PRINTED: 05/23/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345558	B. WING_		05/09/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/00/2011	
NOOTATE	WETERANG HOME DIA		1	62 LAKE EDEN ROAD	20	
NCSIAIE	VETERANS HOME-BLA	CK MOUNTAIN		BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 242 SS=E	MAKE CHOICES The resident has the reschedules, and health her interests, assessminteract with members inside and outside the about aspects of his orare significant to the resident and record reviews, the fact residents with the amount they wanted each week (Resident #119, #126, The findings included: 1. Resident #119 was 03/28/14 with diagnost weakness, chronic kid glaucoma. The most re (MDS), an admission at 04/04/14, indicated the intact and usually able able to make himself usindicated Resident #17 with at least part of bat two or more persons. Interview with Resident PM revealed the resident stated he had been toll were assigned to get to the resident of the stated he had been toll were assigned to get the stated he had been toll were assigned to get the resident was stated he had been toll were assigned to get the resident was stated he had been toll were assigned to get the resident was stated he had been toll were assigned to get the resident was stated he had been toll were assigned to get the resident was stated he had been toll were assigned to get the resident was stated he had been toll were assigned to get the resident was stated he had been toll were assigned to get the resident was stated he had been toll were assigned to get the resident was stated he had been toll were assigned to get the resident was stated he had been toll were assigned to get the resident was stated he had been toll were assigned to get the resident was stated he had been toll were assigned to get the resident was stated he had been toll were assigned to get the resident was stated he had been toll were assigned to get the resident was stated he had been toll were assigned to get the resident was stated he had been toll	d staff interviews and cility failed to provide bunt of baths/showers that ek for 5 of 6 residents #123, #125, and #40). admitted to the facility on es which included muscle ney disease, and recent Minimum Data Set assessment dated e resident was cognitively to understand and usually inderstood. The MDS also 19 needed physical help thing with the assistance of at #119 on 05/05/14 at 3:22 ent enjoyed taking showers sore neck. Resident #119 d all residents at the facility	& C BI	What corrective action will be accomplished for the residents four have been affected by the deficient practice? Residents # 119, 126, 123, 125, and be interviewed by the Transport Coordinator regarding shower/ preferences and a new schedule will by RN Supervisors/Unit Managers be those preferences. How will you identify other resident practice and corrective action will be taken? All current residents who are also oriented will be interviewed by the land Administration Team for shower/ preferences and scheduled according those preferences. What measures will be put in play what systemic changes will be mensure that the deficient practice reoccur? The Clinical Admission packet wexpanded to include a question pertaining to Resident choice shower/bathing. This will be completed to RN Senior Care Partner or Admission Care Partner or Adm	40 will 6 June 2014 ortation bathing I be set ased on sidents by the what June 6,2014 ortand Nursing bathing ding to vill be June 6, 2014 or ade to will no vill be June 6, 2014 or ade to will no vill be onnaire as on orted by	
ABORATORY	DIRECTOR'S OR PROVIDER/SU	JPPLIER REPRESENTATIVE'S SIGNATURE		21	(X6) DATE	
	Dulier (Teleson 12	JUN 05	2014 2 adnersteet R.	ensel 6-5-14	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Original Signature Date: 5/30/14

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	N 18 18 18 18 18 18 18 18 18 18 18 18 18	PLE CONSTRUCTION G		SURVEY PLETED
			A. BOILDIN			
		345558	B. WING _		05	/09/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE	VETERANS HOME-BLA	CK MOUNTAIN		62 LAKE EDEN ROAD		
NOUNTE	VETERANO HOME-BEA	OK MOOK PAIN		BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIED TO THE	BE	(X5) COMPLETION DATE
				Continued from page 1		
F 242	Continued From page	: 1	F 2	42 Clinical Competency Coordinator	or	June 6, 2014
	the facility how many	showers he'd like to receive		designee will educate nursing staf		
	each week and he wa			new bathing preference and sche		
		choice about their shower		process.		
	frequency. Resident			process.		
		er to have three or four		The Senior Care Partner/Desi	البيد مممد	
	1/50	ad of the two assigned to		The Senior Care Partner/Designal		
	him.			validate with all new admission		
	Interview with Nurse A	Aide (NA) #2 on 05/07/14 at		admission the integration of the		
		residents got two baths or		bathing preference onto Resident	Care Plar	ì
		heduled by their room		and CNA/ ADL guide.		
		ed a couple of residents in				
		howers a week, because		Education on preference process	vill be	
		uested the additional shower		provided to Interdisciplinary team	by	
	in writing to the admin			Clinical competency Coordinator/	lesignee	
		ntly surprised at the shower		100	N. TO. 1.5	
		dmitted and tell her they've		How will the corrective a	tion be	
	taken showers every	ted she explained to them		monitored to assure that the		
		ents were scheduled two		practice will not reoccur, i.e., wh		
		nd she reminded residents		assurance program will be put in		
	frequently which days				ontinued	
		presented the facility shower		compliance	ontinueu	1
	schedule which was p	osted at the nurse's desk.		compliance		
	Review of the shower			6 . 6 . 5 . 75		_
	Resident #119 was as			Senior Care Partner/Designee wil		111no 6 7/117/1 I
	Tuesdays and Fridays	i.		log of all Admissions and Re-	dmission	•
	Interview with Nurse 4	8 on 05/07/14 at 2:05 PM		preferences .		
		r schedule was kept at the				
		assigned each resident two		Log of admitting preferences	will be	l C 204.4
		ding to their room numbers.		reviewed by Interdisciplinary tea	n weekly	June 6, 2014
		vas unaware of any nurse or		for four weeks then monthly	for four	
	nurse aides who aske			months.		
	shower frequency pre-	ferences.				
				Education will be provided to new	nartners	June 6, 2014
	Interview with the Sen			upon general and job specific o	ientation	2.50
		evealed residents were told				
	at admission about the	e shower schedule kept at		on bathing schedules and prefere	ces.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2 2		CONSTRUCTION		SURVEY PLETED
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		345558	B. WING _			05	/09/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NO STATE	VETERANG HOME DI A	CK MOUNTAIN		62	2 LAKE EDEN ROAD		
NOSIAIE	VETERANS HOME-BLA	CKIMOONTAIN		В	LACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242	Senior Care Partner's member came to her shower frequency chastaff and family to accommodate accommodate assess shower prefer with the posted shower attention by the resident stated facility staff did assess their preference frequency but if a resident stated facility staff did assess their preference frequency but if a resident stated according to resident with they would make an extra extended and the nurse aide schedulate and the nurse aide schedulate and the nurse aide schedulate and the residents with based on their room in during resident initial aresidents were asked shower the resident president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred an extra shift it in but it was rare so the president precision of the president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency president preferred the during the morning or shower frequency preferred the during the morning or shower frequency preferred the during the morning or showe	which assigned each shower days per week. The stated if a resident or family with a specific request of lange, she would work with commodate that request. In the stated she did not ences unless a problem er days was brought to her ent or family. #2 on 05/08/14 at 3:05 PM re scheduled twice weekly room numbers. Nurse #2 not go to each resident and ces regarding shower dent or family member a schedule change request, effort to work the change into ale. #4 on 05/09/14 at 10:08 AM do a shower schedule that the two showers per week number. Nurse #4 stated admission assessment, about the type of bath or referred and whether the ir shower to be provided the evening, but residents' ferences were not stated when a resident over the staff attempted to staff were able to do so. If of Social Services on revealed residents were or baths weekly based on	F2		Continued from page 2 All reports will be submitted to Assurance and Performance Impro Committee monthly for validate compliance with update/chan indicated.	vemen	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY OMPLETED	
		345558	B. WING _		0	05/09/2014	
	ROVIDER OR SUPPLIER	CK MOUNTAIN	STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		es es	70	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CRO\$S-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 242	sure each resident renurse aide schedules. The Director of Socia not aware of any facil assessment for show their resident assessment for show their resident assessment for Social assessment for show their resident assessment for show their resident assessment for show their resident assessment for show their two scadmission. The DON between the morning Mondays through Satigot two showers a we shower load was not DON stated an assess frequency preference assessments. Interview with the Act at 1:09 PM revealed a staff member who ass frequency preference stated a shower sche two shower days per residents were asked their assigned showe. 2. Resident #126 was 04/28/14 with diagnos airway obstruction, veneuropathy, and glaud #126 had not yet beer cognition or ability to the director of nursing	deen developed to make delived two showers and were fair and balanced. It Services stated she was alty staff including an er frequency preferences in ments. Dector of Nursing (DON) on revealed residents were cheduled shower days upon stated showers were split and evening hours on urdays so that each resident leek and the nurse aide too heavy on any day. The sment of resident showers was not part of their witties Director on 05/09/14 she was not aware of any sessed resident showers. The Activities Director dule existed that assigned week to each resident but if they preferred to have r in the morning or evening. Se admitted to the facility on less which included chronic mous insufficiency, coma. Although Resident in formally assessed for understand by facility staff, submitted Resident #126's lents who were alert and	F 24	42			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	G		DATE SURVEY COMPLETED
		345558	B. WING			05/09/2014
	ROVIDER OR SUPPLIER	ACK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP COI 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
F 242	PM revealed he had shower daily until enterprefer to have them in weekly. Resident #1 shower schedule asson Monday and Thur and was never asked Resident #126 state additional shower, hower day he was schedule with Nurse 10:48 AM revealed a showers per week, sonumbers. NA #2 state the facility got three state families had require in writing to the admit residents were frequeschedule when first at taken showers every coming here. She stin the facility, all residently which days shower days. NA #2 schedule which was Review of the shower Resident #126 was a Mondays and Thurson Interview with Nurse revealed a set shower ursing station which showers weekly accounting #8 stated she in the shower weekly account	ent #126 on 05/05/14 at 3:45 always taken a bath or tering the facility and would much more than twice 26 stated he was told of the signed to his room, showers saday, when he was admitted a about his preferences. If when he had asked for an e had been reminded of the eduled to receive a shower. Aide (NA) #2 on 05/07/14 at at a couple of residents in showers a week, because uested the additional shower instrator. NA #2 stated ently surprised at the shower admitted and tell her they've day of their lives until ated she explained to them dents were scheduled two and she reminded residents is were their scheduled presented the facility shower posted at the nurse's desk. It is signed showers on lays. #8 on 05/07/14 at 2:05 PM or schedule was kept at the assigned each resident two ording to their room numbers. Was unaware of any nurse or each residents about their	F 24	42		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	35 150	IPLE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
		345558	B. WING _			05/09/2014
	ROVIDER OR SUPPLIER	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPLICATION OF THE APPLICAT	OULD BE	(X5) COMPLETION DATE
F 242	at admission about the each nursing station, resident room to two selections are came to here shower frequency chartest and family to accome the Senior Care Partial assess shower prefere with the posted shower attention by the resident stated facility staff did assess their preference frequency but if a resident stated facility staff did assess their preference frequency but if a resident stated facility staff did assess their preference frequency but if a resident stated facility staff did assess their preference frequency but if a resident such as the nurse aide schedule. Interview with Nurse # revealed each unit has provided residents with based on their room in during resident initial a residents were asked shower the resident preferred their during the morning or shower frequency prefered assessed. Nurse #4 sequested an extra she	atior Care Partner on evealed residents were told a shower schedule kept at which assigned each shower days per week. The tated if a resident or family with a specific request of ange, she would work with commodate that request. The tated she did not ences unless a problem are days was brought to her ent or family. 12 on 05/08/14 at 3:05 PM are scheduled twice weekly room numbers. Nurse #2 not go to each resident and less regarding shower dent or family member a schedule change request, affort to work the change into le. 14 on 05/09/14 at 10:08 AM a shower schedule that he two showers per week umber. Nurse #4 stated admission assessment about the type of bath or referred and whether the reshower to be provided the evening, but residents' ferences were not	F2	42		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION 3		ATE SURVEY OMPLETED
		345558	B. WING			05/09/2014
	ROVIDER OR SUPPLIER	ACK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	ч	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 242	o5/09/14 at 11:58 AM provided two shower their room number a schedule, which had sure each resident renurse aide schedule. The Director of Socianot aware of any factor assessment for show their resident assess. Interview with the Di 05/09/14 at 12:44 PM told about their two sadmission. The DOI between the morning Mondays through Sagot two showers a wishower load was not DON stated an asses.	or of Social Services on a revealed residents were as or baths weekly based on and the existing shower been developed to make eceived two showers and s were fair and balanced. All Services stated she was allity staff including an over frequency preferences in	F 24	\$2		
	at 1:09 PM revealed staff member who as frequency preference stated a shower schetwo shower days per residents were asked their assigned shower 3. Resident #123 was 04/23/14 with diagnoneuropathy, muscles spondylosis. Althougheen formally assess	tivities Director on 05/09/14 she was not aware of any sessed resident shower es. The Activities Director edule existed that assigned week to each resident but d if they preferred to have er in the morning or evening. as admitted to the facility on ses which included weakness, and cervical gh Resident #123 had not yet sed for cognition or ability to y staff, the director of nursing				

