STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345521	A. BUILDING _____ B. WING _____	C 05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SNUG HARBOR ON NELSON BAY	272 HIGHWAY 70 SEALEVEL, NC 28577

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 05/19/19 through 05/24/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #QQB811.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey. Event ID #QQB811.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §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 information correctly for 1 of 3 sampled closed records (Resident #36) whose Minimum Data Set (MDS) assessments were reviewed. The findings included: Resident #36 was admitted to the facility on 04/26/19 and discharged home on 05/03/19. Cumulative diagnoses of aftercare following joint replacement surgery, presence of right artificial hip joint and unilateral primary osteoarthritis, right hip. The Discharge Assessment MDS dated on 05/03/19 revealed that section A was coded under discharge status (A2100) as acute hospital.	F 641	F 641 483.21(g) 1. The discharge assessment for Resident□s #36 has been re-assessed for section A (A2100), and the discharge assessment was updated and transmitted May 29, 2019, to indicate that the resident was discharged home. Both Minimum Data Set(MDS)coordinators have been in-serviced and re-educated on the importance of accuracy of assessments on section A (discharge status) by the director of nursing on June 6, 2019. Failure to complete accurate assessments related to discharge status by the MDS coordinator will result in further re-education and also may result in disciplinary action up to and including termination of employment through the	6/21/19

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

Electronically Signed | 06/11/2019

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F 641	Continued From page 1 The recapitulation sheet for Resident #36 revealed that the resident was discharged home on 05/03/19. During an interview with the MDS Coordinator on 05/23/19 at 12:45 PM, she stated that she checked the wrong box in error. She further stated that it was her expectation that the MDS is coded correctly and double checked before she signs them. During an interview with the Director of Nursing (DON) on 05/24/19 at 3:10 PM, he stated that it was his expectation that the MDS is coded accurately for each resident. During an interview with the Administrator on 05/24/19 at 5:00 PM, she stated that it was her expectation the MDS assessments are accurately coded.	F 641	facility progressive disciplinary policy. 2. Residents discharged in the past thirty days have been reviewed for section A2100 to ensure accurate assessment. There were no identified inaccurate coding of section A2100. 3. No systemic changes are necessary, only the education and re-education of both the Minimum Data Set (MDS)coordinators The facility will take steps through training and quality assurance to ensure that solutions are sustained. 4. The facility will review discharge assessments of residents to ensure accurate coding of A2100. Reviews will be conducted by the director of nursing weekly for four (4) weeks and monthly for six months, and then two discharge assessments per month for six months to ensure accuracy of discharge assessments. If accuracy is sustained, then no further audits will be conducted. Negative findings will be presented through the facility Quality Assessment and Performance Improvement(QAPI)program and corrective actions taken as necessary to ensure that solutions are sustained. The administrator is responsible through Quality Assessment and Performance Improvement program for overall compliance. 5. Date of compliance on June 21, 2019.	

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F 727 SS=B	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to schedule a Registered Nurse (RN) eight consecutive hours on 5 of 405 days during the weekends and week days since the last recertification survey. The findings included: The daily nursing staffing sheets from since the last recertification survey of April 14, 2018 to May 23, 2019 revealed the there was no RN coverage as working on the following days: July 28, 2018 - Saturday - census 39; September 3, 2018 - Monday - census 38; September 4, 2018 - Tuesday - census 38; September 10, 2018 - Monday - census 36; November 10, 2018 - Saturday - census 38. During an interview with the Administrator on 05/21/19 at 3:50 PM, she stated that it was her	F 727	F 727 483.35 (b)(1)-(3) 1. The staffing coordinator, Director of Nursing (DON), Assistant director of nursing (ADON) and Material data set (MDS) coordinator have been in-serviced by the administrator on the requirement of having a registered nurse (RN) for at least eight consecutive hours a day, seven days a week. No specific resident is affected by the deficient practice, so the plan of correction for this deficiency will be identified below. 2. The staffing schedule will be posted weekly with the RN coverage to meet the current requirements of eight hours a day, seven days a week. The DON will be notified if this requirement cannot be met related to staffing issues. The Director of Nursing will ensure the requirement is met	6/21/19

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F 727	Continued From page 3 expectation that an RN is scheduled 7 days a week for 8 consecutive hours. During an interview with the Director of Nursing (DON) on 05/24/19 at 3:15 PM, he stated that it was his expectation that an RN is scheduled 7 days a week for 8 consecutive hours.	F 727	through scheduling of his or herself, Minimum Data Set (MDS) registered nurse, the selected registered nurse, and Assistant Director of Nursing. 3. No systemic changes are necessary. The facility will take steps through training and quality assurance to ensure solutions are sustained. 4. To ensure corrective actions are sustained the facility will complete audits by the ADON and the Director of Nursing weekly for four (4) weeks, monthly for (3 months), and quarterly thereafter. Negative findings will be presented through the facility Quality Assessment and Performance Improvement (QAPI)program and corrective actions taken are achieved or sustained. The administrator is responsible through Quality Assessment and Performance Improvement (QAPI)program for overall compliance. 5. Date of compliance: June 21, 2019	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		6/21/19

