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 04/08/2022

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 and complaint investigation survey was conducted on 04/04/2022 through 04/08/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SLSX11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/04/2022 through 04/08/2022. Event ID#SLSX11 Three of the 16 complaint allegations were substantiated with deficiencies. Intake numbers: NC00184610, NC00185723, NC00186235, NC00187598, NC00187600 and NC00186043	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	F 561		5/3/22

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

Electronically Signed | 04/29/2022

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F 561	Continued From page 1 facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews the facility failed to honor a resident's request to get out of bed for 1 of 15 residents sampled for choices. (Resident #16) Findings included: Resident #16 was admitted to the facility on 04/14/2017. The quarterly Minimum Data Set (MDS) dated 01/14/2022 had Resident #16 coded as cognitively intact and needed extensive assistance with activities of daily living (ADL). The comprehensive care plan dated 01/17/2022 had focus of a self-care deficit with ADLs requiring extensive to total assistance with all his daily care needs. An interview with Resident #16 was conducted on 04/05/2022 at 6:22 PM. The resident stated he could not get up out of bed on the weekend of 04/02/2022 because the Nursing Assistants (NA) told him there werenot enough staff to get him up. The resident stated he needs to be up in his wheelchair due to his neck and back pain. The	F 561	The timeline investigation and plan of correction constitutes a written allegation of substantial 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 Director of Nursing pulled the schedule on 4/5/2022 to review for the next 14 days to ensure there was enough direct-care nursing staff in the right places throughout the facility. Step 2	

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F 561	Continued From page 2 Resident stated that more than once he was not able to get out of bed as result of staffing, but could not recall the exact dates. An interview with NA #1 was conducted on 04/06/2022 at 9:13 AM. The NA stated she worked the weekend of 04/02/2022 and there was an issue on "B" wing, and she went to that wing. The NA also stated Resident #16 wanted to get up in his wheelchair daily but Resident #16 did not get out of bed due to staffing that weekend. An interview with NA #2 was conducted on 04/06/2022 at 9:19 AM. The NA stated the weekend of 04/02/2022, she had around 25 residents, there was four NAs scheduled on hall, but one came in after 11:00 AM and one was sent to another hall. They were not able to get everyone up, but the residents were bathed, clean and dry. An interview with the Director of Nursing (DON) was conducted on 04/06/2022 at 10:33 AM. The DON stated Resident #16 does like to be up in his wheelchair. The weekend of 04/02/2022, they had enough employees in the facility, but they were not in the right areas. NAs came in at 11:00 AM but it was not timely enough to get residents their morning care. An interview with the Administrator was conducted on 04/06/2022 at 1:49 PM. The administrator stated 25 residents for a nurse aide to care for was too many to get the work done effectively. A telephone interview with Nurse #4 was conducted on 04/07/2022 at 9:29 AM. The nurse	F 561	The Director of Nursing reviewed the schedule on 4/15/2022 for a rolling 30 days to ensure there is enough direct-care nursing staff throughout the facility and in the right areas. Step 3 a. The Clinical Competency Coordinator will educate the Licensed Nurses that when there are changes to the staffing schedule to make operational changes that reflect appropriate staffing levels throughout the facility based on acuity and census. If further guidance is required, communication with the Director of Nursing or Designee will be made. b. Director of Nursing/Designee will monitor/review the schedule to ensure there is enough direct-care nursing staff as follows: 5 times per week x 4 weeks, 2 times per week x 3 months, and monthly x 3 months. Step 4 The Director of Nursing/Designee will be responsible for monitoring to ensure that there is direct care nurse staffing in the right areas throughout the facility per day will be done by the Director of Nursing/Designee 5 times per week x 4 weeks, 2 times per week x 3 months, and monthly for three months. Results of monitoring will be reported by the Quality Assurance Coordinator monthly to the Quality Assurance	