	CORRECTION	IDENTIFICATION NUMBER:	8 4	G		COMPLETED
		345558	B. WING			05/09/2014
	ROVIDER OR SUPPLIER	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 242	Interview with Reside AM revealed he had a home and since being had only received showeek. Resident #123 he wasn't offered sho no staff had asked hir offered him any option. Interview with Nurse #10:48 AM revealed all showers per week, so numbers. NA #2 state the facility got three so their families had require writing to the admir residents were frequeschedule when first at taken showers every coming here. She stain the facility, all resid showers each week a frequently which days shower days. NA #2 schedule which was preview of the shower Resident #123 was as Mondays and Thursd Interview with Nurse #1 revealed a set shower ursing station which showers weekly acconverse #8 stated she was prevented to the shower weekly acconverse #8 stated she was interview #8 stated she was prevented to the shower weekly acconverse #8 stated she was interview #8 stated she was prevented to the shower weekly acconverse #8 stated she was interview #8 stated	and a list of lert and oriented at the gotten showers daily at gradmitted to the facility, he owers about once each a stated he was upset that wers more frequently and or about his preferences or ans about shower frequency. Aide (NA) #2 on 05/07/14 at I residents got two baths or cheduled by their room led a couple of residents in howers a week, because uested the additional shower distrator. NA #2 stated and the shower distrator and tell her they've day of their lives until lated she explained to them lents were scheduled two and she reminded residents as were their scheduled presented the facility shower loosted at the nurse's desk I schedule revealed assigned showers on	F 24	42		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	8 8	LE CONSTRUCTION 3		ATE SURVEY OMPLETED
		345558	B. WING			05/09/2014
	ROVIDER OR SUPPLIER	ACK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		2
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 242	at admission about each nursing station resident room to two Senior Care Partner member came to he shower frequency of staff and family to at The Senior Care Partner with the posted show attention by the resident stated facility staff drassess their prefere frequency but if a reapproached staff with the nurse aide scheet Interview with Nurse revealed each unit in provided residents were asked on their room during resident initiaresidents were asked shower the resident resident preferred the during the morning of shower frequency presented an extra stage of the state of t	enior Care Partner on a revealed residents were told the shower schedule kept at a shower days per week. The restated if a resident or family er with a specific request of thange, she would work with accommodate that request. The restated she did not erences unless a problem wer days was brought to her dent or family. Et 2 on 05/08/14 at 3:05 PM ere scheduled twice weekly at room numbers. Nurse #2 id not go to each resident and noces regarding shower sident or family member that a schedule change request, a effort to work the change into dule. Et 44 on 05/09/14 at 10:08 AM and a shower schedule that with two showers per week number. Nurse #4 stated I admission assessment d about the type of bath or preferred and whether the neir shower to be provided or the evening, but residents'	F 24			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2 (5)	IPLE CONSTRUCTION		TE SURVEY MPLETED	
		345558	B. WING_			05/09/2014	
	ROVIDER OR SUPPLIER	ACK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CO 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HEAPPROPRIATE	(X5) COMPLETION DATE	
F 242	Interview with Director 05/09/14 at 11:58 AM provided two shower their room number at schedule, which had sure each resident renurse aide schedule. The Director of Sociation of aware of any facin assessment for show their resident assess. Interview with the Director of Sociation of aware of any facin assessment for show their resident assess. Interview with the Director of Sociation of Soci	or of Social Services on a revealed residents were as or baths weekly based on and the existing shower been developed to make exceived two showers and as were fair and balanced. All Services stated she was lity staff including an over frequency preferences in ments. The ector of Nursing (DON) on a revealed residents were cheduled shower days upon a stated showers were split and evening hours on a stated showers were split and evening hours on a stated shower and the nurse aide too heavy on any day. The essment of resident shower as was not part of their tivities Director on 05/09/14 she was not aware of any sessed resident shower as. The Activities Director adule existed that assigned week to each resident but a fif they preferred to have are in the morning or evening. The admitted to the facility on ses which included muscle and atrial fibrillation. The	F2	2.42			

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F 242	resident was cognitive understand and make MDS also indicated R physical help in part or requiring the assistant Interview with Resider AM revealed he had a shower each day at he to the facility, he had do baths. Resident #125 more showers than who was very offended that him how many he wou with the schedule. Respect to the facility of the admin scheduled by nurse at 10:48 AM revealed all showers per week, so numbers. NA #2 states the facility got three showers were frequently which days schedule when first act taken showers every coming here. She stain the facility, all resides showers each week at frequently which days shower days. NA #2 pschedule which was preview of the shower Resident #125 was as Mondays and Thursday.	ely intact and able to himself understood. The esident #125 needed if the bathing activity, ce of two or more persons. Int #125 on 05/06/14 at 8:39 always taken a hot bath or ome but since his admission only received about two stated he felt he needed that he was offered and he at the staff had never asked ald like or if he was satisfied esident #125 stated he had his showers were des. Inde (NA) #2 on 05/07/14 at residents got two baths or heduled by their room and a couple of residents in howers a week, because ested the additional shower distrator. NA #2 stated and tell her they've day of their lives until ted she explained to them ents were scheduled two and she reminded residents were their scheduled oresented the facility shower osted at the nurse's desk. schedule revealed signed showers on	F 24	2	

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F 242	nursing station which showers weekly according to resider staff of assess their preference and the staff of assess their preference and the staff of approached staff with shower staff and shower staff and shower preference assess shower preference assess their preference approached staff with shower staff and shower shower shower shower shower shower preference assess shower preference assess shower shower shower shower showers according to reside assess their preference showers approached staff with showers approached staff with showers and showers are approached staff with showers are showers.	ver schedule was kept at the ch assigned each resident two cording to their room numbers. It was unaware of any nurse or ked residents about their preferences. Venior Care Partner on the revealed residents were told the shower schedule kept at the name of a revealed resident or family er with a specific request of the shower days per week. The restated if a resident or family er with a specific request of the shange, she would work with a recommodate that request. For each of the shand was brought to her ident or family. Vere scheduled twice weekly the room numbers. Nurse #2 were scheduled twice weekly introom numbers. Nurse #2 wild not go to each resident and winces regarding shower esident or family member the a schedule change request,	F 24			
	Interview with Nurse revealed each unit I provided residents to based on their room during resident were asked shower the residents.	e #4 on 05/09/14 at 10:08 AM and a shower schedule that with two showers per week an number. Nurse #4 stated al admission assessment ed about the type of bath or a preferred and whether the neir shower to be provided				

