STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345492	A. BUILDING _____ B. WING _____	C 02/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS HOME - FAYETTEVILLE	214 COCHRAN AVENUE FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641 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 observations, record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 1 sampled resident (Resident #10) with restraints; code the dental status for 1 of 1 sampled resident (Resident #28); code medications accurately for 2 of 5 sampled residents reviewed (Resident #74 and Resident #94) and code resistive care for 1 of 1 sampled resident reviewed for resistive care (Resident #66). Findings included: 1. Resident #10 was admitted to the facility on 06/18/17 with diagnoses that included Personal history of Traumatic Brain Injury, Hypokalemia, Quadriplegia, Protein-Calorie Malnutrition, Epilepsy, Contracture, Dysphagia and Convulsions. Review of the Annual Minimum Data Set (MDS) assessment dated on 10/11/17 indicated that the resident was coded as severely impaired for daily decision making and total care with two persons physical assist for all activities of daily living. The resident was coded as not used for bed rails, other (mittens) and chair prevents rising (table top) in section P (Restraints). Review of the care plan dated on 01/17/18 read in part "problem onset: Resident uses lap tray when	F 641	This time line investigation and plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove substantial noncompliance. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. F 641 483.20 Step 1. Assessments with deficiency found for Resident #10, Resident #28, Resident #74, Resident #94, and Resident #66 were modified by the Case Mix Director (RN) on 2/21/2018 to comply with RAI Manual/Medicaid/Federal Guidelines. Step 2. To complete a 100% audit of quarterly	2/28/18

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

Electronically Signed | 02/23/2018

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F 641	Continued From page 1 in wheelchair due to impaired cognition and unaware of safety. This is for safety and proper positioning and to prevent injury from sliding out of chair. Diagnosis: Quadriplegia Secondary to history of traumatic brain injury in 1993 when he was assaulted. Goal: Resident will be free of injuries and will have least restrictive devices through next review period. Approaches: Document/observe effectiveness or adverse reactions to restraint per facility policy. Place resident in reduction program and follow up per facility policy. Remove devices frequently and follow facility protocol. Make sure resident is properly aligned and reposition as needed while in wheelchair with lap tray. Therapy referral for positioning." Observation was made of Resident #10 on 01/31/18 at 4:37 PM lying in bed asleep with a mitten on right hand, splint on left hand and four side rails in the up position. Resident #10 is tube fed and has a Tracheostomy. During an interview on 01/31/18 at 4:45 PM Nurse #5 stated that the side rails, mitten and table top were being used per request from the resident's mother. She further stated that the table top was used for positioning and mittens were used because the resident would sometime hit himself on the head and try to pull out his Tracheostomy (trach). During an interview on 02/01/18 at 2:10 PM the Director of Nursing stated that it is her expectation that if a device is being used as a restraint that it be coded accurately as a restraint on the MDS. Observation was made of Resident #10 on	F 641	assessments will be conducted by the Case Mix Director (RN)for all active residents from 12/1/2017 to 2/23/2018 to ensure accuracy in section P, section L, section N, and section E. Step 3. a. Education began on 2/5/2018 by the Clinical Reimbursement Coordinator and Senior Nurse Consultant for the Case Mix Director (CMD) and Interdisciplinary Team on completing the MDS accurately, with emphasis on sections P, section L, section N, and section E with quarterly assessments, per the RAI Manual/Federal Guidelines. b. An assessment audit tool for section P, section L, section N, and section E will be implemented by the Case Mix Director (CMD) and will be implemented as follows:5 times per week for 4 weeks, then 2 times per week for 4 weeks, then audit done monthly for three months. Step 4. Monitoring will be done by the Case Mix Director (CMD), Director of Nursing (RN) and Administrator to ensure accuracy in section P, section L, section N, and section E. Continued monitoring will then occur 5 times per week for 4 weeks, then 2 times per week for 4 weeks, then audit done monthly for three months. Results of the monitoring with tracking and trending will be reported by the Case Mix Director monthly to the Quality	