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F 561	Continued From page 3 stated she worked the weekend of 04/02/2022 and there were two NAs that worked "C" wing. There were approximately 47 residents on the hall and Resident #16 was not out of bed due to the staffing. An interview with NA #3 was conducted on 04/07/2022 at 11:27 AM. The NA stated she worked with Resident #16 the weekend of 04/02/2022. There was two NAs on the hall and they each had over 20 residents. The ADLs were completed but we were not able to get him up due to staffing.	F 561	Committee for recommendations and suggestions for improvements and changes.	
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interviews, observations, and record reviews, the facility failed to prevent Resident #53 from abusing Resident #90 on the secure memory support unit for 1 of 1 resident (Resident #53) reviewed. Resident #90 had been	F 600	The timeline investigation and plan of correction constitutes a written allegation of substantial requirements. Preparation and/or execution of this correction does not constitute admission or agreement by	5/3/22

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F 600	Continued From page 4 hit in the arm and received a skin tear to the elbow during one incident and had been kicked in the face and received a bloody nose during another incident. In addition, the facility failed to prevent Resident #29 from abusing Resident #57 on the secure memory support unit for 1 of 1 resident (Resident #29) reviewed. Resident #57 sustained a cut to his left side cheek with moderate bleeding. Findings included: 1.Resident #53 was admitted to the facility on 7/18/17 with diagnoses that included schizophrenia and dementia with behavioral disturbance. His quarterly Minimum Data Set (MDS) dated 4/15/21 indicated he had moderate cognitive impairment and required extensive assistance for transfers, bed mobility, dressing, and limited assistance for locomotion. His MDS indicated he received an antipsychotic and antianxiety for 7 of the 7 days reviewed. No behaviors were noted. An incident report dated 5/27/21 revealed a witnessed altercation in which Resident #90 came into Resident #53's room and Resident #53 hit the resident on the arm to get him to leave. Resident #90 sustained a skin tear to his elbow. The Care Plan indicated a resident-to-resident altercation on 5/27/21 in which a stop sign was placed at the entryway to Resident #53 to keep other residents from entering. An incident report dated 8/25/21 revealed Resident #90 came into Resident #53's room and Resident #53 hit him to get him to leave. There	F 600	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. Resident #53 was seen by psychiatry on 12/1/20221. Resident was seen by psychotherapy on 12/1/2021. Resident #53 continues to be seen by both psychiatry and psychotherapy. b. On 3/26/2022 Resident #29 and Resident #57 were separated and reassurance was provided, assessed for injury, and moved into a calm environment. c. An x-ray was ordered for Resident #57, and the results were negative for any injury. A warm compress was applied under his eye for a break in the skin and redness. d. Resident #29 was referred to psychiatry services. e. The nurse called the police and a report was filed. f. Resident #29 experienced a medication change, per MD on 3/26/2022, adding Ativan 0.5mg every 8 hours. g. Incident cited between Resident #90 and Resident #53 that occurred on 11/30/2021 was investigated by Division of Health Service Regulation during a	

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F 600	Continued From page 5 were no injuries noted. An incident report dated 11/30/21 reported an unwitnessed altercation in which Resident #53 admitted to kicking Resident #90 in the face causing a nosebleed. Resident #53 stated he kicked Resident #90 because he was in his room. The resident did not sustain any other injuries. The report further revealed Resident #53 takes down the stop sign at the entryway to his room and forgets to put it back up. Interventions included employee education about replacing the stop sign. A Care Plan dated updated 2/22/22 focused on socially inappropriate behavior indicated Resident #53 could become verbally and physically aggressive. Goals included resident will not harm self or others secondary to inappropriate behavior through next review. Interventions included refer to psychological services or social services as needed, assess for medication side effects that may be contributing to aggressive behavior, attempt distraction as indicated, encourage resident to go to his room or quiet environment as indicated, and maintain safety of resident and others by removing from any unsafe environment or situation as indicated. During an interview on 4/6/22 at 2:40 PM, Nurse #9 revealed that the stop sign at Resident #53's door was to keep other residents from entering but sometimes he forgot to replace it when entering or other residents would take it down. Staff monitored his room for other residents entering. During an interview on 4/7/22 at 1:30 PM, the Administrator revealed that a stop sign had been	F 600	complaint investigation of Facility Reported Incidents 12/1/2021 through 12/3/2021 and was substantiated without deficiency. Step 2 a. Resident #53 was seen by psychiatry on 12/20/2021, 1/12/2022, 1/25/2022, 2/16/2022, 3/23/2022, 3/30/2022. Resident was seen by psychotherapy on 12/1/2021, 1/12/2022, 2/9/202, and 3/11/2022. Resident #53 continues to be seen by both psychiatry and psychotherapy. b. For Resident #53 we will continue to explore with resident past effective and ineffective coping mechanisms. c. For Resident #53 we will continue to reassure resident when frustration and fear is present. d. Psychiatry services saw Resident #29 on 4/6/2022. e. COVID-19 restrictions regarding social distancing remain in place while dining, therefore Resident #29 was already sitting a table by himself on 3/26/2022. e. Resident #57 continues to be redirected when he gets up during fining to ensure the other Residents personal space is respected, as best as possible. g. Resident #29 is in a room without a roommate. h. MD added Ativan 0.5mg on 3/26/2022 every 8 hours. Step 3 a. Staff working on the Memory Support	