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		345558	B. WING	<u></u>		05/09/2014
	ROVIDER OR SUPPLIER EVETERANS HOME-BL	ACK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	.	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 242	during the morning of shower frequency prassessed. Nurse #4 requested an extra so fit it in but it was rare and interview with Direct 05/09/14 at 11:58 All provided two shower their room number as schedule, which has sure each resident rourse aide schedule. The Director of Socianot aware of any fact assessment for show their resident assessment for shower as we shower load was not DON stated an assessments. Interview with the Act at 1:09 PM revealed staff member who as frequency preference stated a shower scheme two shower days per residents were asked.	or the evening, but residents' references were not a stated when a resident shower the staff attempted to e staff were able to do so. For of Social Services on a revealed residents were resorbaths weekly based on and the existing shower and the existing shower and services two showers and services stated she was all Services stated she was all the staff including an over frequency preferences in	F 24			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345558	B. WING		05/	/09/2014
	ROVIDER OR SUPPLIER EVETERANS HOME-BLA	CK MOUNTAIN	62 L	ET ADDRESS, CITY, STATE, ZIP CODE AKE EDEN ROAD CK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 242	O4/18/14 with diagnos pain syndrome, atrial Although Resident #1 formally assessed for understand by facility assessment indicated oriented, and compresented, and compresented, and compresented with Reside AM revealed when live taken one shower we he would rather take the facility staff made stated he was very not the jets in the whirlpoof twice weekly. He staff strong, calling the tub had never experience Resident #40 stated he was going, and control the water and result of his feelings, I didn't want to be bather once weekly but he had revealed no medical of frequency of baths/sh wound. Interview with Nurse A 10:48 AM revealed all showers per week, so numbers. NA #2 state the facility got three sides.	admitted to the facility on ses which included chronic fibrillation, and cellulitis. 23 had not yet been cognition or ability to staff, the admission I the resident was alert, hended all information. Int #40 on 05/06/14 at 9:51 ing at home, he had usually ekly. Resident #40 stated one shower each week but him take two. Resident #40 ervous about the power of old tub used to bathe him ed the jets were really a powerful machine and he did anything like that. In edidn't like the way his foot is wet and the powerful there was no way he could it frightened him. As a Resident #40 stated he ed or showered more than and no choice. 40's medical record order for whirlpool bath or owers related to foot Aide (NA) #2 on 05/07/14 at residents got two baths or heduled by their room ed a couple of residents in nowers a week, because uested the additional shower	F 242			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	22 - 52)	A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345558	B. WING_			05/09/2014	
	ROVIDER OR SUPPLIER EVETERANS HOME-BLA	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP COI 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
F 242	residents were frequents chedule when first are taken showers every coming here. She stain the facility, all resides showers each week a frequently which days shower days. NA #2 schedule which was preview of the shower Resident #40 was ass Tuesdays and Fridays. Interview with Nurse # revealed a set shower nursing station which showers weekly according station which showers weekly according with the Sen 05/08/14 at 8:38 AM reat admission about the each nursing station, resident room to two senior Care Partners member came to here shower frequency chastaff and family to according the senior Care Partners with the posted shower attention by the resident frequency with Nurse # revealed Resident #40 line for the senior Care Partners with the posted shower attention by the resident frequency with Nurse # revealed Resident #40 line for the senior Care Partners with the posted shower attention by the resident frequency with Nurse # revealed Resident #40 line for the senior Care Partners with Nurse # revealed Resident #40 line for the senior Care Partners with Nurse # revealed Resident #40 line for the senior Care Partners with Nurse # revealed Resident #40 line for the senior Care Partners with Nurse # revealed Resident #40 line for the senior Care Partners with Nurse # revealed Resident #40 line for the senior Care Partners with Nurse # revealed Resident #40 line for the senior Care Partners with Nurse # revealed Resident #40 line for the senior Care Partners with Nurse # revealed Resident #40 line for the senior Resident #40 line for the senior Care Partners with Nurse # revealed Resident #40 line for the senior Care Partners with Nurse # revealed Resident #40 line for the senior Resident #40	antity surprised at the shower dmitted and tell her they've day of their lives until ated she explained to them ents were scheduled two and she reminded residents were their scheduled presented the facility shower costed at the nurse's desk. schedule revealed aigned showers on a schedule was kept at the assigned each resident two reding to their room numbers. Was unaware of any nurse or desidents about their ferences. In Care Partner on evealed residents were told as shower schedule kept at which assigned each shower days per week. The stated if a resident or family with a specific request of any shower days per week. The stated if a resident or family with a specific request of any explain and shower days was brought to her and as problem or days was brought to her and or family. 4 on 05/08/14 at 9:22 AM or saughter had on tub be used once weekly	F2	42			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345558	B. WING		1	05/09/2014	
	ROVIDER OR SUPPLIER VETERANS HOME-BLA	CK MOUNTAIN	20	STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 242	#6 stated Resident #4 reliable with information Resident #40' bathing preferences.	baths or showers. Nurse 10 was alert, oriented, and on, but he was not aware of type or frequency	F 24	42		8	
	according to resident stated facility staff did assess their preference frequency but if a resi approached staff with	dent or family member a schedule change request, iffort to work the change into					
	revealed each unit had provided residents with based on their room in during resident initial aresidents were asked shower the resident president preferred the during the morning or shower frequency predassessed. Nurse #4 strequested an extra should be asked to be a second to	d a shower schedule that the two showers per week number. Nurse #4 stated admission assessment about the type of bath or referred and whether the ir shower to be provided the evening, but residents ferences were not stated when a resident ower the staff attempted to staff were able to do so.				5	
	05/09/14 at 11:58 AM provided two showers their room number an schedule, which had be sure each resident reconurse aide schedules	peen developed to make beived two showers and were fair and balanced. Services stated she was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345558	B. WING		05/09/2014
	ROVIDER OR SUPPLIER VETERANS HOME-BLA	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 242 F 253 SS=D	assessment for shower their resident assessment for shower their resident assessment for shower their resident assessments. Interview with the Dire of 05/09/14 at 12:44 PM told about their two so admission. The DON between the morning Mondays through Sat got two showers a we shower load was not to DON stated an assess frequency preferences assessments. Interview with the Activat 1:09 PM revealed so staff member who assess frequency preferences tated a shower days per wesidents were asked their assigned shower 483.15(h)(2) HOUSEM MAINTENANCE SER The facility must provimaintenance services sanitary, orderly, and of the facility fron-functioning alarminesident (Resident #80.000).	er frequency preferences in ments. Sector of Nursing (DON) on revealed residents were sheduled shower days upon stated showers were split and evening hours on urdays so that each resident ek and the nurse aide oo heavy on any day. The sment of resident shower is was not part of their vities Director on 05/09/14 whe was not aware of any ressed resident shower in the Activities Director dule existed that assigned week to each resident but if they preferred to have in the morning or evening. CEEPING & VICES de housekeeping and recessary to maintain a comfortable interior. is not met as evidenced in, record review and staff ailed to replace an ordered,	F 24		eficient ated to May 9, 2014 continue May 12, 2014

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 8	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345558	B. WING		05/09/2014
	ROVIDER OR SUPPLIER VETERANS HOME-BLA	CK MOUNTAIN	1	STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 253	04/30/13 with diagnost convulsions. The most (MDS) dated 02/07/14 severely impaired cogperson assistance with and with range of mot sides of his body and Care Area Assessmer impaired balance, seiz of falls prior to his administration of the side of the bed, check plate (every) shift." Review May, 2014 revealed transfer initials noted on the period of 05/06/14. An observation on 05/Resident #84's room right side of the bed with cord. An alarm was of floor mat on the left side (NA) #5 was obstalarm and floor mat alimat on the right side of wire. Nurse Aide (NA) over both floor mats a sound, the floor mats a sound, the floor mats a	admitted to the facility on es including dementia and st recent Minimum Data Set a coded Resident #84 with unition, requiring total 2 h all activities of daily living ion impairment on both with all extremities. The not triggered for falls due to cure disorder and a history mission. His care plan included the risk for falls oppriate interventions. 34's monthly physician revealed the current order all alarms to each side of bed accement and function q of treatment records for anscription of this order with all days and all shifts for	F 253	Common Use Bath Tubs/Spa clear Environmental Services How will you identify other rehaving the potential to be affected same deficient practice and corrective action will be taken? Sign place on Door by Maint Department for "Out of Order" to any bathing in specified tub/spa unt complete Visual posted instructions placed Tub/spa room to ensure proper of after use. Audit performed by Maint Department for any additional afloor mats. No additional Resident alarming floor mats identified. What measures will be put in put what systemic changes will be mensure that the deficient practice reoccur? Clinical Competency Coordinated designee will educate the Certified Assistants on proper sanitation of after each use	esidents I by the what tenance May 9, 2014 prevent il repair in each May 9, 2014 cleaning tenance May 30, 2014 larming its with lace or lade to will no or or June 6, 2014 Nursing

