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 _____	02/13/2020

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 02/10/20 through 02/13/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # SPSD11.	E 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 the Minimum Data Set (MDS) assessments for 1 of 3 sampled residents reviewed for Preadmission Screening Resident Review(PASRR)(which is an evaluation for mental illness or intellectual disability for all persons who live in or seek entry to a Medicaid-certified nursing facility).(Resident # 91) Findings included: 1. Resident # 91 was admitted to the facility on 10/3/2017 with multiple diagnoses that included major depressive disorder, hypertension,suicidal ideations,schizophrenia and unspecified anxiety disorder. The resident's medical record contained a PASRR Level II Determination Notification that was dated 4/23/2018. The Annual Minimum Data Set dated 1/2/2020 indicated a "No" to question A1500 which asked if Resident # 91 had been evaluated by a level II	F 641	The timeline 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. Step 1. a. The assessment with deficiency found for Resident #91 was modified by the Case Mix Director (RN) on 2/11/2020 to comply with RAI Manual/Medicaid/Federal Guidelines.	3/2/20

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

Electronically Signed | 02/28/2020

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F 641	Continued From page 1 PASRR and determined to have a serious mental illness and/or intellectual disability or a related condition. During the interview on 2/12/2020 at 1:29 PM, Minimum Data set (MDS) nurse reviewed the discharge MDS and confirmed it was inaccurate. The MDS nurse explained it was coded in error as Resident # 91 had been approved for a level II PASRR on and determined to have a serious mental illness. During an interview on 2/13/2019 at 1:35 pm with the Director of Nursing (DON) she acknowledged Resident # 91's Annual MDS was inaccurately coded. She stated that it is her expectation that the MDS should be coded accurately. Interview with the Administrator on 09/26/19 at 4 :15 PM revealed her expectation is that all MDS documentation be coded accurately.	F 641	Step 2. a. Complete 100% audit of comprehensive assessments will be conducted by the Case Mix Director (RN) or designee from 1/01/2020 to 2/11/2020 to ensure accuracy for section A1500 will be completed by 2/28/2020. Step 3. a. Education was done by the Clinical Reimbursement Consultant (RN) for The Case Mix Director (RN) and Case Mix Coordinators (LPN) on completing the MDS accurately, with emphasis on section A1500 and PASRR level on 2/19/2020. b. An assessment audit tool will be implemented by the Case Mix Director (RN) and will be implemented as follows: 5 times per week for weeks, then 2 times per week for 4 weeks, and then monthly for three months. Step 4. a. Monitoring will be done by the Case Mix Director (RN) or designee, Director of Nursing (RN), Clinical Reimbursement Coordinator (RN)and Administrator to ensure accuracy of A1500 and PASRR level. Monitoring will occur 5 times per week times 4 weeks, then 2 times per week times 4 weeks, and monthly times 3 months. Results of the monitoring with tracking and trending, will be reported by the Director of Nursing (RN) and Assistant	

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F 641	Continued From page 2	F 641	Director of Nursing (RN) monthly to the Quality Assurance and Performance Improvement committee for recommendations and suggestions for improvement and changes.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to make a referral for re-evaluation after a change in mental health status for 2 of 3 sampled residents reviewed for Preadmission Screening and Resident Review(PASRR). (Resident # 91and # 59) Findings included:	F 644	The timeline 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	3/2/20

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F 644	Continued From page 3 1. Resident # 91 was admitted to the facility on 10/3/2017 with multiple diagnoses that included major depressive disorder, hypertension,suicidal ideations, unspecified and anxiety disorder. The Annual Minimum Data Set (MDS) assessment dated 1/2/2020 indicated Resident #91's cognition was intact. Her active diagnoses included anxiety,depression and schizophrenia. Review of Resident # 91's medical record revealed a new diagnosis of schizophrenia was added on 1/10/2019. An observation was conducted of Resident # 91 on 2/12/2020 at 11:30 AM. There were no observed behavioral issues noted. An interview was conducted with Social Worker (SW) on 2/12/2020 at 11:40 AM. SW confirmed that Resident # 91 had a level II PASRR. SW confirmed Resident # 91 was not admitted to the facility with the diagnoses of schizophrenia. She revealed she had not referred Resident # 91 to the PASRR authority for a re-evaluation related to the new diagnosis of schizophrenia. An interview was conducted with the Director of Nursing(DON) on 2/12/19 at 2:00 PM. She stated that she was not very familiar with the regulations related to PASRR, but that she expected the regulations to be followed in reference to completing a PASRR for a newly identified mental illness diagnosis. 2. Review of Resident #59's Pre-Admission Screening and Annual Resident Review (PASARR) Level I Determination Notification letter dated 2/14/18 revealed the resident had been assessed to be Level I. There had been no	F 644	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. a. Resident #91 PASRR rescreened due to added psychiatric diagnosis. Resident level changed from a level A to level H. b. Resident #59's PASRR was rescreened due to a one-year limitation on level B. No change in the level of PASRR as a result of the rescreen. Step 2. a. 100% audit and screening of PASRR screenings for all PASRR levels with new mental health diagnosis, excluding ones with level H was completed by 2/28/2020. b. Social Services Director or designee will screen and review for PASRR level B and level C re-evaluations within the one-year limitation. c.Social Services Director or designee will re-evaluate residents with a new mental health diagnosis with a new PASRR screening. d. Social Services Director or designee will notify MDS of all PASRR levels.	