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F 600	Continued From page 6 placed on the outside of Resident #53's room to keep other residents from entering as he did not like people coming into his room. She did admit that at times Resident #53 takes the sign down and forgets to put it back up. She revealed the last resident-to-resident altercation occurred in his room in November. The stop sign was in use at that time. Observations were made on 4/4/22 at 10:10 AM, 4/5/22 at 1:00 PM, 4/6/22 at 9:40 AM, and 4/7/22 at 12:45 PM of Resident #53 in his room with a cloth stop sign hung across the door to his room. No behavioral concerns were noted. 2. Resident #29 was admitted to the facility on 10/14/2021 with diagnoses that included non-traumatic brain dysfunction, anemia, hypertension and dementia. Review of the Minimum Data Set (MDS) dated 01/06/2022 indicated the resident had severe cognitive impairment. The MDS indicated the resident required extensive assistance for bed mobility, supervision with transfer, extensive assistance with dressing, supervision with eating and toilet use. The resident was not checked for behavioral symptoms. Resident #57 was admitted to the facility on 06/25/2021 with diagnoses that included non-traumatic brain dysfunction, Coronary Artery Disease, Diabetes and dementia. Review of the Minimum Data Set (MDS) dated 02/17/2022 indicated the resident had severe cognitive impairment. The MDS indicated he required supervision for bed mobility, transfer, eating and limited assistance with dressing. The	F 600	Unit, as they are trained in Dementia training and person-centered care, were educated to ensure Resident #53 is to Reassure resident when frustration and fear is present. b. Staff working on the Memory Support Unit, as they were trained in Dementia training and person-centered care, were educated to ensure that Resident #29 maintains his space during meals in an effort to continue person-centered care. Monitoring will be done 5 times per week x 4 weeks, 2 times per week x 3 months, and monthly for three months. Step 4 1. Director of Nursing/Designee will be responsible to monitor that the care plan is followed accordingly for Resident #53 5 times per week x 4 weeks, 2 times per week x 3 months, and monthly for three months; 2. Director of Nursing/designee will be responsible to monitor that the care plan is followed accordingly for Resident #29 5 times per week x 4 weeks, 2 times per week x 3 months, and monthly for three months. Results of monitoring will be reported by the Quality Assurance Coordinator monthly to the Quality Assurance Committee for recommendations and suggestions for improvements and changes.	

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F 600	Continued From page 7	F 600		

resident also required extensive assistance with toilet and personal hygiene. The resident was not coded for behavioral problems. Resident #29's care plan dated 03/26/2022 indicated a problem area of striking other resident. Resident has a history of physical aggression towards other residents when he feels his space has been violated or others touching his belongings. The interventions included: monitor resident's behavior, prevent triggers that would cause resident to strike another resident and remind resident he is not to strike other residents.

Nurse# 9's nurse note dated 03/26/2022 at 07:39 PM, revealed Resident # 29 was in the dining room sitting at the table eating. Resident #57 came and took his iced tea and Resident #29 became very upset and struck Resident #57 multiple times in the face with his fist. Resident #29 had been verbally aggressive for the past few days. Responsible party (RP), the physician on call and police were notified of incident.

Nurse # 9's nurse note dated 03/26/2022 indicated the nurse visited Resident #57 shortly after incident. He was alert and disoriented per his usual. He was ambulatory and did not appear to be in discomfort. He was noted to have a small laceration on his left cheek and a couple of small reddened areas on his left cheek and chin. The police spoke to Resident #57 and noted the areas on his face.

