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 01/10/2019

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
E 000	Initial Comments An unannounced Recertification survey was conducted on 01/07/19 through 01/10/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SJRI11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted on 01/10/19. Event ID# SJRI11.	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 interview, the facility failed to accurately code the Minimum Data Set (MDS) reflecting anticoagulant medication use for 1 of 36 sampled residents whose MDS assessments were reviewed for coding accuracy. (Resident # 138). The findings included: Resident #138 was admitted to the facility on 12/19/18 with diagnoses of dementia, depression, asthma, hyperlipidemia, hypertension and coronary artery disease. Review of the Medication Administration Record for December 2018 revealed there was no anticoagulant medications prescribed or given. Review of the Physician Orders dated for the	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	2/6/19

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

Electronically Signed | 02/03/2019

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F 641	Continued From page 1 month of December 2018 revealed there was no anticoagulant medications prescribed. The admission Minimum Data Set (MDS) dated 12/26/18 coded Resident #138 as receiving anticoagulant medication 3 days out of the previous 7 days. Interview with MDS Nurse #1 on 01/09/19 at 10:15 AM revealed she miscoded the anticoagulant medications during the look back period for the MDS of 12/26/18 as she misread the coding on her forms. The MDS Nurse #1 revealed the 3 days should have been coded as antibiotic medications. Interview with the Administrator on 01/09/19 at 4:00 PM revealed her expectation is that all MDS documentation be coded correctly.	F 641	Step 1. The assessment with deficiency found for Resident #138 was modified by the Case Mix Director (RN) on 1/09/2019 to comply with RAI Manual/Medicaid/Federal Guidelines. Step 2. To complete a 100% audit of admission assessments will be conducted by the Case Mix Director (RN)for all active residents from 12/1/2018 to 2/07/2019 to ensure accuracy in section N. Step 3. a. Education was done on 1/17/2019 by the Clinical Reimbursement Coordinator for the Case Mix Director (CMD) on completing the MDS accurately, with emphasis section N, with quarterly assessments, per the RAI Manual/Federal Guidelines. b. An assessment audit tool for section N, 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	

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F 641	Continued From page 2	F 641	section N. 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 Assurance Performance Improvement committee for recommendations and suggestions for improvement and changes.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental	F 645		2/6/19

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F 645	Continued From page 3	F 645		

condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3)

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F 645	Continued From page 4 or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to apply information for a resident with a diagnosis of Depression and Post Traumatic Stress Disorder (PTSD) for a Preadmission Screening and Resident Review (PASARR) level II re-evaluation for 1 of 5 sampled residents. (Resident #68). The findings included: Resident #68 was originally admitted to the facility on 07/18/18 with diagnoses which included: PTSD and Depression. Record review of Resident #68's Admittance Minimum Data Set (MDS) dated 7/25/18 had resident coded as having had received antidepressant medication for 7 of the 7 days during the assessment period. Record review of Resident #68's care plan which was revised on 9/24/18 indicated the resident was care planned for use of an antidepressant due to diagnoses of depression. Record review revealed that the resident had the diagnoses of Depression and PTSD when he was admitted on 07/18/18. During an interview with the Social Worker (SW) on 01/10/19 at 01:06 P.M., the SW stated the resident was admitted 7/18/18 with a diagnosis of Depression and PTSD. The SW also stated it was her expectation when a resident has a diagnosis of mental illness the PASARR level II	F 645	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. F645 483.20 Step 1. PASARR screening and resident review for (PASARR) level 2 re-evaluation for Resident #68 was submitted on 1/9/2019. Step 2. To complete a 100% audit of PASARR screenings and level 2 re-evaluations for all new admissions from 2/3/2018 to 1/31/2019. Step 3.	

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F 645	Continued From page 5 be submitted for re-evaluation. During an interview with the Administrator on 01/10/19 01:18 PM revealed that it was her expectation when a resident has a diagnosis of mental illness the PASARR level II be submitted for re-evaluation.	F 645	a. Education was done on 1/9/2019 by the Administrator for the Social Worker's on PASARR screening and level 2 re-evaluations for all new admissions. b. A monitoring tool for Preadmission PASARR screenings will be implemented by the Social Services Director on 2/1/2019 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 Social Services Director, Director of Nursing, and Administrator to ensure the Preadmission PASARR screenings and level 2 re-evaluations were done. 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 Social Services Director monthly to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvement and changes.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		2/6/19

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F 812	Continued From page 6 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to discard expired food items and failed to label and date food items in 2 of 3 nourishment room refrigerators observed. The findings included: A review of the facility's "Patient/Residents' Personal Food Policy, revised 11/21/16, indicated, in part, 1. Foods requiring refrigeration must be stored in the nursing unit refrigerator or the patient/residents' personal refrigerators... Food requiring refrigeratoration must be labeled and dated and will be discarded after 48 hours. 2. Nursing Personal will be responsible for the disposal of outdated foods maintained in the patient/residents' room and those stored in the nursing unit refrigerators. During an observation of the "C" Wing nourishment room refrigerator, with the Dietary	F 812	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 812 483.60 Step 1.	