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F 641	Continued From page 2 02/01/18 at 4:27 PM lying in bed asleep with splint on left hand and mitten on his right hand. Observation was made of Resident #10 on 02/02/18 at 11:00 AM sitting up in his wheelchair with table top tray applied. The resident has a splint on left hand. During an interview on 02/02/18 at 12:00 PM NA #2 stated that the table top is placed on the resident's wheelchair when he is out of bed. He further stated that the resident mitten is placed on him to prevent him from pulling out his trach and feeding tube. NA #2 further stated that the resident's mother removes his mitten when she is visiting with him. During an interview on 02/02/18 at 12:27 PM the MDS Coordinator stated that it is her expectation that the MDS be coded accurately. 2. Resident #28 was admitted to the facility on 02/20/15 with the diagnoses which included dementia with behavioral disturbance, major depressive disorder, anxiety disorder, pneumonia, muscle weakness, dysphagia, lack of coordination and symbolic dysfunctions. The quarterly MDS dated 10/19/17 indicated Resident #28 was cognitively impaired. She required extensive assistant with personal hygiene. There were no oral/dental issues identified on the MDS. Resident #28 was observed on 01/29/18 at 10:19 AM, and she had broken upper teeth in the front of her mouth.	F 641	Assurance Performance Improvement committee for recommendations and suggestions for improvement and changes.	

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The MDS Nurse #1 was interviewed on 02/01/18 at 3:45 PM. She revealed Section L was not coded on the quarterly assessment.

During an interview with the Director of Nursing and the Facility Administrator on 02/01/18 at 4:05 PM, they acknowledged Resident #28 did have broken teeth, the family had refused dental interventions and the MDS was inaccurately coded. They explained the MDS Coordinator would make the correction and their expectation was the MDS will be accurately coded for dental for all residents in the facility.

3. Resident #74 was admitted to the facility on 04/29/16, with the diagnoses which included diabetes mellitus, personality disorder, degenerative disease of nervous system, chronic pain syndrome, presbyopia, blindness, hemiplegia following cerebral infarction, peripheral vascular disease, constipation, cutaneous abscess of neck, muscle weakness, osteomyelitis, difficulty in walking, and history of falling.

Review of quarterly MDS dated 12/04/17 indicated Resident #74 received insulin medication for 7 of 7 days of the assessment period.

Review of Resident's November 2017 and December 2017 Medication Administration Record (MAR) revealed the resident did not receive insulin during the 7 days look back period.

The MDS Nurse #1 was interviewed on 02/01/18 at 3:45 PM. After reviewing the chart and the MDS Assessment she revealed Section N was

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F 641	Continued From page 4	F 641		

not coded correctly on the quarterly assessment.

During an interview with the Director of Nursing and the Facility Administrator on 02/01/18 at 4:05 PM, they acknowledged Resident #74 did not have insulin during his quarterly assessment and the MDS was inaccurately coded. They explained the MDS Coordinator would make the correction and their expectation was the MDS will be accurately coded for Section N: Medications for all residents in the facility.

4. Resident #94 was admitted to the facility on 10/03/17 with the diagnoses which included diagnoses of Vitamin D Deficiency, hyperlipidemia, major depressive disorder, anxiety disorder, chronic pain syndrome, hypertension, cerebral infarction, benign prostatic hyperplasia, and post-traumatic stress syndrome.

Review of quarterly MDS dated 12/13/17 indicated Resident #94 received insulin medication for 7 of 7 days of the assessment period.

Review of Resident ' s November 2017 and December 2017 Medication Administration Record (MAR) revealed the resident did not receive insulin during the 7 days look back period.

The MDS Nurse #1 was interviewed on 02/01/18 at 3:45 PM. After reviewing the chart and the MDS Assessment, she revealed Section N was not coded correctly on the quarterly assessment.

During an interview with the Director of Nursing and the Facility Administrator on 02/01/18 at 4:05 PM, they acknowledged Resident #94 did not

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F 641	Continued From page 5	F 641		

have insulin during his quarterly assessment and the MDS was inaccurately coded. They explained the MDS Coordinator would make the correction and their expectation was the MDS will be accurately coded for Section N: Medications for all residents in the facility.
5. Resident #66 was admitted to the facility on 9/5/2014 with cumulative diagnoses which included chronic kidney failure, hyperlipidemia and diabetes.

The quarterly Minimum Data Set (MDS) dated 11/24/2017 indicated the resident's cognition was intact, he required extensive assistance with 1 person assist with bed mobility, extensive assistant with 2 person assistance with bed mobility and was total dependent on staff for bathing. Section E was not coded for rejection of care.

Review of the resident's nurse notes indicated the resident resisted care on the following dates: 8/26/2017 refused bath in the morning, 9/17/2017 refuses care if outside of particular preferences.

Review of the skilled daily nurse's note for the month of November 2017 revealed the resident was checked daily for the behavior of rejecting care.