Nurse #9's nurse note dated 03/26/2022 indicated Resident #57 was in the dining room and was hit by Resident #29. Resident #57 sustained a cut to his left side cheek with moderate bleeding. Pressure applied to face. Resident #57 also had noted swelling beneath his right eye.

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During the interview on 04/06/2022 at 3:45 PM, Nurse Aide (NA) #1 revealed she was in the dining room when the altercation between Resident #29 and Resident #57 occurred. She indicated Resident #57 took Resident #29's iced tea and Resident #29 proceeded to punch Resident #57 several times on his face. NA #1 reported she asked for help from Nurse #9 since she was the only staff in the dining room. NA #1 further indicated Resident #29 had history of verbal altercations but not physical altercation with other residents in memory unit.

During the interview on 04/06/2022 at 4:00 PM, Nurse #9 revealed that on 03/26/2022 she was on a medication cart passing medication in the unit when she had NA#1 called her to go to the dining room because she needed assistance in the dining room. Upon arriving in the dining room, she assisted NA #1 to separate Resident #29 and Resident #57 who were in a fight. The resident (Resident #57) had a small laceration on the side of his face which NA#1 indicated Resident #29 had hit Resident #57 with his fist several times. She reported Resident #57 took Resident #29's iced tea. Nurse #9 reported pressure was applied on the laceration to stop the bleeding, the physician was notified, and the police was notified. The police came to the facility to investigate the incident but did not file any charges. Nurse #9 indicated Resident #29 had shown verbal aggression towards other residents in the unit prior to the current incident that occurred on 03/26/2022.

During an interview on 4/7/22 at 9:25 AM, Director of Nursing (DON) acknowledged that the staff in the memory unit should have monitored

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F 600	Continued From page 9 Resident #29 closely since he had history of not wanting other residents touching his items in his room or in dining room. During an interview on 4/7/22 at 12:30 PM, the Administrator acknowledged that Resident #29 had been moved several times to different rooms due to not getting along with his roommates. She reported the staff in the memory unit will continue to monitor the resident very closely to prevent any further verbal or physical altercations with other residents. Observations were made on 4/5/22 at 9:10 AM, 4/5/22 at 11:00 PM and 4/7/22 at 10:45 PM of Resident #29 in his room, hallway and dining room. No behavioral concerns were noted.	F 600		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	F 623		5/2/22

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F 623	Continued From page 10	F 623		

(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State

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

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F 623	Continued From page 11 Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide written notification to the	F 623	The timeline investigation and plan of correction constitutes a written allegation	

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F 623	Continued From page 12 resident or resident representative of the reason for discharge to the hospital for 2 of 2 sampled residents (Resident #25 and Resident #92) reviewed for hospitalization. This deficient practice had the potential to affect other residents. The findings included: 1. Resident #25 was admitted to the facility on 04/12/2019. The resident's Minimum Data Set (MDS) dated 01/26/2022 revealed the resident's cognition was severely impaired. Review of Resident #25's medical records revealed he was sent to the hospital on 03/31/22. Review of Resident #25's medical record revealed that written notification of discharge was not provided to the resident or resident representative for hospitalization on 03/31/22. Resident #25 was readmitted to the facility on 04/04/22. During an interview on 4/6/22 at 9:00 AM with the facility Administrator, she stated nursing staff usually notified resident representative (RP) of resident's transfer by telephone call and documented in resident's record. She indicated the facility had not been providing resident or RP with written notifications of the reason for transfers. She explained going forward she would ensure a written notice of the reason for transfer was sent to resident or RP. 2. Resident #92 was initially admitted to the facility on 9/6/18.	F 623	of substantial 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 Notification letters provided to resident/responsible party within 24 hours of discharge/transfer to hospital from 4/3/2022 to present. Step 2 a. The Business Office Manager/Designee will review all discharge/transfers each day while completing census changes to ensure letters are sent out accordingly. b. The Business Office Manager/Designee will also review discharges daily with clinical team during case mix meeting to ensure letters are sent out accordingly. Step 3 a. Education was provided to the Business Office Manager regarding written notification to the resident/resident	