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F 812	Continued From page 7 Manager in attendance, on 01/10/19 at 3:09 p.m., the refrigerator was observed to contain the following items: 1. A plastic bag containing two paper wrapped sandwiches. The items had not been labeled or dated. 2. One clear re-usable beverage container, filled with a clear liquid. This item had not been labeled or dated. 3. One clear container, labeled by the manufacturer as Ice Tea, with a Best If Used By date of 12/12/18. The container had been re-filled with a clear liquid. The item had not labeled or dated. During an observation of the "B" Wing nourishment room refrigerator, with the Dietary Manager in attendance, on 01/10/19 at 3:15 p.m., the refrigerator was observed to contain the following items: 1. One clear plastic cup filled with a rice preparation and a plastic utensil, covered by a paper napkin. The item had not been labeled or dated. 2. One Styrofoam container with two servings of pureed sweet potatoes. The item had not been labeled or dated. 3. One-half of a sandwich, wrapped in plastic wrap. This item had not been labeled or dated. 4. One box of peach cobbler, labeled with a resident's name. This item had not been dated. 5. One plastic container of ricotta cheese. The expiration date had been 08/04/18. During an interview with the Dietary Manager on 01/10/19 at 3:15 p.m., the Dietary Manager stated dietary employees stocked the nourishment room refrigerator with food items and beverages the facility provided. The Dietary Manager stated the	F 812	Nourishment room refrigerators for both B Wing and C Wing were cleaned and all foods that were outdated, not labeled, and not dated were disposed of by the Dietary Manager on 1/10/2019. Step 2. A complete 100% audit of all nourishment room refrigerators were cleaned and maintained on 1/11/2019 by the Dietary Manager. Step 3. a. Education was done by the Assistant Director of Nursing (ADHS) on 2/3/2019 for all staff on ensuring the proper disposal of expired food items, proper labeling, and dating of food items stored in the nourishment room refrigerator. b. An audit tool for maintain the nourishment room refrigerators will be implemented on 2/3/2019 by the Dietary Manager (DM) 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 Dietary Manager (DM), Director of Nursing, and Administrator to ensure the proper disposal of expired food items, proper labeling, and dating of food items in the nourishment room refrigerators. Continued monitoring will then occur 5	

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F 812	Continued From page 8 housekeeping department and nursing department were responsible for labeling, dating, and removing expired items in the nourishment room refrigerators. During an interview with the Administrator on 01/10/19 at 3:17 p.m., the Administrator stated the nursing department staff and the housekeeping department staff monitored the food in the nourishment room refrigerators. The Administrator stated the dietary department staff were responsible for stocking the refrigerators and freezers with items from the facility. The Administrator stated if a family member brought food in for a resident, the nursing department staff were responsible for dating and labeling the food prior to it being placed in the refrigerator or freezer. The Administrator stated it was her expectation food stored in the nourishment room refrigerators and freezers be labeled, dated and discarded appropriately.	F 812	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 Dietary Manager (DM) monthly to the Quality Assurance and Performance Improvement committee for recommendations and suggestions for improvement and changes.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 2/02/18 recertification survey. This	F 867	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	2/6/19

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F 867	Continued From page 9 was for the recited deficiency in the area of Assessment Accuracy (F641). It was cited again on the recertification survey of 1/10/19. The continued failure of the facility from the two consecutive federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: F641 Assessment Accuracy: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) reflecting antibiotics and anticoagulant medication use for 1 of 36 sampled residents. (Resident # 138). During the 2-02-18 recertification survey, the facility had a F641 citation for failing to accurately code the Minimum Data Set for restraints, dental status, medications and for resistive care. An interview was conducted with the Administrator on 01/10/19 at 6:00 PM. The Administrator stated the facility has a functioning Quality Assessment and Assurance Committee with committee members representing all departments. The Administrator indicated her expectation was to revisit the assessment accuracy in their Quality Assessment and Assurance meeting and re-examine systems to find the root cause of the issue to address it with total team involvement.	F 867	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. Step 1. Assessments with deficiency found for Resident #138 was modified by the Case Mix Director (RN) on 1/09/2019 to comply with RAI Manual/Medicaid/Federal Guidelines. Step 2. To complete a 100% audit of admission assessments will be conducted by the Case Mix Director (RN)for all active residents from 12/1/2018 to 2/07/2019 to ensure accuracy in section N. Step 3. a. Education was done on 1/17/2019 by the Clinical Reimbursement Coordinator for the Case Mix Director (CMD) on completing the MDS accurately, with emphasis section N, with quarterly assessments, per the RAI Manual/Federal Guidelines. b. An assessment audit tool for section N, will be implemented by the Case Mix	

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F 867	Continued From page 10	F 867	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 six months. Step 4. Monitoring will be done by the Case Mix Director (CMD), Director of Nursing (RN), Administrator, and Clinical Reimbursement Coordinator to ensure accuracy in section N. 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 Assurance Performance Improvement committee and Clinical Reimbursement Coordinator for recommendations and suggestions for improvement and changes.	