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY		
		345558	B. WING		05/	09/2014		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
NC STATE	VETERANS HOME-BLA	OK MOUNTAIN		62 LAKE EDEN ROAD				
NOSIAIE	VETERANS HOME-BLA	CK MOUNTAIN		BLACK MOUNTAIN, NC 28711				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 253	with a visitor. The flood the bed was observed cord. An alarm was of floor mat on the left sit stepping on the floor of the right side of the bed cord. An alarm was of floor mat on the left sit stepping on the floor of the right side of the bed cord. An alarm was of floor mat on the left sit stepping on the floor of the room and standing resident was observed low position. A floor of the bed with exposed was observed lying on of the bed with no blind cord. Alarm boxes we left and right upper bed blinking light. An interview on 05/09/#1 revealed she had juroom to administer mostated staff knew alarm working when staff stealarm would sound. Salarm box showed a bed	revealed the resident in bed or mat on the right side of with a broken connecting bserved connected to the de but with no signal. Upon mats no alarm sounded. 77/14 at 7:41 AM of revealed the floor mat on ed with a broken connecting bserved connected to the de but with no signal. Upon mats no alarm sounded. 78/14 at 7:41 AM of revealed the floor mat on ed with a broken connecting bserved connected to the de but with no signal. Upon mats no alarm sounded. 79/14 at 7:01 AM of revealed Nurse #1 outside of at a medication cart. The disleeping in his bed in a mat was observed on the ith a connecting cord lying reopper wire. An alarm box of a bedside table to the right king light and no attached wire observed hanging on the dirails, both with a green 714 at 7:06 AM with Nurse rust been in Resident #84's brining medications. She med floor mats were pped on them and an the stated if activated the linking green light and if the ord was removed from the	F 25	3 Continued from page 18 Night shift Supervisor to check tubs, for cleanliness daily Education provided to staff re "Work Order" report submissi broken/non functioning equipment. Environmental Services Departm place Common Use Tubs/Spa on deep cleaning schedule How will the corrective actimonitored to assure that the d practice will not reoccur, i.e., what assurance program will be put in p	egarding on for ent to weekly on be eficient Quality lace for ntinued ertment monitor a week or four is eartners eation tment	June 6, 2014		
		the floor mat to the left side						

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345558	B. WING		05/09/2014
	ROVIDER OR SUPPLIER VETERANS HOME-BLA	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 253	box and it blinked red room earlier that more glucose finger stick at pad away so as to pre sounding if she stepp was observed looking on top of the fall mat that and stated the cord wobserved picking up that table to the right of the cord connector was stitle cord was broken if #1 stated staff were expected that broken reported immediately rooms. She stated Napad alarms each shift functioning properly.	cting cord from the alarm She stated she was in the aling to perform a blood at that time moved the vent the alarm from ed on the mat. Nurse #1 at the connecting cord lying to the right side of the bed as broken. Nurse #1 was the alarm box on the bedside to bed and stated a plastic suck in the box and stated from the connector. Nurse expected to complete work the equipment and put them the esk. She stated it was	F 253	Continued from page 19 All reports will be submitted to Assurance and Performance Impro Committee monthly for four mor validation of compliance.	vement
	revealed she was ass had not yet been in his normally was not assignot worked in days. Sto the night shift whom remember her name, with Resident #84 and concerning his alarms walked into a room with would step on the mat would go off, then she sure it also alarmed. An observation on 05/	igned to Resident #84 but is room to get him up, she igned to his unit and she had he stated the NA assigned in she relieved, but could not stated everything was fine id did not speak anything. She stated when she first is alarmed floor mats, she to make sure the alarm would unplug it to make			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3 3		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345558	B. WING			05/	09/2014
	ROVIDER OR SUPPLIER	CK MOUNTAIN		6	STREET ADDRESS, CITY, STATE, ZIP CODE 2 LAKE EDEN ROAD 3 LACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	box hanging on left be sounded. She stated floor mat the alarm she was observed moving resident's bed, looking lying across the floor have been attached to observed picking up the bedside table to the ri and stated the plastic off in the box. She staprobably for the floor Resident #84's bed. Swas found broken the to the nurse. An interview on 05/09 Director of Nursing (Dwere not working staff system in place with the She stated staff were when in place. An observation on 05/DON of Resident #84' mats leaning up again DON was observed picord to the floor mat a side of the bed and stand staff should have 2. Review of a printed Unit revealed numerouthe margins and body resident room number Mondays and Thursday	NA #1 unplugged the this fall mat to the alarm ed rail and the alarm when she stepped on the would have gone off. NA #1 to the right side of the g at the connecting cord mat and stated it should of an alarm box. NA #1 was the alarm box lying on the ght of the resident's bed cord connector was broken ated this alarm box was mat on the right side of She stated when equipment expectation was to report it 1/14 at 8:20 AM with the ON) revealed if alarms fivere to use the reporting the maintenance director. expected to check alarms 1/15 at 8:30 AM with the shoot roughly should be should be alarm to the right at the wall on the right at the wall should be alarm to the printed schedule of the printed schedule of	F:	253			

	CORRECTION	IDENTIFICATIONNUMBER:	100 100	A. BUILDING		COMPLETED
		345558	B. WING			05/09/2014
	ROVIDER OR SUPPLIER	ACK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE .
F 253	word "whirlpool." An schedule for Charlie handwritten word "wirooms on Wednesda observation on 05/05 E59, in the hallway bunits, revealed a white and clean. An observation on 05 room E59 revealed a dry with an approxim greasy ring was obset the tub. Similar obset 05/07/14 at 7:56 AM AM. An interview on 05/07 Aide (NA) #2 revealed availability of the white stated not many resist there was a cleaning as a part of the tub the down the tub after us housekeeping staff heads. An interview on 05/07 revealed his awarene received tub baths be were. He stated after from the tub and retue expected to return to tub, with cleaning sufit was not hard to cle expected after the bathe next resident.	review of a printed bath Unit revealed the hirlpool" next to numerous hys and Saturdays. An hirl at 9:00 AM of spa room hetween Bravo and Charlie hirlpool type tub that was wet hirlpool type tub that was hirlpool that was hirlpool that at 11:22 Hirlpool tub for residents but hirlpool tub for residents hirlpool tub for	F 25	3		

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		345558	B. WING			05/09/2014	
	ROVIDER OR SUPPLIER	ACK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 253	recommended for rebreakdown to stimul necessary, as requestated NAs who assexpected to clean the housekeeping looked but they did not clear routine. An observation on 0 E59 with the DON a whirlpool type tub the approximate 1 inches was observed midw. The DON stated the there was at one timulit Manager stated week and no cleaning the tub room. An interview on 05/0 in the presence of the stated was at the stated was at the stated week and no cleaning the tub room.	(DON) stated tub bathing was esidents with risk of skin late blood flow and debride as ested by residents. She isted with the baths were tub. She stated at the tubs for cleanliness in them as part of their set	F 25	3			
*	resident but when sl found in the tub roor she did not know wheth. An interview on 05/0 Maintenance Director Manager, revealed functioned properly, demands on the unit multiple residents we someone was in the	ne did cleaning supplies were m. The Unit Manager stated here cleaning supplies were 18/14 at 3:29 PM with the for, in the presence of the Unit he tub in room E59 but due to hot water les, staff had to make sure here not taking showers while tub. The Unit Manager					
	multiple residents w someone was in the stated the housekee available for an inter	ere not taking showers while					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	5 8	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 253 F 279 SS=D	Manager stated if the morning 05/05/14, the on Tuesday morning 0 did no work on it, she by a resident sometim 05/05/14 and Tuesday 483.20(d), 483.20(k)(1 COMPREHENSIVE C	es for the tub The Unit tub was clean on Monday bath tub ring was observed 05/06/14 and Maintenance had to assume it was used to between Monday 05/06/14.) DEVELOP ARE PLANS results of the assessment	F 259		
	The facility must deve plan for each resident objectives and timetal medical, nursing, and needs that are identified assessment.	f care. lop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial ed in the comprehensive		Resident #13 Plan of Care revised to loose stools and to reflect physicial as follows: 5/12/14 Diet changed to Lactose 5/14/14 No Dairy products a Lactaid milk	n orders Free and d/c
	to be furnished to attain highest practicable phypsychosocial well-bein §483.25; and any service be required under §48 due to the resident's e	5) 5		Resident# 127 Plan of Care review updated to reflect: Request for follow-up with dermatologist for lesion removal left upper ear. Area on left upper ear to be evaluation. Skin Integrity Coordinator, and discussed with physician.	current site on nated by
	by: Based on observation interviews, and medica failed to develop care	is not met as evidenced s, family interviews, staff al record review, the facility plans for changes in bowel acquired ear wound for 2		How will you identify other rehaving the potential to be affected same deficient practice and corrective action will be taken?	d by the