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F 623	Continued From page 13 Resident #92's medical records revealed he was sent to the hospital on 2/16/22. Review of Resident #92's medical record revealed that written notification of discharge was not provided to the resident or resident representative for hospitalization on 2/16/22. Resident #92 was readmitted to the facility on 3/1/22. The most recent comprehensive Minimum Data Set (MDS) dated 3/4/22 indicated Resident #92 was cognitively impaired. During an interview on 4/6/22 at 9:00 AM with the facility Administrator, she stated nursing staff usually notified resident representative (RR) of resident's transfer by telephone call and documented in resident's record. She indicated the facility had not been providing resident or RR with written notifications of the reason for transfers. She explained going forward she would ensure a written notice of the reason for transfer was sent to resident or RR.	F 623	representative of the reason for the discharge to the hospital. b. The Business Office or designee will review the discharges daily and send out notifications to the responsible parties or legal representative along with bed hold letter. A copy of the letter will be uploaded to the resident's chart. c. Business office or designee will review the discharges/transfers in daily morning meetings with the clinical team to verify all notifications have been mailed out. Monitoring will be done by the Business Office Manager as follows: 5 times per week x 4 weeks, 2 times per week x 3 months, and 5 times per month x 3 months. Step 4 The Business Office Manager/Designee will be responsible for monitoring to ensure that the resident/resident representative received written notification of the reason for discharge to the hospital will be done 5 times per week x 4 weeks, 2 times per week x 3 months, and 5 times per month x 3 months. Results of monitoring will be reported by the Quality Assurance Coordinator monthly to the Quality Assurance Committee for recommendations and suggestions for improvements and changes.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		5/3/22

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F 656	Continued From page 14 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 15 section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan for 2 of 24 residents sampled for care plans (Resident #40, and Resident #219). Findings included: 1. Resident #40 was admitted to the facility on 01/19/2022 with diagnosis including Parkinson's disease. The admission Minimum Data Set (MDS) dated 01/26/2022 noted Resident #40 was severely cognitively impaired, needed extensive assistance with activities of daily living (ADL), had received antipsychotic medications and no behaviors were noted. The care plan dated 01/09/2022 did not include information or interventions related to antipsychotic medication use. A review of the April 2022 Medication Administration Record (MAR) revealed Resident #40 received antipsychotic medication. An interview with MDS Nurse #2 was conducted on 04/07/2022 at 10:09 AM. The nurse stated the Care Area Assessment (CAA) was completed 1/31/22. It included the psychotropic medication was identified and should have been care planned. The nurse also stated it was due to an oversite. An interview with the Director of Nursing (DON) was conducted on 04/06/2022 at 10:33 AM. The DON stated the care plans are expected to cover the residents care areas to include goals and	F 656	The timeline investigation and plan of correction constitutes a written allegation of substantial 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. Care plan for Resident #40 was updated on 4/7/2022. b. Resident #219 was discharged on 1/19/2022. Step 2 a. Case Mix Director conducted a 100% audit of the care plans on 4/7/2022 for all Veterans who are currently on antipsychotic medications to ensure the antipsychotic medications were care planned accordingly. b. Case Mix Director conducted a 100% audit on 4/7/2022 of the care plans for everyone with wounds, per the wound report on 4/8/2022 to ensure the wounds were care planned accordingly.	