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F 761	Continued From page 4 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to discard two expired vials of insulin medication from 1 of 1 medication cart observed (Medication Cart 1-20). The findings included: During an observation of Medication Cart 1-20 on 05/24/19 at 10:45 a.m., an expired vial of Humalog insulin was observed marked with a "date opened" of 04/23/19 and marked with an "expiration date" of 05/21/19. Medication Cart 1-20 also contained an expired bottle of Levemir insulin marked with a "date opened" of 04/09/19; there had been no "expiration date" marked on the vial. During an interview with the Director of Nursing (DON) on 05/24/19 at 11:53 a.m., the DON stated the facility pharmacy's "Medication Discard Date"	F 761	F 761 483.45 (g)(h) (1)(2) 1. On May 24, 2019 the Director ensured that both of the expired vials of insulin were removed from the medication cart and returned to pharmacy for proper destruction. 2. On May 24, 2019, the Director of Nursing performed and audit of all medication carts to ensure that the carts did not have expired medications on the carts. No other expired medications were found. 3. Educational in-services will be provided by 06-14-2019 to each licensed practical nurse, and registered nurse (LPN/RN) on proper removal and discarding of expired medications. A list	

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F 761	Continued From page 5 reference tool indicated Levemir insulin should have been discarded 42 days after it had been opened and Humalog insulin should have been discarded 28 days after it had been opened. The DON stated he expected nursing staff to check the "Medication Discard Date" reference tool, located in the front of each of the Medication Administration Record notebooks, and discard medications that are recommended to be discarded as per pharmacy protocols. During an interview with the Administrator on 05/24/19 at 11:50 a.m., the Administrator stated it was her expectation nursing staff discard expired medications.	F 761	of medications with Discard Dates will be provided to all nurses in the education session and will be reviewed with them by the Director of Nursing. In addition, the Medication Discard Dates reference sheets will be placed in front of the Medication Administration Record books as an easy reference guide to each nurse. A weekly audit of each medication cart beginning 06-04-2019 will be conducted by the Director of Nursing or a Registered Nurse designated by the Director of Nursing to complete the cart audit. This will be submitted monthly to the Quality Assurance Committee and quarterly to the Quality Assessment and Performance Improvement Committee by the Director of Nursing. 4. The Quality Assurance and Quality Assessment and Performance Improvement Committees will be responsible along with the facility Administrator to review the weekly audits to ensure that compliance is achieved, maintained and sustained. The Quality Assessment and Performance Improvement Committee will be responsible for making adjustments to the audits or the procedure to ensure that compliance is achieved and sustained. 5. Completion Date: June 21, 2019	
F 851 SS=C	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform	F 851		6/21/19

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F 851	Continued From page 6 format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).	F 851		

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F 851	Continued From page 7 §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on the record review and staff interview the facility failed to electronically submit complete and accurate direct care staffing information based on payroll data to Centers for Medicare and Medicaid (CMS). The findings included: Record review revealed that there were no payroll based journals on file to support the daily nursing staffing sheets. During an interview with the Administrator on 05/21/19 at 3:55 PM, she stated that when she started working at the facility during the month of May 2019 she was told by the business office staff that the facility did not have a system in place to report to the (CMS) the required payroll based journals. The Administrator stated that the business office staff received some training in	F 851	F 851 483.70 (q)(1)-(5) 1. Payroll Based Journal is a requirement by Centers for Medicare and Medicaid. It does not affect the day to day quality of care delivered by Snug Harbor. It does not affect any specific resident. 2. The resident daily population is not affected by the deficient practice of not submitting Payroll Based Journal to Centers for Medicare and Medicaid. 3. An educational in-service has been completed on June 10, 2019 for the Business Office Manager on the requirement of collecting payroll and consultant hours data to be used to submit payroll based journal information	

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F 851	Continued From page 8 April 2019 by the corporate financial consultant and there is more training to be done. The Administrator further stated the facility was still not submitting the direct care staffing information to CMS, but it was her expectation that the facility submitted the required payroll based journals to CMS every quarter.	F 851	to the Centers for Medicare and Medicaid. In addition, a consultant has been secured to assist with accurate collection of data and entry of data in the Centers for Medicare and Medicaid Payroll Based Journal system. The facility will submit by August 14, 2019 the required data from April 1, 2019 through June 30, 2019 for the current quarterly required reporting period. 4. At the monthly Quality Assurance Committee Meetings, the Office Manager will be responsible for reporting on the data collection and data entry into the Payroll Based Journal System with Centers for Medicare and Medicaid. The Quality Assessment and Performance Improvement Committee which meets quarterly will be responsible for reviewing the actual submission of the information as required by Centers for Medicare and Medicaid and ensuring that it has occurred. A Quality Improvement Data Collection Form will be used to report this information to the Quality Assessment and Performance Improvement Committee. The Quality Assessment and Performance Improvement Committee along with the facility Administrator will be responsible for altering or adjusting the procedure to ensure compliance is achieved and sustained. 5. Completion Date: June 21, 2019	