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	5 8	ECONSTRUCTION	COMF	SURVEY
		345558	B. WING		05/	09/2014
	ROVIDER OR SUPPLIER	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 279	of 2 residents reviewer #13 and #127). The findings included 1. Resident #13 was a 10/24/12 with diagnos Alzheimer's disease, weakness, constipation The Quarterly Minimum 03/24/14 coded Resident #13 from term cognitive in coded Resident #13 from and toileting, and was and frequently incontinuated in the company of the bowel 2014 indicated Resident with multiple A review of the bowel 2014 indicated Resident with multiple A review of the bowel 2014 indicated Resident with multiple A review of the bowel 2014 indicated Resident with multiple A review of the bowel 2014 indicated Resident Resi	admitted to the facility on ses which included anemia, strokes, generalized muscle on, and diarrhea. Im Data Set (MDS) dated lent #13 with moderately king skills, and long and inpairment. The MDS further or required extensive staff hobility, transfers, dressing, always incontinent of bowel mence of bladder. Import records for January ent #13 had 31 watery liquid 19 days with the nurse of the 19 days were siple watery stools. In the 18 days were siple watery stools.	F 279	Director of Health Services or design perform an audit of all admissions/ladmissions last 30 days to identify a additional residents at risk for loose or skin integrity issues. Evaluation, intervention, reporting and docume will follow as indicated. What measures will be put in put what systemic changes will be nensure that the deficient practice reoccur? Nursing will pull data from Elimination Report and "No BM" from Electronic Medical Record as 24 hour report daily and policy/protocol for action regarding stools as needed. Licensed Neducate C.N.A. immediately if disconding to between electronic documentation and C.N.A. documentation a	Re- iny stools intation lace or nade to will not Bowel Report well as follow ig loose urse to repancy BM entation ated to facility hart for tified to	June 6, 2014 June 6, 2014
	The second secon	#13 was noted to have 10 rring that 5 day time frame notation.		Nurse when loose stool/watery selected during documentation		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	A. BUILDIN	PLE CONSTRUCTION G		E SURVEY PLETED
		345558	B. WING _		05	/09/2014
	ROVIDER OR SUPPLIER	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	2014 indicated Reside stools documented in notified notation, 4 of documented with multiple of the bowel 05/01/14 through 05/	report records for April ent #13 had 19 watery liquid 15 days with the nurse the 15 days were iple watery stools. report records dated 18/14 reflected Resident #13 y liquid stools documented notation. ian's progress notes dated sident #13 was seen due to or evaluation regarding vomiting and diarrhea. The sam indicated Resident oft and diffusely tender and red vomiting and diarrhea andicated adding the mg by mouth every 6 enitor closely and notify the for any changes in his sian orders dated 03/18/14 ten for Imodium ea) 2 mg by mouth every 6 farrhea. Itans revealed the last 124/14. The care plan were constipation, history of assistant care plan was in place for	F 2	Nurses educated on immediat Interim/Individualized Care planotification, Skin Integrity Coonotification, and initiation of indicated for any skin integrity during resident assessment. C.N.A's to be educated on immereporting of any skin integrity licensed nurse on duty on that How will the corrective monitored to assure that practice will not reoccur, i.e., assurance program will be pumonitoring to assure compliance? Skin Integrity Coordinator will new admissions with areas with integrity issues twice per week weeks, then weekly for four wonthly for four months.: Education will be provided to upon general and job specific on immediate actions and not be taken for loose stocidentification of skin integrity.	an, physician ordinator treatment if vissues found nediate issues to tunit. action between deficient what quality it in place for continued monitor thiskin k for four eeks, then new partners to orientation of the continued of	June 6, 2014 June 6, 2014
		tinent care and had a brief				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	IPLE CONSTRUCTION NG		E SURVEY PLETED
		345558	B. WING_		05	/09/2014
	ROVIDER OR SUPPLIER	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 279	Continued From page that was soiled with a stool. Additional obse PM and 05/08/14 at 7 #13 had loose watery During an interview o Nurse #7 who was fa Resident #13 stated at that Resident #13 had Nurse #7 explained that when a resident would initiate standing diarrhea, and the med Nurse #7 added the monitored and assess in his bowel pattern a for a resident with dia An interview was con AM with the Medical I stated he was not aw persistent watery diar his expectation that n resident's condition further stated Imodium order to treat resident a short term period, b persistent the resident medical conditions or cause the loose stool was given for Imodium	e 26 In mustard colored liquid ervations on 05/05/14 at 1:47 2:13 AM revealed Resident mustard colored stools. In 05/08/14 at 4:57 PM miliar with the care for she had not been notified divatery diarrhea stools. In the diarrhea the floor nurse gorders for medications for dications would be given. It was her expectation had diarrhea the floor nurse gorders for medications for dications would be further sed for continued changes and care would be planned rrhea. In the diarrhea were gorders for medications that was a standard standing the sas needed for diarrhea for the diarrhea were got would be assessed for medications that would so the MD verified the order min March and it was his			o Quality nprovement	June 6, 2014
,	The MD confirmed nu Imodium medications diarrhea continued he assessment, evaluation explained that persist stools should be reso	ons were given as ordered. Itsing would use the It for 2 to 3 days and if the It would be notified for further It on and/or orders. The MD It watery diarrhea loose Ived within a couple of days on was paramount for		8		

		A. BUILDING	3		MPLETED
	345558	B. WING			5/09/2014
NAME OF PROVIDER OR SUPPLIER NC STATE VETERANS HOME-BLACK	K MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
AM with the MDS Coord MDSC stated Resident constipation but not for added she was not notif having a problem with d The MDSC explained if problem area, a care plainitiated. The MDSC concommunication should through nursing of new medications from the M morning staff meetings development of a new of MDSC verified that a or diarrhea would not resu persistent problem of discare plan. An interview was condupt with the Director of stated she was aware of loose stools since his act was not aware of any didiarrhea or gastrointesti explained Resident #13 diarrhea added in March medication order for Immod/18/14. The DON reverse expectation that the nurordered for diarrhea epis should be monitored an loose stools, and communifurther assessments, even DON added that care please in the problem of the construction of the constr	arrhea or changes in a acted on 05/09/14 at 10:04 dinator (MDSC). The #13 had a care plan for diarrhea. The MDSC fied of Resident #13 diarrhea or loose stools. she were notified of the ean would have been infirmed that have been provided orders for diarrhea D and addressed during resulting in the eare plan for diarrhea. The fiet time occurrence of arrhea would result in a arrhea would result in a cted on 05/09/14 at 12:59 Nursing (DON). The DON f Resident #13 having dmission to the facility but agnoses to address any had a diagnosis of fin of 2014 and he had a bodium in place on ealed that it was her ses give the Imodium as sodes; the resident d assessed for further unicated to the MD for reluations and orders. The	F 27	79		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345558	B. WING _			05/09/2014
AV/63002960-2760. 1480	ROVIDER OR SUPPLIER	CK MOUNTAIN		STREET ADDRESS, CITY, ST 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC		i i
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	
F 279	for Resident #13. The care plan in place for 2. Resident #127 was	DON verified there was no diarrhea. s admitted to the facility	F 2	779		
		es which included pernicious der, and history of rectal				
	Head/Face, a sub-hear noted. In this section L (left) ear" was docur section face, neck, an "normal". There was rassessment regarding	n assessment dated d. Under the heading of ading of Pain Location was "skin Ca (cancer) removed mented. In the Body Audit d ears were described as no other notation in the g a wound on the resident's n assessment was signed				
		are plan dated 04/22/14 and Γhe wound was not entered				
	04/28/14 indicated Re severely impaired. The resident was understood and required extensive with activities of daily I note a surgical wound plans initiated with this include a plan of care	od, understands others e to limited staff assistance iving. The MDS did not present. A review of care s assessment did not for the ear wound.				
	an open area on Resid	06/14 at 8:39 AM revealed dent #127's left ear. The e top of the outer left ear. mately ½ to ¾ inch in			•	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345558	B. WING	X	05/09/2014
NAME OF PROVIDER OR SUPPLIER NC STATE VETERANS HOME-BLACK MOUNTAIN		CK MOUNTAIN	621	STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 279	indented the top of the observation on 05/07, the wound was unchasted. An interview was con Nurse on 05/07/13 at interview, the Wound on Resident #127's le not known of this wou Nurse explained this reported to her so care ensure healing without. An interview was con 05/08/14 at 8:27 AM. Resident #127 to the #4 explained the residence being admitted did not report this wound was not explan dated 04/22/14. An interview was concoordinator #1 on 05, stated when gathering does a face to face as Resident #127. The find not notice a woundear. She added if the care plan would have An interview was conconsuring (DON) on 05, DON stated the woundear should have been wound assessment metal.	lor, without drainage, and e ear. An additional /14 at 10:23 AM revealed anged. ducted with the Wound 1:53 PM. During this Nurse observed the wound eft ear. She stated she had and until now. The Wound wound should have been re could be planned to ut complication. ducted with Nurse #4 on He stated he admitted facility on 04/22/14. Nurse dent had a skin cancer outer ear the morning if to the facility. He added he and to the Wound Nurse. Intered onto the interim care ducted with the MDS /08/14 at 3:15 PM. She is g MDS information, she is sessment and did so with MDS Coordinator stated she don Resident #127's left wound had been noted, a	F 279		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345558	B. WING		05/09/2014
	ROVIDER OR SUPPLIER	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 279	important since the sk removed the morning facility. The DON add for the wound to be er		F 279	. as	
F 309 SS=E	483.25 PROVIDE CAI HIGHEST WELL BEIN Each resident must reprovide the necessary or maintain the highes mental, and psychoso accordance with the cand plan of care. This REQUIREMENT by: Based on observation interviews, and medic failed to comprehensing bowel patterns and an residents reviewed for and #127). The findings included: 1. Resident #13 was a 10/24/12 with diagnos Alzheimer's disease, sweakness, and constitution diagraphical was added 03. Minimum Data Sets (No3/24/14 coded Residents reviewed Residents reviewed Residents reviewed for an account of the reviewed for an account of the reviewed Residents rev	accive and the facility must or care and services to attain of practicable physical, cial well-being, in comprehensive assessment is not met as evidenced as, family interviews, staff all record review, the facility wely assess changes in ear wound for 2 of 2 well being (Residents #13) and dmitted to the facility on es which included anemia, strokes, generalized muscle pation. The diagnosis of	F 309	accomplished for the residents of have been affected? Resident #13 Physician notified of loose stonew orders written. Plan of Care updated to interventions for loose stools. Medication Administration documentation to reflect any orders regarding loose stools Resident # 127 Follow up appointment request dermatologist.	reflect Record ohysician May 30, 2014 ted with assessed ent plan esidents d by the