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F 644	Continued From page 4 further PASARR referrals for Resident #59 in the medical record. Resident #59 was admitted to the facility on 9/13/17 with a diagnosis which included dementia, psychotic disorder, and anxiety. The annual Minimum Data Set (MDS) assessment dated 7/18/19 indicated Resident #59's cognition was severely impaired. Resident #59 had been assessed with feeling tired or having little every nearly every day; having a poor appetite or overeating for 2 to 6 days; feeling bad about himself or that he was a failure or have let himself or his family down nearly every day; had trouble concentrating on things, such as reading the newspaper or watching television for two to six days. He had been administrated antipsychotic medications and antianxiety medication on 7 of 7 days assessed. His active diagnoses included dementia, psychotic disorder and anxiety disorder. Review of Resident #59's provider progress noted dated 12/05/19 revealed Resident #59 had been seen for monitoring/evaluation of existing diagnoses. The progress notes specified facility staff reported memory loss, disorientation, and mood changes. The staff denied behavioral change, depression or hallucinations. The current noted diagnoses included unspecified dementia with behavioral disturbance, anxiety disorder, and psychotic disorder. Review of Resident #59's February 2020 physician's order summary and Medication Administration Records indicated Resident #59 continued to receive antipsychotic medications, antidepressant and antianxiety medications.	F 644	Step 3. a. Education was done on 2/10/2020 by the Clinical Reimbursement Consultant (RN) and Senior Nurse Consultant (RN) for the Social Worker's on PASRR screening for all new mental health diagnosis and PASRR's with one-year limitations. b. A monitoring tool for mental health diagnosis will be implemented by the Social Services Director on 3/2/2020 and will be implemented as follows: 2 times per week for 4 weeks, then 1 time per week for 4 weeks, then audit done monthly for three months. c. Social Services Director or designee will pull a new diagnoses list one time per week. Step 4. a. Monitoring will be done by the Social Services Director, Director of Nursing, Assistant Administrator, Administrator to ensure the PASRR screenings for new mental health diagnosis and PASARR's with one-year limitation are complete. Continued monitoring will then occur 2 times per week for 4 weeks, then 1 time per week for 4 weeks, then audit done monthly for three months. b. Results of the monitoring with tracking and trending will be reported by the Social Services Director monthly to the Quality Assurance and Performance	

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F 644	Continued From page 5 An observation was conducted of Resident #59 on 2/11/20 at 9:30 AM. There were no observed behavioral issues noted. An interview with the Social Worker and the Minimum Data Set Nurse on 02/12/20 at 3:00 PM revealed the facility had missed sending the resident's data for a PASARR Level II evaluation. An interview with the Administrator on 02/12/20 at 3:45 PM, the Administrator stated the PASARR Level II screen was missed for Resident #59 and it should have been sent for evaluation.	F 644	Improvement committee for recommendations and suggestions for improvement 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 1/10/19 and 02/02/2018 recertification survey. This was for the recited deficiency in the area of Assessment Accuracy (F 641). It was cited again on the recertification survey of 02/13/2020. The continued failure of the facility from the three consecutive federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality	F 867	The timeline 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	3/2/20

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F 867	Continued From page 6 Assessment and Assurance Program. Findings included: F 641 Assessment Accuracy: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments for 1 of 3 sampled residents reviewed for Preadmission Screening Resident Review(PASRR)(which is an evaluation for mental illness or intellectual disability for all persons who live in or seek entry to a Medicaid-certified nursing facility).(Resident # 91) During the 1/10/2019 recertification survey, the facility had a F 641 citation for failing to accurately code the Minimum Data Set (MDS) reflecting anticoagulant medication use. During the 2/02/2018 recertification survey, the facility had a F 641 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 02/13/2020 at 3:00 PM. The Administrator reported the facility had a functioning Quality Assessment and Assurance Committee with committee members representing all departments. The Administrator further indicated her expectation was to have communication between the Minimum Data Set (MDS) staff and all other disciplines to assure accurate assessments on the MDS at the facility.	F 867	demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. Step 1. a. The assessment with deficiency found for Resident #91 was modified by the Case Mix Director (RN) on 2/11/2020 to comply with RAI Manual/Medicaid/Federal Guidelines. Step 2. a. Complete 100% audit of comprehensive assessments will be conducted by the Case Mix Director (RN) or designee from 1/01/2020 to 2/11/2020 to ensure accuracy for section A1500 will be completed by 2/28/2020. Step 3. a. Education was done by the Clinical Reimbursement Consultant (RN) for The Case Mix Director (RN) and Case Mix Coordinators (LPN) on completing the MDS accurately, with emphasis on section A1500 and PASRR level on 2/19/2020. b. An assessment audit tool will be implemented by the Case Mix Director (RN) and will be implemented as follows: 5 times per week for weeks, then 2 times per week for 4 weeks, and then monthly for three months. Step 4.	

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F 867	Continued From page 7	F 867	a. Monitoring will be done by the Case Mix Director (RN) or designee, Director of Nursing (RN), Clinical Reimbursement Coordinator (RN)and Administrator to ensure accuracy of A1500 and PASRR level. Monitoring will occur 5 times per week times 4 weeks, then 2 times per week times 4 weeks, and monthly times 3 months. Results of the monitoring with tracking and trending, will be reported by the Director of Nursing (RN) and Assistant Director of Nursing (RN) monthly to the Quality Assurance and Performance Improvement committee for recommendations and suggestions for improvement and changes.	