picture of an 8 MM inner order. The resident was soon go 11/16/17, and returned for worder. When he returned on been provided with specific bout exactly what type of and she had not yet set up upplies in the supply room. Infirmed that the information in sent by the hospital was for hula, and the nurses were cannula. The supply clerk resident's tracheostomy had ome point from an 8 mm to a 7 and when this had occurred. It corporate nurse consultant on evealed the following reses should verify needed at the actual tracheostomy formation stamped on the some type of written esident's medical record. Ident # 1's nurse practitioner on revealed it was her medical ident's hospitalizations had not my lack of care at the facility, to other factors. Evealed Resident # 2 was lity on 6/24/15. The resident with stomy placement and chronic	F 6	95			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		, ,	(X3) DATE SURVEY COMPLETED		
	345367	B. WING			C 03/08/2018		
	E		STREET ADDRESS, CITY, STATE, ZIP CODE 7348 NORTH WEST STREET FALCON, NC 28342	,	03/03/2010		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE		
assessment, dated resident could commintact, and required Review of the reside on 1/3/18, revealed have a tracheostom impaired breathing resident's care plan. "Ensure that trach ti Give humidified oxy apply PMSV (Passy to trach as desired. and PRN (as neede Review of physician revealed the resider care on day shift eventhere was no writte orders or care plans tracheostomy and sersident's tracheostomy to a nursion 2/16/18 at 9:30 Fe tube had been replated the resident." Interview with the read again on 3/8/18 following information tracheostomy for material resident was tracheostomy information tracheostomy for material residents of the resident was tracheostomy for material residents."	12/13/17, revealed the nunicate, was cognitively assistance with her care. ent's care plan, last reviewed the "focus" area entitled, "I y with risk for complications, mechanics." There were four for this focus area on the These were as follows. The search secured at all time. These were as follows. The way and as needed. The way and as needed. The information within the regarding the size of pecific care related to the formy inner cannula. The sident of the hospital when the started to come out. The needed the resident returned the word of the resident returned the size of the size of the size of the started to come out. The sident of the resident returned the size of the size of the size of the sident of the hospital when the started to come out. The sident of the resident returned the size of the size o	F 69	95				
	SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From page assessment, dated resident could comminated, and required Review of the reside on 1/3/18, revealed have a tracheostom impaired breathing resident's care plan. "Ensure that trach tis Give humidified oxygapply PMSV (Passy to trach as desired. and PRN (as needed Review of physician revealed the resider care on day shift ever there was no written orders or care plan in tracheostomy and significant was tracheostomy to the resident was tracher tracheostomy to a nursi on 2/16/18 at 9:30 Fe tube had been replated trach." Interview with the reand again on 3/8/18 following information tracheostomy for mattribute the tracheocare. At the time of the session of the second review for mattribute the tracheocare. At the time of the session of the second review for mattribute the tracheocare.	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 assessment, dated 12/13/17, revealed the resident could communicate, was cognitively intact, and required assistance with her care. Review of the resident's care plan, last reviewed on 1/3/18, revealed the "focus" area entitled, "I have a tracheostomy with risk for complications, impaired breathing mechanics." There were four listed interventions for this focus area on the resident's care plan. These were as follows. "Ensure that trach ties are secured at all time. Give humidified oxygen as prescribed. I may apply PMSV (Passy-Muir speaking valve) or cap to trach as desired. Provide good oral care daily and PRN (as needed)." Review of physician orders, dated 1/3/18, revealed the resident was to have tracheostomy care on day shift every day and as needed. There was no written information within the orders or care plan regarding the size of tracheostomy and specific care related to the resident's tracheostomy inner cannula. Record review revealed on 2/16/17 at 8:52 AM the resident was transferred to the hospital when her tracheostomy tube started to come out. According to a nursing note the resident returned on 2/16/18 at 9:30 PM, and the tracheostomy tube had been replaced with a "size 4 Shiley	ROVIDER OR SUPPLIER YEARS NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 assessment, dated 12/13/17, revealed the resident could communicate, was cognitively intact, and required assistance with her care. Review of the resident's care plan, last reviewed on 1/3/18, revealed the "focus" area entitled, "I have a tracheostomy with risk for complications, impaired breathing mechanics." 