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345558	B. WING		05/09/2014
	ROVIDER OR SUPPLIER EVETERANS HOME-BLA	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 309	short term cognitive in coded Resident #13 for assistance with bed mand toileting, and was and frequently incontinual. Review of the facility so 06/15/12 included me were included in the coadmission. The standing plemented by writing an order on the Medicand notifying the physo of the standing order. specified documentating the standing order. specified documentating the standing order. specified documentating in the standing order. specified documentating the standing order. specified documentation the standing order. specified documentation the standing order. specified documentation in the standing order. specified documentation in the symptomatic, which explays the standing or 24 hours or unit symptomatic, which explays the physician if symptoms hours for further order representative. A review of the bowel nursing assistants for Resident #13 had 31 value documented in 19 day notation, 10 of the 19 multiple watery stools. A review of the medical (MAR) dated 01/01/14 no orders written on the standing or the standing order.	mpairment. The MDS further for required extensive staff nobility, transfers, dressing, a always incontinent of bowel nence of bladder. Standing orders dated dication orders for diarrhea chart on the resident's ing orders were to be ag a telephone order, writing cation Administration Recordician of the implementation. The standing orders including but a complaints, pain, bowel as. The orders indicated give on for diarrhea), begin with 4 bouth initially, then 2 mg by se stool not to exceed 16 til resident is no longer over is sooner. Notify the as persist for greater than 24 are and notify the family or report records recorded by January 2014 indicated watery liquid stools as with the nurse notified days were documented with	F 30	Audit performed by Director of Services or nursing designee utiliz Data Collection History BM Report f Electronic Medical Record data bas residents. Evaluation, interreporting and documentation as in for issues identified during audit. Director of Health Services or design perform audit of all Admissions/Readmissions last 30 days to identify a additional residents at risk. Evaluati intervention, reporting and docume as indicated for loose stool or skin in issues identified during audit. What measures will be put in pwhat systemic changes will be mensure that the deficient practice reccur? Nurse Supervisor or designee will p from Bowel Elimination Report and report tool daily and initiate actinotify physician as indicated. Electronic Medical Record SMART Cl CNA's automatically sends nurse not Nurse when loose stool/watery stool selected during documentation.	rom the e for all vention, ndicated nee to June 6, 2014 ny ion, ntation ntegrity lace or nade to will not ull data June 6, 2014 24 hour on and hart for June 6, 2014 tified to

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	V - W - W - W - W - W - W - W - W - W -	SURVEY PLETED
		345558	B. WING _		05:	/09/2014
	ROVIDER OR SUPPLIER	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	nursing assistants for Resident #13 had 32 documented in 18 day notation, 11 of the 18 multiple watery stools	report records recorded by February 2014 indicated watery liquid stools ys with the nurse notified days were documented with .	F 3	O9 Continued from page 32 Nursing Assistants educated to fall loose stools via facility report tool as well as reportinintegrity issues to licensed nuimmediately.	eport 24 hour g of all skin	
	02/28/14 revealed no for anti-diarrhea medi medications given for A review of the bowel nursing assistants for Resident #13 had 27 days with the nurse no days were documented stools. During the Mai period Resident #13 viliquid stools during the nurse notified notation. A review of the MAR of 03/31/14 revealed an entered 03/18/14 by a	report records recorded by March 2014 indicated watery liquid stools in 17 of the 17 of with multiple watery rch 16th through the 20th was noted to have 10 watery at 5 day time frame with the order written on the MAR in arrow for Imodium 2 mg rs as needed for diarrhea		Licensed Nurses educated to base record of "No BM" Notified" for daily review Nurses educated on immediate Interim/Individualized Care planotification of MD notification Integrity Coordinator and inititate treatment if indicated for any issues identified How will the corrective monitored to assure that practice will not reoccur, i.e., assurance program will be pumonitoring to assure compliance?	and "Nurse te update of an, and Skin fation of skin integrity action be the deficient what quality ut in place for	
	nursing assistants for Resident #13 had 19 documented in 15 day notation, 4 of the 15 d multiple watery stools A review of the MAR of 04/30/14 revealed ord	watery liquid stools vs with the nurse notified ays were documented with		Education will be provided to upon general and job specific On notification and action loose stools and skin integrity All reports will be submitted Assurance and Performance Committee monthly for compliance with update indicated.	required for issues. ed to Quality Improvement	v

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345558	B. WING		05/	/09/2014
	ROVIDER OR SUPPLIER	CK MOUNTAIN	2	STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page		F 309			
	nursing assistants dat 05/08/14 reflected Re watery liquid stools do notified notation. A review of the MAR of 05/31/14 revealed ord anti-diarrhea medicating given for diarrhea. A review of the physic 03/18/14 indicated Renursing staff request fromplaints of nausea, physician's physicial eights abdomen was sonursing staff had report The physician's plan in medication Imodium 2 hours for diarrhea, more physician immediately condition. A review of the physic revealed an order writh (medication for diarrhea) hours as needed for diarrhea hours as needed for diarrhea hours as needed for diarrhea hours as sollows: 1) The nurse note day Nursing assistant (NA) large soft loose stool the complaints of cramping the stools and the stools assistant (NA) large soft loose stool the complaints of cramping the stools are stools as sold to complaints of cramping the stools are stools as sold to complaints of cramping the stools are stools as sold to complaints of cramping the stools are stools as sold to complaints of cramping the stools are stools as sold to complaints of cramping the stools are stools as sold to complaints of cramping the stools are stools as sold as the stools are stools as sold as the stools are stools as sold as the stools are stools as the s	sident #13 had 3 days with ocumented with the nurse dated 05/01/14 through ders written on the MAR for ons with no medications dian's progress notes dated sident #13 was seen due to or evaluation regarding and diarrhea. The exam indicated Resident oft and diffusely tender and red vomiting and diarrhea andicated adding the 2 mg by mouth every 6 onitor closely and notify the or for any changes in his dian orders dated 03/18/14 ten for Imodium ea) 2 mg by mouth every 6 diarrhea. The ses from March 18, 2014 dealed 3 nurses notes and o3/19/14 at 12:21 AM of reported resident with		Nursing Administration and Skin Inte Coordinator will monitor newly adm residents with skin integrity issues w for four weeks, then monthly for fou months. Results of these finding to reported to QAPI committee month four months.	nitted veekly ur be	June 6, 2014

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
		345558	B. WING		05	/09/2014
	ROVIDER OR SUPPLIER	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	revealed resident was standing orders for was standing orders for was 3) The nurse note of revealed Resident #1: movement this evening cramping, distress or one episode only and loose stools. A review of the care plast reviewed dated 00 history of weight loss interventions. Interventially due to intolerance and nutritional supples physician, and assisting dining assistance by splace for diarrhea to reduce the properties of the properties o	ate 03/19/14 at 2:34 PM and administered Imodium per latery stool. ated 04/12/14 at 11:03 PM and large loose boweling, no complaints of lausea and vomiting. Noted continue to monitor for lans revealed care plans and nurse assistant care lations included were lactaid and include	F 30			
	was noted wearing a liquid stool. NA #6 pro incontinent care. The observed to have no be this time. NA #6 stated frequently had watery During an observation #6 had assisted Resid loose, unformed stool	residents' bottom was breakdown or irritation at d that Resident #13				
	at this time. During an observation	on 05/08/14 at 7:13 AM				