During the interview on 1/31/2018 at 11:30 AM, the Unit manager (Nurse #2) indicated the resident usually rejects getting showers, baths and getting weighed.

During the interview on 1/31/2018 at 12:30 PM, Nurse Aide (NA) #1 reported the resident refuses getting showers and baths in regularly basis.

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F 641	Continued From page 6 During the Interview on 2/1/2018 at 2:25 PM, the MDS coordinator, she indicated the behavior section E of the MDS assessment should have been coded for rejection of care. She added it was an error which was made by another MDS coordinator. Interview on 2/1/2018 at 3:02 PM with the Administrator revealed she expected rejection of care should have been coded under section E on the MDS assessment.	F 641		
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. §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	F 761		2/22/18

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F 761	Continued From page 7 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to lock an unattended treatment cart for 1 of 3 treatment carts observed. (A wing treatment cart) Findings Included: During observation on 1/30/18 at 8:31 AM the A wing treatment cart was observed to be unlocked and unattended next to the nurse's station. Two housekeeping staff members walked past the unlocked treatment cart. No other staff members were visible. At 8:37 AM a therapy nurse aide was observed to walk past the unlocked treatment cart. At 8:38 AM a maintenance staff member was observed to walk past the unlocked treatment cart. At 8:40 AM a resident was observed to walk by the unlocked treatment cart. At 8:45 AM Nurse #1 exited the closed medication to answer a phone at the nurse's station. The treatment cart was still unlocked. During an interview on 1/30/18 at 8:45 AM Nurse #1 stated that it was the facility's policy all treatment carts be locked at all times when unattended. She further stated that the treatment cart contained medications including hydrogen peroxide, hydrocortisone cream, triamcinolone cream, lidocaine cream nystatin cream, tretinoin cream, and mupirocin ointment. She stated the A wing treatment cart was unlocked and had been unattended and it should have been locked. She further stated she did not know who had last interacted with the cart but that as the unit manager, she insured the carts at the nurse ' s station remained locked when unattended and did	F 761	This time line investigation and plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove substantial noncompliance. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. F761 $84.35 Storage of Drugs and Biologicals Step 1. A Wing treatment cart was immediately locked by the Wound Nurse. Step 2. A 100% complete audit was conducted by the Skin Integrity Coordinator(RN) on 1/30/2018 of all treatment carts to ensure they were locked, if they were unattended. Step 3. a. All licensed nursing staff were educated by the Skin Integrity Coordinator (RN) on	

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F 761	Continued From page 8 not notice the treatment cart was unlocked. During observation on 1/31/18 at 1:12 PM the A wing treatment cart was observed to be unlocked and unattended next to the nurse ' s station. Two visitors were observed to walk past the unlocked medication cart. At 1:15 PM Treatment Nurse #1 returned to the nurse ' s station. During an interview on 1/31/18 at 1:15 PM Treatment Nurse #1 stated that the A wing treatment cart was his treatment cart. He further stated treatment carts should never be left unlocked and unattended. He further stated there was no reason why he left the A wing treatment cart unlocked and that it should have been locked. The treatment cart contained medications including hydrogen peroxide, hydrocortisone cream, triamcinolone cream, lidocaine cream nystatin cream, tretinoin cream, and mupirocin ointment. During an interview on 1/31/18 at 1:30 PM the Director of Nursing stated that the treatment carts must be locked at all times when not in use. She further stated if they walk away from the treatment cart it should be locked. She further stated that it was her expectation that staff lock treatment carts while unattended and the A wing treatment cart should have been locked.	F 761	the expectation that all treatment carts are to be locked when unattended and not in use. All licensed nursing staff will be educated upon hire and as needed. b. A monitoring tool was implemented by the Skin Integrity Coordinator (RN)on 2/21/2018 to audit the treatment carts twice per shift to verify the treatments carts are locked when unattended or not in use and will completed as follows: 5 times per week for 4 weeks, then 2 times per week for 4 weeks, then audit done monthly for three months. Step 4. Monitoring will be done by the Skin Integrity(RN) and the Director of Nursing (RN) to ensure the treatment carts are locked when unattended or not in use. Continued monitoring will then occur 5 times per week for 4 weeks, then 2 times per week for 4 weeks, then audit done monthly for three months. Results of the monitoring with tracking and trending will be reported by the Skin Integrity Coordinator monthly to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvement and changes.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		2/23/18