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Interview with the resident on 3/7/18 at 9:05 AM and again on 3/8/18 at 8:35 AM revealed the following information. The resident had her tracheostomy for many years, and did not attribute the tracheostomy dislodgement to facility care. At the time of the dislodgement, the	ROVIDER OR SUPPLIER YEARS NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL (FEGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 6 assessment, dated 12/13/17, revealed the resident of the resident returned on 2/16/18 at 9:30 PM, and the tracheostomy the started to come out. Record review revealed on 2/16/17 at 8:52 AM the resident was transferred to the hospital when her tracheostomy tube started to come out. According to a nursing note the resident returned on 2/16/18 at 9:30 PM, and the tracheostomy tube had been replaced with a "size 4 Shiley trach." Interview with the resident on 3/7/18 at 9:05 AM and again on 3/8/18 at 8:35 AM revealed the following information. The resident had her tracheostomy of the resident to tacility care. At the time of the dislodgement to facility care. Interview with the resident the facility care. At the time of the dislodgement to facility care.	ROVIDER OR SUPPLIER 7348 NORTH WEST STREET SUMMARY STATEMENT OF DEPOSENCIES REACH OF DEPOSENCY MUST FAR PRINCED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 Continued From page 6 Continued From page 16 Continued From page 16 Continued From page 16 Review of the resident's care plan, last reviewed on 1/3/18, revealed the resident could communicate, was cognitively intact, and required assistance with her care. Review of the resident's care plan, last reviewed on 1/3/18, revealed the "focus" area entitled, "I have a tracheostomy with risk for complications, impaired breathing mechanics." There were four listed interventions for this focus area on the resident's care plan. These were as follows. "Ensure that trach lies are secured at all time. Give humidified oxygen as prescribed. I may apply PMSV (Passy-Muir speaking valve) or cap to trach as desired. Provide good oral care daily and PRN (as needed)." Review of physician orders, dated 1/5/18, revealed the resident was to have tracheostomy care on day shift every day and as needed. There was no written information within the orders or care plan regarding the size of tracheostomy and specific care related to the resident was transferred to the hospital when her tracheostomy time resident tertumed on 2/16/18 at 9:30 PM, and the tracheostomy tube had been replaced with a "size 4 Shiley trach." Interview with the resident on 3/7/18 at 9:05 AM and again on 3/8/18 at 8:35 AM revealed the following information. The resident had her tracheostomy for many years, and did not attribute the tracheostomy disodegment, the resident tracheostomy disodegment to facility care. At the time of the dislodegment to facility care. At the time of the dislodegment, the		

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		345367	B. WING		C 03/08/2018		
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 7348 NORTH WEST STREET FALCON, NC 28342	03/06/2016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETION		
F 695	tracheostomy in place the hospital, and the with a 4 mm tracheosize. Interview with Nurse and again on 3/8/18 following information returned from the hospital that tracheostomy inner or cannula, and the fact with which to replace nurse, the inner cannor for the resident althous therefore she continufacility did not have a linterview with the fact 10:30 AM revealed size of Resident # 2's on 2/16/18, and she inner cannulas for the tracheostomy inner cannulas for the facility nurse consumple for the facility in the polinoted to be different inner cannulas." The clean disposable innoted to	e. The resident was sent to tracheostomy was replaced stomy, which was smaller in # 2 on 3/8/18 at 9:15 AM at 11:45 AM revealed the . When the resident had spital the previous month, s different. The trannula was a disposable dity had no inner cannulas to hers. According to the hula was continuing to work ugh it was disposable, and used to clean it since the any with which to replace it. Stility supply clerk on 3/8/18 at the had not been aware the stracheostomy had changed thad not ordered any new	F 69				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER YEARS NURSING HOME	L		STREET ADDRESS, CITY, STATE, ZIP CODE 7348 NORTH WEST STREET FALCON, NC 28342	l	03/08/2018	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 695	were working to set userspiratory care service have more policies and had not finalized the care service provider. 