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F 656	Continued From page 16 interventions. 2. Resident #219 was admitted to the facility on 11/26/2021 with diagnoses which included peripheral vascular disease and non-pressure chronic ulcer of other part of left foot with fat layer exposed. The admission Minimum Data Set (MDS) dated 12/02/2021 revealed Resident #219 was coded as cognitively intact and needed supervision with activities of daily living. Resident #219 was also noted as having a pressure reducing device. A review of the care plan dated 11/26/2021 did not include information or interventions related to a foot ulcer A review of the November 2021 Medication Administration Record (MAR) revealed Resident #219 was being treated for an ulcer on his left great toe. Treatment included: cleanse with normal saline, apply triple antibiotic ointment, and dry a dressing. An interview with MDS Nurse #1 on 04/07/2022 at 10:25 AM. The nurse stated she did the admission MDS on 11/26/2021. The assessment was completed 12/02/2021 which included an ulcer to left toe. The nurse also stated it was an oversite and should have been care planned.	F 656	c. The Director of Nursing and Skin Integrity Nurse reviewed Wound Manager in the Electronic Health Record on 5/2/2022 to ensure it aligns the wound report. d. The Director of Nursing and Skin Integrity Nurse conducted a 100% audit on 5/2/2022 of all orders according to the wound report , to ensure the orders match the wound report. Step 3 a. Education provided by the Clinical Reimbursement Consultant (RN)to Interdisciplinary Team concerning Comprehensive Plans and Updating Care plans. b. The Social Worker/Designee will be responsible to monitor the Facility Activity Report to ensure and antipsychotic medication list to ensure the care plan is updated accordingly. c. The Case Mix Director/Designee will be responsible to monitor and review orders to catch any new orders for antipsychotic medications to ensure care plans are updated accordingly. The Skin Integrity Nurse/Designee will be responsible for monitoring wound manager and cross-reference the wound report weekly; c. The Skin Integrity Nurse/Designee will be responsible to monitor the facility activity report; Monitoring will be done 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per month for 4 months.	

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F 656	Continued From page 17	F 656	Step 4 1. The Social Worker/Designee will be responsible to monitor that all Veterans who are currently on antipsychotic medications are care planned accordingly and monitoring will be done 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per month for 4 months. 2. The Skin Integrity Nurse/Designee will be responsible for monitoring to ensure that care plans will be developed and updated appropriately will be done 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per month for 4 months. Results of monitoring will be reported by the Quality Assurance Coordinator monthly to the Quality Assurance Committee for recommendations and suggestions for improvements and changes.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and	F 695	The timeline investigation and plan of	5/3/22

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F 695	Continued From page 18 physician interviews, the facility failed to administer supplemental oxygen at the prescribed rate for 1 of 2 residents (Resident #116) reviewed for respiratory care. The findings included: Resident #116 was admitted to the facility on 3/1/2019 with diagnoses that included chronic obstructive pulmonary disease (COPD) and chronic respiratory failure with hypoxia. Physician order dated 3/20/2020 indicated administer oxygen at 2 liters/minute via nasal cannula continuously. The most recent Minimum Data Set (MDS) assessment dated 1/5/2022 indicated Resident #116 was cognitively intact and received oxygen therapy. Diagnoses included COPD and respiratory failure. Resident #116's care plan last revised 4/5/2022 indicated focus area of oxygen use related to COPD and respiratory failure. Interventions included administer oxygen per physician orders. During observation on 4/4/2022 at 12:40 PM Resident #116 was observed with the oxygen nasal canula. Resident #116's oxygen regulator on the concentrator was set at 3.5 liters/minute when viewed horizontally at eye level. During observation on 4/4/2022 at 3:35 PM Resident #116 was observed with the oxygen nasal canula. Resident #116's oxygen regulator on the concentrator was set at 3.5 liters/minute when viewed horizontally at eye level. During observation on 4/5/2022 at 8:55 AM	F 695	correction constitutes a written allegation of substantial 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 Oxygen for resident #116 was adjusted to the settings per the MD order on 4/5/2022. Step 2 a. The Case Mix Director conducted a 100% audit on 4/7/2022 of the orders for oxygen on all residents. b. The Case Mix Director conducted an 100% review on 4/7/2022 of all oxygen settings, and updated the care plans accordingly. Step 3 a. The Clinical Competency Coordinator educated all Licensed Nurses on validation of oxygen settings during medication administration and documenting such validation the Medication Administration Record.	