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	05/09/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE COMPLETION
F 309 Continued From page 35 NA#7 was observed completing care for Resident #13. NA #7 stated the bowel movement was very loose. The brief was observed containing a loose and unformed stool. During an interview on 05/08/14 at 1:46 PM NA #6 stated Resident #13 frequently had watery stools which she documented in the bowel records each time. NA #6 further stated she had been taking care of Resident #13 for the past 3 months and he had loose stools like this frequently and she had reported the loose stools to the nurses. During an interview on 05/08/14 at 4:57 PM Nurse #7 who was familiar with the care for Resident #13 had watery diarrhea stools. Nurse #7 further stated that it was her expectation that when a resident had diarrhea the NAs would notify their floor nurses. Nurse #7 added the floor nurse would be intrinses. Turnse #7 added the floor nurse would be further monitored and assessed for continued changes in his bowel pattern. Nurse #7 reviewed the MARs and confirmed there was a physician's order for Imodium was added on 03/18/14 for Imodium. Nurse #7 also confirmed the Imodium had not been administered to Resident #13 for diarrhea since the order was written. During an interview on 05/08/14 at 5:06 PM Nurse #8 stated she was the floor nurse today but was normally the nurse supervisor. Nurse #6 added she had not been notified that Resident #13 had watery diarrhea stools. Nurse #6	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345558	B. WING _		-	05/09/2014
	ROVIDER OR SUPPLIER	CK MOUNTAIN		STREET ADDRESS, CITY, STA 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECT CROSS-REFERENCE)	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)	
F 309	reported. Nurse #6 ex expectations were for diarrhea stools to the provide the intervention which was to give the An interview was come. AM with the Medical I stated he was not away persistent watery diarrhis expectation that more in the further stated Imodium order to treat resident a short term period, by persistent the resident a short term period, by persistent the resident as a short term period, by persistent the resident medical conditions or cause the loose stool was given for Imodium his expectation medicordered. The MD contained the diarrhea continue further assessment, ethe MD explained the loose stools should be days and that communication that communication is condition. An interview was condained the MDSC stated Resider constipation but not for added she was not not having a problem with	r diarrhea when it was replained it was her the NA to report watery nurses and the nurse would on to handle the diarrhea anti-diarrhea medication. ducted on 05/09/14 at 8:52 Director (MD). The MD are of Resident #13 having rhea stools and that it was urses communicated the or further orders. The MD as a standard standing is as needed for diarrhea for ut if the diarrhea were it would be assessed for medications that would is. The MD verified the order in March 2014 and it was ations were given as affirmed nursing would use ons for 2 to 3 days and if if the would be notified for valuation and/or orders. It persistent watery diarrhea is resolved within a couple of inication was paramount for diarrhea or changes in a diucted on 05/09/14 at 10:04 ordinator (MDSC). The int #13 had a care plan for or diarrhea. The MDSC offified of Resident #13 in diarrhea or loose stools. If she were notified of the	F3	309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345558	B. WING_			05/09/2014	
	ROVIDER OR SUPPLIER EVETERANS HOME-B	LACK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CO 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	1711, Spin 2	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HEAPPROPRIATE	(X5) COMPLETION DATE	
F 309	through nursing of a medications from the morning staff meeting development of a number of a nursing problem of a nursing the time resident. Nurse #4 nursing procedure the nurses and or the number of a nurses initiated star medications, and as notified the physicial watery stools for fur Nurse #4 confirmed Resident #13 having. An interview was confirmed a number of a number	C confirmed that bull have been provided new orders for diarrhea ne MD and addressed during ngs resulting in the ew care plan for diarrhea. The a one time occurrence of result in a care plan but a of diarrhea would result in a onducted with Nurse #4 on the Bravo and Charley e Resident #13 was a explained it was standard that NAs notified the floor curse supervisors of residents tools. Nurse #4 added the adding orders for anti-diarrhea assessed, documented and an of the resident's loose ther evaluations and orders. The was not aware of g problems with diarrhea. Inducted on 05/09/14 at 12:59 or of Nursing (DON). The DON are of Resident #13 having its admission to the facility but the diagnoses to address any testinal disease. The DON #13 had a diagnosis of larch of 2014 and he had a r Imodium in place on	F3	09			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	11830 4080 - 17880 54.0		ONSTRUCTION		DATE SURVEY COMPLETED
	v.	345558	B. WING				05/09/2014
3757 00 00 00 00 00 00 00 00 00 00 00 00 00	ROVIDER OR SUPPLIER	CK MOUNTAIN	•	62 L	REET ADDRESS, CITY, STATE, ZIP CODE LAKE EDEN ROAD ACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	loose stools, and comfurther assessments, The DON added care implemented when the for Resident #13. The and stated it was not of #13 received Imodium during the months of 2014, except one time notes on 03/19/14. The standing orders should watery diarrhea stools been notified for further further confirmed that as ordered and should	municated to the MD for evaluations, and orders. plans should have been e new diagnosis was added DON reviewed the MAR documented that Resident of for diarrhea at any time January through May of e as noted in the nurse's e DON confirmed that d have been initiated for s and that MD should have er assessment. The DON the Imodium was not given d have been given after se DON verified there was	F	309			
	04/22/14 with diagnos pernicious anemia, mo of rectal cancer. The nursing admission 04/22/14 was reviewe Head/Face, a sub-heanoted. In this section L (left) ear" was docur section, face, neck, ar "normal". There was massessment regarding left ear. The admission by Nurse #4. A review of Resident # revealed an interim care	ental disorder, and history n assessment dated d. Under the heading of eding of Pain Location was "skin Ca (cancer) removed mented. In the Body Audit and ears were described as no other notation in the g a wound on the resident's an assessment was signed					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRU	ICTION		E SURVEY PLETED
		345558	B. WING_			05	/09/2014
SCHOOL STATE OF STATE	ROVIDER OR SUPPLIER VETERANS HOME-BLA	CK MOUNTAIN		62 LAKE ED	DRESS, CITY, STATE, ZIP CODE DEN ROAD OUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	dated 04/26/14. The #2. The section design contained a mark by "medical record review dated 04/26/14 writter not describe "discolor body audit. An admission Minimu 04/28/14 indicated Reseverely impaired. The resident was understor required extensive to activities of daily living surgical wound present An observation on 05/an open area on Resident area was approxidark red in color, with the top of the ear. An 05/07/14 at 10:23 AM unchanged. An interview was conducted of the color of the ear of the color of	ted of a body audit form form was signed by Nurse gnated face, neck and ears discoloration". Continued a revealed a nursing note in by Nurse #2. The note did ation" as designated on the m Data Set (MDS) dated esident #127's cognition was ne MDS specified the bod, understands others and limited staff assistance with graph. The MDS did not note a int. 106/14 at 8:39 AM revealed dent #127's left outer ear. In mately ½ inch in length, but drainage, and indented additional observation on revealed the wound was ducted with Nurse #2 on a Nurse #2 stated the noted on the body audit elated to a redness she in #127's face and neck. She ke the resident had been #2 added she did not notice ent's left outer ear.	F3	609			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345558	B. WING		05/09/2014
	ROVIDER OR SUPPLIER	CK MOUNTAIN	62	TREET ADDRESS, CITY, STATE, ZIP CODE LAKE EDEN ROAD LACK MOUNTAIN, NC 28711	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 309	had not known of this Wound Nurse explain been reported to her sensure healing without. An interview was condected was unable to recall	ft outer ear. She stated she wound until now. The ed this wound should have so it could be monitored to t complication. ducted with Nurse Aide (NA) 5 PM. NA #2 stated she and on the left ear since dimitted to the facility. NA #2 ed the wound to a nurse but which nurse. ducted with Nurse #4 on He stated he admitted facility on 04/22/14. Nurse lent had a skin cancer outer ear on the morning of admitted to the facility. He ohysician's orders referring res #4 added he did not ne Wound Nurse but he ed the admission occurred oon. Nurse #4 and Nurse should have nd. When asked how he urse of skin issues, he rbally. Jucted with MDS on 05/08/14 at 3:15 PM. Bering MDS information, she sessment and did so with C stated she did not notice #127's left ear. She added noted, a care plan would did the wound added to the	F 309		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
9		345558	B. WING		05/09/2014	
	ROVIDER OR SUPPLIER VETERANS HOME-BLA	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	BE COMPLETION	
F 312 SS=D	Nursing (DON) on 05/DON stated the wound outer ear should have to a wound assessme followed. The DON er important since the sk removed on the morni admission to the facilitishould have been entecould be assessed and 483.25(a)(3) ADL CAFDEPENDENTRESIDE A resident who is unat daily living receives the maintain good nutrition and oral hygiene. This REQUIREMENT by: Based on observation interviews, and medicalled to provide oral concepts (Resident #119, #106, extensive or total assistiving. The findings included: 1. Resident #119 was 03/28/14 with diagnost weakness, chronic kid	ducted with the Director of 09/14 at 1:38 PM. The d on Resident #127's left been measured and added int module where it could be in cancer had been in g of 04/22/14 before by. She stated the wound ered on a care plan so it dimonitored. RE PROVIDED FOR ENTS Dele to carry out activities of the necessary services to in, grooming, and personal is not met as evidenced as, resident interviews, staffinal record review, the facility are for 3 of 3 residents and #72) requiring stance for activities of daily admitted to the facility on the swhich included muscle	F 312	What corrective action was accomplished for the residents for have been affected by the opractice? Resident #119 Plan of care and CNA ADL/Care updated to include CNA assistantoral hygiene during AM and PM care updated to include CNA assistantoral hygiene during AM and PM care updated to include CNA assistantoral hygiene during AM and PM care Resident #72 Plan of care and CNA ADL/Care updated to include CNA assistantoral hygiene during AM and PM care updated to include CNA assistantoral hygiene during AM and PM care updated to include CNA assistantoral hygiene during AM and PM care updated to include CNA assistantoral hygiene during AM and PM care	e guide May 30, 2014 ce with e May 30, 2014 e guide ce with e e guide ce with e e guide ce with e e guide ce with	
	giaucoma. The most r	ecent willimum Data Set				

	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLET					
		345558	B. WING		05	/09/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NO STATE	VETERANG HOME DI	A CK MOUNTAIN		62 LAKE EDEN ROAD		
NUSTATE	VETERANS HOME-BLA	ACK MOUNTAIN .		BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	Continued From page (MDS), an admission		F 31	2 Continued from page 42 How will you identify other resider	ıtc.	
		ne resident was cognitively		having the potential to be affected		
		le to understand and usually			by the	
	able to make himself	understood. The MDS also		same deficient practice and what corrective action will be taken?		
		119 needed extensive		corrective action will be taken?		
	assistance with perso			Audit to be conducted by Director of	£	June 6, 2014
	not indicate the resid	more persons. The MDS did		Audit to be conducted by Director o	И	Julie 0, 2014
	not maicate the resid	chi resisted care.		Health Services or designee for all Residents who are identified on the		
	Interview with Reside	ent #119 on 05/05/14 at 3:22	1			
		lped him to brush his teeth		Minimum Data Set as dependent fo		
		ut not more often. Resident		to ensure that necessary care and so		
		ound a toothbrush in his		for oral hygiene addressed on plan	or care.	
		arted to try to brush his own ut wasn't able to clean his		Divostor of Hoolth Comises or design	لدعدد	
	teeth very thoroughly			Director of Health Services or design		June 6, 2014
	**************************************	Section through control of the design of the control of the		licensed nurse to perform assessme		
		lent #119 on 05/05/14 at 3:29		oral hygiene for 2 residents who are		
		of food and white and brown		dependent with ADL's per unit wee	150	
		eeth, with film covering top of servation of toothbrush		four weeks and monthly for four mo		
		was dry, in plastic container		and will provide immediate educat		=
	in bathroom next to s			C.N.A. if unsatisfactory oral hygiene	touna.	
	Interview with Nurse	Aide (NA) #2 on 05/07/14 at		What measures will be put in place		
		esidents were to receive oral		what systemic changes will be mad		
		e morning after waking up,		ensure that the deficient practice w	ill not	
		n in the evening before bed.		reoccur?		
		a system used by NAs to ncluded information showing				
		s attempted and level of		CNA staff education on proper AM a	ind PM	June 6, 2014
		out did not show when		oral care.		
		sonal hygiene care or parts of				
		stated as a result, if any				
		with personal hygiene was				
		e, the data would show istance was provided that				
		even if the task wasn't		How will the corrective action be		
	completed.	*		monitored to assure that the defici-	ent	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345558	B. WING		05/09/2014	
	ROVIDER OR SUPPLIER VETERANS HOME-BLA	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		N
F 312	Interview with Nurse # revealed her expectate needed assistance with receive that assistance got up and again after stated nurse aides we residents' teeth for cle when residents were at teeth, and provide assistance of the whole of the who	the servation. Resident #119's been brushed in a week or of Resident #119's bathroom ush and dry sink. The sansigned to fict ompleted care tasks for did not know who had or Resident #119 that day. not completed oral care for the that day. When 19's teeth were very dirty, en his teeth, had a foul I did not appear to have	F 31	Clinical Competency Coordinator or designee to observe oral hygiene for C.N.A.'s per unit weekly for four we monthly for four months and will pimmediate education to C.N.A. if unsatisfactory oral hygiene found. Education will be provided to new pupon general and job specific orient On providing appropriate oral carea.m. and p.m. care. All reports will be submitted to Assurance and Performance Impro Committee monthly for four mont validation of compliance update/change as indicated	eks and rovide artners ation during June 6, 2014 Quality vement June 6, 2014	.4