3. Record review reveadmitted to the facility had multiple diagnose history of cardiac arredamage, persistent verspiratory failure with Review of the resider assessment, dated 2/did not communicate care needs. Review of the resider revealed the "focus" a Tracheostomy with riswere seven interventito address this focus follows. "Ensure that times. Give humidified Observe for and docuagitation, confusion, i bradycardia. Observe consciousness, ment (as needed). Provide PRN. Provide means procedural informatio available immediately Review of physician or revealed the resident care on dayshift events.	p a contract with a ce provider which would on procedures. The facility contract with the respiratory as of the survey. ealed Resident # 3 was on 2/13/18. The resident es. Some of these included est with anoxic brain egetative state, history of on tracheostomy placement. It's minimum data set (MDS) (21/18, revealed the resident and relied on staff for all his est for complications." There ons listed on the care plan area. These were as trach ties are secured at all doxygen as prescribed. Imment for restlessness, increased heart rate, and est for and document level of all status, and lethargy PRN good oral care daily and so of communication and in. Reassure that help is of communication and in. Reassure that help is of communication and the formation within the information within the	F 69				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345367	B. WING			1	00/2048	
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS NURSING HOME			5	STREET ADDRESS, CITY, STATE, ZIP CODE 7348 NORTH WEST STREET FALCON, NC 28342	1 03/	08/2018		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 695	Interview with Nurse and again on 3/8/18 a following information. correct inner cannulathe was admitted. The cannula which the nu using for other reside the tracheostomy can this was not common did not have marking was disposable or received been able to obtain a inner cannula since the 2/13/18. Therefore she daily, and replaced the Interview with the sup AM revealed she had corporate employee to cannulas were needed assistance in him, but still had not be what to order and obt to the supply clerk, the type of inner cannula ordered. The facility's policy, eand last revised in Apa facility nurse consultations and cannot be inner cannot in the cannot be inner cannot	ecific care related to the my inner cannula. # 2 on 3/8/18 at 9:15 AM at 1:45 AM revealed the The hospital had not sent is for his tracheostomy when it resident had an inner rese was not accustomed to ints. According to the nurse inula had "81.0" on it, and ly used. The inner cannula is on it regarding whether it usable. The facility had not inny replacements for the interesident was admitted on it is ecleaned the inner cannula is einner cannula. Toply clerk on 3/8/18 at 10:30 contacted a facility on alert them that inner it is don't the resident and she knowing what to order for one able to verify exactly ain the cannulas. According it is einner cannula was not a typically used and routinely intitled "Tracheostomy Care" in 2011, was reviewed with litant on 3/8/18 at 11:20 AM. It different for residents with ulas" versus "disposable/"	F	695				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345367	B. WING _		C 03/08/2018	
	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 7348 NORTH WEST STREET FALCON, NC 28342	1 00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED OF THE	D BE COMPLETION	
F 835 SS=E	replace them and ho keep using inner can them. According to this information was policy and they were with a respiratory can would have more polifacility had not finaliz respiratory care served. Administration CFR(s): 483.70 §483.70 Administration A facility must be addrenables it to use its refficiently to attain or practicable physical, well-being of each restricted interviews the facility to implement effective procedures to assure Resident # 2, and Residents received set tracheostomies. The Cross Refer to F 695 Based on observation interviews the facility three (Residents # 1 sampled residents wo of the residents (#1, failed to assure a systo have supplies and	e no guidelines when to w long it was acceptable to inulas without replacing the facility nurse consultant, not included in the current working to set up a contract re service provider which licies and procedures. The ted the contract with the ice provider as of the survey. on. ministered in a manner that resources effectively and maintain the highest mental, and psychosocial esident. T is not met as evidenced ons, record reviews, and staff failed to provide leadership re systems, policies, and rethree (Resident #1, resident #3) of three sampled revices related to their findings included: on, record review, and staff refailed to provide services for the failed to provide services failed to provide serv	F 8		to their ultant and care.	