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F 695	Continued From page 19 Resident #116 was observed with the oxygen nasal canula. Resident #116's oxygen regulator on the concentrator was set at 3.5 liters/minute when viewed horizontally at eye level. During an interview on 4/5/2022 at 12:52 PM with Nurse #6, she stated Resident #116 had a physician order for oxygen at 2 liters/minute via nasal cannula continuously. Nurse #6 stated she did not verify Resident #116's oxygen rate on 4/4/2022 7:00 AM - 3:00 PM shift. She verbalized she adjusted Resident #116's oxygen rate from 3.5 liters/minute to the ordered 2 liters/minute when she administered Resident #116's medication at around 10:30 AM on 4/5/2022. During an interview on 4/6/2022 at 9:04 AM with Nurse #7, she stated she had cared for Resident #116 on 4/4/2022 3:00 PM - 7:00 PM. Nurse #7 verbalized she did not verify Resident #116's oxygen rate during second shift on 4/4/2022. During an interview on 4/6/2022 at 9:30 AM with Nurse #8, he revealed he had cared for Resident #116 on 4/4/2022 7:00 PM- 7:00 AM. Nurse #8 indicated he noticed Resident #116's oxygen regulator was set at 4 liters/minute during his shift and documented it in Resident #116's medical records. He stated he did not realize Resident #116 had a physician order for oxygen at 2 liters/minute via nasal cannula continuously. Nurse #8 verbalized he should have verified the oxygen rate with the physician's order, but he assumed that the rate he observed was correct. He verbalized going forward he would check the oxygen flow rate to the ordered rate. An interview was conducted 4/6/2022 3:15 PM with the Director of nursing (DON). She stated	F 695	b. The Clinical Competency Coordinator educated all Licensed Certified Nursing Assistants on observing oxygen settings per Care Assist ad report any discrepancies immediately to the License Charge Nurse. c. The Director of Nursing/Designee will monitor the care assist and Medication Administration Record to ensure validation of oxygen settings are done by the Licensed Nurse and Certified Nursing Assistant, per the MD order. The Director of Nursing/Designee will be responsible for monitoring will be done 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per month for 4 months. Step 4 The Director of Nursing/Designee will be responsible for monitoring to ensure that the oxygen settings are validated in care assist and documented on the Medication Administration Record 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per month for 4 months. Results of monitoring will be reported by the Quality Assurance Coordinator monthly to the Quality Assurance Committee for recommendations and suggestions for improvements and changes.	

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F 695	Continued From page 20 Resident #116 had a physician order for oxygen at 2 liters/minute via nasal cannula continuously and she expected nursing staff to administer oxygen per physician orders. She further stated nurses were to call the physician if they needed to titrate the oxygen rate. During an interview on 4/7/22 at 8:32 AM with the facility Administrator, she indicated Nurse #6, Nurse #7 and Nurse #8 should have verified Resident #116's oxygen regulator was set at the physician ordered rate. The Administrator explained she expected nursing staff to follow physician orders and to request an updated order if there was a need to titrate the oxygen. An interview was conducted on 4/7/22 at 1:49 PM with the facility Physician. She stated she expected nursing staff to follow physician orders as given.	F 695		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following	F 725		5/3/22

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F 725	Continued From page 21 types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to provide sufficient nursing staff resulting in a resident not being assisted out of bed per his preference. This affected 1 of 15 resident (Resident #16) reviewed for choices. The findings included: This tag is cross referenced to: F561: Based on record review, resident interview and staff interviews the facility failed to honor a resident ' s request to get out of bed for 1 of 15 residents sampled for choices. (Resident #16) An interview with the nursing scheduler (NS) was conducted on 04/06/2022 at 12:47 PM. The NS stated the NAs are assigned 11-15 residents each. However, the weekend of 04/02/2022, there were four NAs schedule for that hall, one NA was scheduled to come in at 11:00 AM, another NA was sent to another hall because there was a NA coming in at 11:00 AM. That left one NA to care for the residents and that would not help the NAs get there morning ADLs	F 725	The timeline investigation and plan of correction constitutes a written allegation of substantial 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. Director of Nursing pulled the schedule on 4/5/2022 to review for the next 14 days to ensure there was enough direct-care nursing staff in the right places throughout the facility. Step 2 The Director of Nursing reviewed the	