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(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or

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F 842	Continued From page 10 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record reviews and staff interviews, the facility failed to document identified bruise for 1 of 1 sampled resident who had fragile skin. (Resident # 18) Findings included: Resident # 18 was admitted to the facility on 4/24/2016 with the diagnosis which included Coronary Artery Disease, Hypertension, and Thyroid disorder, Alzheimer's disease, Depression and Arthritis. The Minimum Data Set (MDS) dated 10/13/2017 indicated the resident's cognition was severely impaired, she require extensive assistance with 2 persons for bed	F 842	This time line investigation and plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove substantial noncompliance. It also demonstrates our good faith and desire to continue to improve the quality of care	

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NC STATE VETERANS HOME - FAYETTEVILLE	214 COCHRAN AVENUE FAYETTEVILLE, NC 28301

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F 842	Continued From page 11 mobility and transfers. Resident # 18's care plan updated 1/4/2018 revealed the resident was care planned for potential for skin breakdown, incontinent episodes, decreased mobility, Alzheimer's dementia- impaired decision making due to advance age and fragile skin essential tremors- she could accidentally hit her skin on objects. The approaches included "monitor resident's skin during routine daily care, report abnormalities to nurse (i.e. irritation, redness, open areas rashes, and bruises), and long sleeves due to skin irritation." Review of the treatment record for January 2018 revealed a left lower leg skin tear. The treatment indicated "apply calcium alginate with dry dressing." Which was to be done every 3 days and as needed. Observation of the resident on 1/31/2018 at 10:30 AM, revealed the resident sitting in a Geri chair. The resident was wearing a long sleeve blouse. No skin tear observed. During the interview on 1/31/2018 at 1:00 PM, the Nurse Aide (NA) # 1 reported she discovered a bandage on the resident's leg on 12/29/2017 and reported the findings to Nurse # 4. She added it was her practice to report to the nurse any discovered skin changes. During the Interview on 1/31/2018 at 1:10 PM, Nurse # 4 indicate that on 12/29/2017, NA # 1 reported to her about the newly discovered bandage on Resident # 18. Nurse # 4 added she reported the findings to the treatment Nurse # 3. During the interview on 2/1/2018 at 1:20 PM, Treatment Nurse # 3 indicated she did not recall	F 842	and services to our residents. F 842 483.20 Step 1. A complete body audit was done by the Skin Integrity Coordinator for Resident #18 and results were noted on a Body Observation Form and documented in the medical record. Step 2. A protocol for reporting any skin changes was initiated by the Director of Nursing (RN) on 1/31/2018. This protocol stated that a Body Observation will be performed on Resident #18 each shift using the Body Observation Form. The Charge Nurse (LPN) will review each Body Observation Form and sign for accuracy. If new areas are discovered, the nurses are to observe and document findings, notify Unit Manager (RN), Medical Provider, and Responsible Party. The Charge Nurse (LPN) will document time and date when the Responsible Party was notified on Body Observation Form and Medical Record. The Unit Manager will discuss the previous day observation of Resident #18 during morning clinical rounds. Step 3. A monitoring tool was developed by the Director of Nursing (RN)on 2/15/2018 to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345492	A. BUILDING _____ B. WING _____	C 02/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 12 Nurse # 4 reporting to her about a bandage on 12/29/2017. She added it was on 1/4/2018 when she saw the bandage on the resident's leg and began the treatment on the residents bruise which was on her leg. During the interview on 2/2/2018 at 10:00 AM with the Director of Nursing (DON), she reported her expectation of staff was for the Nurse Assistants at the facility to report any skin changes to the charge nurse and the charge nurse to document any findings in the resident's record as soon as possible. DON also added the charge nurse was expected to document the findings and notify Unit Manager, Medical Director and Responsible Party.	F 842	monitor any change in condition and notification of Responsible Party each day. Any changes will be discussed each day in morning clinical rounds. Monitoring will occur as follows: 5 times per week for 4 weeks, then 2 times per week for 4 weeks, then audit done monthly for three months. Step 4. Monitoring will be done by the Skin Integrity Coordinator(RN) and the Director of Nursing (RN) to ensure that any change in condition and notification of Responsible Party each day. Continued monitoring will then occur 5 times per week for 4 weeks, then 2 times per week for 4 weeks, then audit done monthly for three months. Results of the monitoring with tracking and trending will be reported by the Skin Integrity Coordinator monthly to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvement and changes.	