Facility ID: 923188

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345367	B. WING			03/0) 08/2018
	ROVIDER OR SUPPLIER YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7348 NORTH WEST STREET FALCON, NC 28342	<u> </u>		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 835	Continued From page (Resident # 1) of thre to assure infection co observed during sucti	e residents the facility failed ontrol methods were	F	in conjunction with the proced Contracted Respiratory Consuguide tracheostomy care pracleast annually, the Quality Assommittee, in conjunction with contracted respiratory consult review and approve all tracheorelated policies and procedure. On 3/9/18 the Director of Nurse Nurse Consultant developed assure that each resident with tracheostomy will have tracheostomy will have tracheostomy. This profully implemented by 3/30/18. On 3/9/18 the Director of Nurse Nurse Consultant developed assure that any newly admitter re-admitted residents with a tracheostomy will have the ordered tracheose equipment on hand, prior to the admission or readmission to the tracheostemy in the processes will be fully in as of 3/30/18. The procedure for implementing acceptable plan of correction in specific deficiency cited: On 3/9/2018, the Director of Nurse Processes will be fully in the procedure for implementing acceptable plan of correction in specific deficiency cited: On 3/9/2018, the Director of Nurse Processes will be fully in the procedure for implementing acceptable plan of correction in specific deficiency cited: On 3/9/2018, the Director of Nurse Processes will be fully in the procedure for implementing acceptable plan of correction in the procedure for implementing acceptable plan of correction in the procedure for implementing acceptable plan of correction in the procedure for implementing acceptable plan of correction in the procedure for implementing acceptable plan of correction in the procedure for implementing acceptable plan of correction in the procedure for implementing acceptable plan of correction in the procedure for implementing acceptable plan of correction in the procedure for implementing acceptable plan of correction in the procedure for implementing acceptable plan of correction in the procedure for implementing acceptable plan of correction in the procedure for implementing acceptable plan of correction in the procedure for implementing acceptable plan of correction in the procedure for implementing	ultant to dices. At surance in the surance in the sant, will ostomy es. ses and a process in a costomy dividually ach resided cess will be ses and a process of	to the ent be to my the fall	

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MI IDENTIFICATION NUMBER: A. BUIL		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
345367 B. WING_				C 03/08/2018			
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI		CORRECTION ON SHOULD BE HE APPROPRIATE Y)	(X5) COMPLETION DATE	
F 835	Continued From page	e 12	F8	supplies, along with facility to tracheostomy suctioning importance of having ordere the bedside prior to initiating time, part time and per diem be educated by the Director and Contracted Respiratory and have the Director of Nu Contracted Respiratory Corobserve a return demonstratracheostomy care and suct 3/30/18. The Director of Nurses will department managers and time and per diem nurses a process changes made to the admission/readmission procesupply process for all reside tracheostomies by 3/22/18. The monitoring procedure to the plan of correction is effect specific deficiency cited remand/or in compliance with the requirements: The Director of Nurses will observe nurse practice for a facility policy related to track care/suctioning/infection contracheostomy process revisible done on all shifts including the supply manager's adhermal manager and the supply manager's adhermal manager and the supply manager's adhermal manager and the supplies will be directly observed to the supplies will be directly observed to the revised admission/oprocess for residents with the revised	/care and the ed supplies at g care. All full in nurses will r of Nurses / Consultant urse or insultant ation of tioning by educate all fulltime, part is to the he cess and ents with o ensure that ective and that in a corrected in eregulatory randomly adherence to heostomy introl and in the costomy introl and in the costomy erved by the Compliance readmission		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345367		B WING	B. WING			C		
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	08/2018	
	to the Little of the Country of the				348 NORTH WEST STREET			
GOLDEN '	YEARS NURSING HOME				ALCON, NC 28342			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE	
F 835			F 835					
F 880 SS=D	Infection Prevention 8 CFR(s): 483.80(a)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	(2)(4)(e)(f) ntrol blish and maintain an nd control program	F	380	4/05/2018		4/5/18	

I ' '		IDENTIFICATION NUMBED:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345367	B. WING		C 03/08/2018		
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP COD 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 880	development and tradiseases and infection program. The facility must est and control program a minimum, the followard for the providing services under the procedures for the put are not limited to (i) A system of surver possible communication infections before the persons in the facilit (ii) When and to who communicable disease reported; (iii) Standard and trate to be followed to pre (iv)When and how is resident; including to (A) The type and du depending upon the involved, and (B) A requirement the	ment and to help prevent the ansmission of communicable ons. prevention and control ablish an infection prevention (IPCP) that must include, at wing elements: tem for preventing, identifying, ing, and controlling infections diseases for all residents, itors, and other individuals inder a contractual upon the facility assessment g to §483.70(e) and following andards; and standards, policies, and program, which must include, one include include in the program of th	F 88				