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(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 725	Continued From page 22 completed. That left two NAs for the hall. An interview with the Director of Nursing (DON) was conducted on 04/06/2022 at 10:33 AM. The DON stated Resident #16 does like to be up in his wheelchair but due to staffing issues the staff was not able to get him up. An interview with the Administrator was conducted on 04/06/2022 at 1:49 PM. The administrator stated due to staffing issues, nursing staff did not get Resident #16 up out of bed.	F 725	schedule on 4/15/2022 for a rolling 30 days to ensure there is enough direct-care nursing staff throughout the facility and in the right areas. Step 3 a. a. The Clinical Competency Coordinator will educate the Licensed Nurses that when there are changes to the staffing schedule to make operational changes that reflect appropriate staffing levels throughout the facility based on acuity and census. If further guidance is required, communication with the Director of Nursing or Designee will be made. b. Director of Nursing/Designee will monitor/review the schedule to ensure there is enough direct-care nursing staff as follows: 5 times per week x 4 weeks, 2 times per week x 3 months, and monthly x 3 months. Step 4 The Director of Nursing/Designee will be responsible for monitoring to ensure that there is direct care nurse staffing in the right areas throughout the facility per day will be done by the Director of Nursing/Designee 5 times per week x 4 weeks, 2 times per week x 3 months, and monthly for three months. Results of monitoring will be reported by the Quality Assurance Coordinator monthly to the Quality Assurance Committee for recommendations and	

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 04/08/2022

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F 725	Continued From page 23	F 725	suggestions for improvements and changes.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:	F 755		5/3/22

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F 755	Continued From page 24 Based on resident and staff interviews and record reviews, the facility failed to acquire and administer a muscle relaxer resulting in four missed doses for 1 of 1 resident (Resident #69) reviewed for medication administration. Findings included: Review of the facility policy titled "Medication Administration: General Guidelines" revised 3/23/21 read in part: "section 2: medications are administered in accordance with written orders of the attending physician" and "section 13: if more than two consecutive doses of a vital medication are withheld or refused, the physician is notified." Record review of Resident #69's physician's order revealed an order dated 3/11/22 for 5 milligram tablet Baclofen (a muscle relaxer) to be given twice a day (9:00 AM and 5:00 PM). Resident #69's medication administration record (MAR) for April 2022 indicated Baclofen was "on hold" for 4/2/22 9:00 AM dose, 4/2/22 5:00 PM dose with comment "reordered", 4/3/22 9:00 AM with comment "on order," and 4/3/22 9:00 AM dose. During an interview on 4/4/22 at 2:10 PM, Resident #69 indicated that he had not receive his Baclofen over the weekend. The nurse had told him he was out of Baclofen, and it had been reordered. He recalled he experienced pain that was resolved with as needed acetaminophen. During an interview on 4/5/22 at 4:00 PM, Nurse #5 revealed she had worked with Resident #59 over the weekend and confirmed he had missed 4 doses of Baclofen. She indicated she faxed the	F 755	The timeline investigation and plan of correction constitutes a written allegation of substantial 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. Medication for Resident #69 was received on 4/3/2022 and administered per the MD order. Step #2 a. The Director of Nursing conducted a 100% audit on 4/7/2022 of the Medication Administration Record to ensure all medications were administered per the Medication Administration: General Guidelines. Step #3 a. The Clinical Competency Coordinator provided education to all Licensed Nurses to ensure that the physician is notified if a medication is refused or withheld. b. The Director of Nursing/Designee will monitor the Medication Administration	

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F 755	Continued From page 25 order to the pharmacy to reorder. She revealed she did not notify her nurse supervisor or the doctor that he had missed the medication. She further revealed she could have called the doctor and possibly gotten the medication from the back up pharmacy or from the electronic medication dispensing machine. During an interview on 4/6/22 at 9:05 AM, the medical director indicated she was not aware Resident #59 had missed his medications over the weekend. She revealed if the on-call provider had been notified, they could have gotten it from the electronic medication dispensing machine or from a local pharmacy. During an interview on 4/7/22 at 9:10 AM, the Administrator revealed the nurse should have call the doctor to get another order or to get from a local pharmacy. She further revealed the nurse supervisor could have gotten the medication from the electronic medication dispensing machine.	F 755	Record to ensure all medications were administered per Medication Administration: General Guidelines. The Director of Nursing/Designee will monitor the Medication Administration Record 5 times per week times 4 weeks, 3 times per week times 4 week, and 2 times per month times 4 months. Step #4 The Director of Nursing/Designee will be responsible for monitoring to ensure that medications are administered per the Medication Administration: General Guidelines 5 times per week x 4 weeks, 2 times per week x 3 months, and monthly for three months. Results of monitoring will be reported by the Quality Assurance Coordinator monthly to the Quality Assurance Committee for recommendations and suggestions for improvements and changes.	