1, 7		IDENTIFICATION NUMBER.		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345367	B. WING		C 03/08/2018
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 7348 NORTH WEST STREET FALCON, NC 28342	03/00/2010
(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 CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 880	must prohibit employ disease or infected s contact with resident contact will transmit if (vi)The hand hygiene by staff involved in disease. S483.80(a)(4) A systidentified under the ficorrective actions takes \$483.80(e) Linens. Personnel must hand transport linens so as infection. \$483.80(f) Annual result that the facility will condust the facility will be facility	is under which the facility ees with a communicable kin lesions from direct is or their food, if direct he disease; and is procedures to be followed rect resident contact. The for recording incidents acility's IPCP and the item by the facility. The findings included and record review, and staff asident # 1) out of three the facility failed to assure tices were followed during and the findings included. The findings included. The findings for are Associated Pneumonia," mmendations by the CDC tem suction is employed,	F 88	Based on observation, record revie staff interviews, for one (Resident # of three sampled residents in the fad failed to assure infection control pra were followed during tracheostomy suctioning. The plan for correcting the specific deficiency and the process that lead alleged deficiency: On 3/7/18 the Director of Nurses re-educated Nurse #1 on facility pol related to tracheostomy suctioning a care with return demonstration of Nu #1's practice observed by the DON.	1) out cility ctices I to the icy and urse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			l c		
		345367	B. WING				/08/2018	
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	00/2010	
				7	348 NORTH WEST STREET			
GOLDEN	YEARS NURSING HOME			F	ALCON, NC 28342			
(X4) ID	4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 880	Continued From page	e 16	F	880				
		the provision of suctioning,			The procedure for implementing the			
		erved to have large amounts			acceptable plan of correction for the			
	of thick tannish colore				specific deficiency cited:			
		oproximately half of the			On 3/8/2018, the Director of Nursing			
	resident's tracheostor				began re-education with return			
		to a washcloth lying below			demonstration observation of all full tim	ıe,		
		suctioning the resident,			part time and per-diem nurses related	.0		
	Nurse # 1 stated she	had last suctioned Resident			facility policy on tracheostomy suctioning	ng		
	# 1 about 1.5 hours b			and care.				
	tended to have large amounts of secretions.				As of 3/19/18 all full time, part time and			
	During the procedure, the nurse was observed to				per diem nurses will be educated by th	е		
	use an opened suction catheter, which was				Contracted Respiratory			
	located by the suction machine, to perform				Consultant/Director of Nurses and the			
	-	ing. Upon completion of the			Contracted Respiratory			
	_	fied with the nurse that this			Consultant/Director of Nurses will obse			
		the same suction catheter on the resident earlier that			a return demonstration of tracheostom	/		
		tated she did not always			care and suctioning by 04/05/18.			
	_	atheter, and she routinely			The monitoring procedure to ensure the	at		
	_	nes before discarding the			the plan of correction is effective and the			
	catheter.	ioo bololo alboaranig allo			specific deficiency cited remains correct			
					and/or in compliance with the regulator			
	On 3/7/18 at 12:30 PI	M the Director of Nursing			requirements:	,		
	(DON) was interviewe			The DON will randomly observe nurse				
	suctioning policies. The DON referenced the facility suctioning policy for nasopharyngeal suctioning. According to the DON, this was the facility policy applicable for tracheostomy suctioning. The DON confirmed nurses were to dispose of suctioning catheters after completing				practice on all shifts including weekend	s		
					and complete the Quality Assurance at	ıdit		
					tool for adherence to facility policy on			
					Tracheostomy Care and Suctioning			
					weekly x 4 then monthly x 3. The Direct	tor		
					of Nursing will present reports to the			
		ing according to their policy,			Administrator weekly, that in turn will b	€		
	and they were to use a new catheter each time a				shared with the Quality Assurance			
	suctioning procedure	was done.			Committee to ensure that corrective			
					action for any identified trends or ongo	•		
					concerns are initiated and monitored a	5		
					appropriate. The Director of Nursing, Minimum Data Set Coordinator, Suppo	rt		
					Nurse, Therapy Manager, Health			
					Information Manager, Dietary Manager			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345367	B. WING _			C 03/08/2018	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		03/0	18/2018
NAME OF T	NOVIDEN ON 301 1 EIEN			7348 NORTH WEST STREET	-		
GOLDEN YEARS NURSING HOME				FALCON, NC 28342			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	Continued From page	÷ 17	F8	Administrator and Medical Dire attends the weekly Quality Ass Meeting. Deficiencies that are during the monitoring process addressed through the facility Assurance process. The title of the person responsimplementing the acceptable process. The Director of Nursing 4/05/2018	surance identified will be Quality sible for		