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII				E SURVEY IPLETED
		345558	B. WING_			0.5	5/09/2014
	ROVIDER OR SUPPLIER	CK MOUNTAIN		62 LA	ET ADDRESS, CITY, STATE, ZIP CODE KE EDEN ROAD CK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	PM revealed small ar (much less than previ Resident #119 stated that morning and it was had been brushed in of Resident #119's bat toothbrush and water Review of the staffing nurse aide #3 was assesident #119. Interview with NA #3 revealed nurse aides #119 lived all worked care for all residents, resident assignments remember the last time assistance for Reside wasn't aware of the lee #119 required with ora Observation of Reside AM revealed food det #119 stated his teeth Observation of Reside revealed dry toothbrush Interview with director 05/09/14 at 12:44 PM that residents who recare will receive assis evening, and after me stated toothbrushing in nurse aides in the facility.	nount of food debris in teeth ous observations). staff had brushed his teeth as the first morning his teeth over a week. Observation throom revealed a moist spots in sink. sheet for 05/08/14 revealed signed to provide care for on 05/08/14 at 3:45 pm on the hall where Resident together to provide morning regardless of specific. NA#3 stated he couldn't tee he had provided oral care int #119. NA#3 stated he vel of assistance Resident al care. ent #119 on 05/09/14 at 9:45 oris on all teeth. Resident had not been brushed yet. ent #119's bathroom sh and dry sink.	F	312			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	130003000000000000000000000000000000000	PLE CONSTRUCTION	100 YEAR (#100)	(X3) DATE SURVEY COMPLETED		
		345558	B. WING _			05/09/2014		
	ROVIDER OR SUPPLIER	ACK MOUNTAIN	9	STREET ADDRESS, CITY, STATE, ZIP C 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HEAPPROPRIATE	(X5) COMPLETION DATE		
F 312	O2/10/14 with diagno kidney disease, must coordination. The m (MDS), an admission O4/17/14, indicated the intact, able to unders. The MDS also indicate extensive assistance of two did not indicate the result of the assistance of two did not indicate the result of the interview with Resider assistance with oral of the the best he counce assisted him with oral in over a month. Dur Resident #106 on 05 resident opened his ron upper and lower the red and swollen gum #106's bathroom revesink. Review of nursing no medical record reveate fusal of care after in 02/10/14. Interview with Nurse 10:48 AM revealed recare assistance in the after lunch, and again NA #2 stated the data document oral care in	as admitted to the facility on ses which included chronic cle weakness, and lack of ost recent Minimum Data Set assessment dated he resident was cognitively tand and to be understood. It ded Resident #106 needed with personal hygiene with for more persons. The MDS esident resisted care. In #106 on 05/05/14 at 3:01 ht #106 did not receive care and he brushed his ld when he remembered. If no nurse aide or nurse had I care or checked his teeth ing the interview with 1/05/14 at 3:01 PM, the mouth, revealing food debris eeth, a film on tongue, and so Observation of Resident ealed a dry toothbrush and tes in Resident #106's led no documentation of ight of facility admission on Aide (NA) #2 on 05/07/14 at esidents were to receive oral emorning after waking up, in the evening before bed. As system used by NAs to included information showing a attempted and level of	F3	12				

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345558	B. WING_			05/09/2014
	ROVIDER OR SUPPLIER	ACK MOUNTAIN		STREET ADDRESS, CITY, STAT 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 2	enne Carretta (Application China)	00.00.2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED		LAN OF CORRECTION TIVE ACTION SHOULD BE SED TO THE APPROPRIAT FICIENCY)			
F 312	hygiene care. NA # attempt of assistance made by a nurse aid personal hygiene as day for the resident, completed. Interview with Nurse revealed she expect assistance with toott assistance in the mode again after each medides were to check for cleanliness after were able to brush the assistance when need to brush the assistance when need to brush the assistance when need the last tree and lower teeth, with mouth. Resident was a friend during observation of resident was a friend during observation with directed the last tree and lower teeth, with mouth. Resident was a friend during observation of the last tree and lower teeth, with mouth. Resident was a friend during observation of the last tree and lower teeth, with mouth. Resident was a friend during observation of the last tree and lower teeth, with mouth. Resident was a friend during observation of the last tree and lower teeth, with mouth. Resident was a friend during observation of the last tree and lower teeth, with mouth. Resident was a friend during observation of the last tree and lower teeth, with mouth. Resident was a friend during observation of the last tree and lower teeth, with mouth and lower teeth and l	esonal hygiene care or parts of 2 stated as a result, if any e with personal hygiene was le, the data would show sistance was provided that even if the task wasn't #8 on 05/07/14 at 2:05 PM led all residents who needed abrushing would receive that bring when they got up and led. Nurse #8 stated nurse independent residents' teeth leach meal when residents heir own teeth, and provide leded. 8 on 05/08/14 at 3:45 pm so on the hall where Resident it together to provide morning so, regardless of specific les. NA #3 stated he couldn't lene he had provided oral care lent #106. NA #3 stated he level of assistance Resident level of assistance Resident level of assistance Resident level of on 05/08/14 at 4:40 lebris on and between upper lefoul odor detected from less in dining room visiting with reation.	FS	100.00		
	that residents who re care will receive ass	of revealed her expectation equire assistance with oral istance in the morning, in the leals as needed. The DON				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345558	B. WING			05/	09/2014
	ROVIDER OR SUPPLIER	CK MOUNTAIN		6	TREET ADDRESS, CITY, STATE, ZIP CODE 2 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	1	(X5) COMPLETION DATE
F 312	nurse aides in the facts of focused on meals at track of oral care. The noticed Resident #106 mouth and needing or with and needing or with and needing or osteoarthrosis, general and lack of coordination. The most recent Minimo4/30/14 specified the impaired cognitively foskills, did not refuse of dependent on staff for A review of the care prelated to self care impintervention for staff to oral and skin care. The for the resident would daily which included or	and not been a priority for allity because they had been and toileting and had lost to DON also stated she had a having a foul odor from his ral care. admitted to the facility on is which included lementia, general alized muscle weakness on. The mum Data Set (MDS) dated to resident was moderately or daily decision making are and was totally personal hygiene. Itan dated 04/30/14 revealed mysical functioning deficit pairment with an provide daily grooming, the care plan identified a goal have personal hygiene met ral care.	F:	312	DEFICIENCY)		
	his teeth and he answ was asked if he brush answered "No." Resid observed and reveale	d if staff helped him to clean ered, "No." Resident #72 es his own teeth and he dent #72's teeth were					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345558	B. WING_			05	/09/2014
	ROVIDER OR SUPPLIER	CK MOUNTAIN		62	TREET ADDRESS, CITY, STATE, ZIP CODE 2 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	dirty. On 05/07/14 at 9:16 A observed in bed watch were observed and no substance accumulaticoating between the treeth. When asked if It this morning and he result that the family me stated she visited a coadded the resident did everyday. She explain she would brush his treamount of substance gums that he hadn't had his teeth member revealed she with the nurses and ai brushed daily. On 05/08/14 at 8:58 A observed in his reclinicesident was noted to between all of his teeth upper and lower teeth and oral mouth care treath bathroom on the sink and oral mouth care treath and oral mo	M Resident #72 was ning television. His teeth of teed to have white and along the gum line and eeth of the upper and lower he had his teeth brushed esponded, "No." ducted on 05/07/14 at 1:36 ember. The family member ouple times a week. She did not get his teeth brushed and his teeth brushed hed on the days she visited, eeth and could tell by the between his teeth and ad his teeth brushed. The Resident #72 had told her in brushed. The family had discussed mouth care des about having his teeth M Resident #72 was ang chair in his room. The have a white substance in his at the gum line of the at the gum line of the and were visibly dry. ident #72 was made on in his recliner in his room. ed if he had his teeth and he responded, "No."	FS	312			
	The resident was note substance in between	all of his teeth at the gum					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
	345558	B. WING_		18	05/09/20	014	
NAME OF PROVIDER OR SUPPLIER NC STATE VETERANS HOME-	BLACK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CO 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	DE			
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIAT		(X5) MPLETION DATE	
tooth brush and on observed in the base visibly dry. An observation of 05/08/14 at 2:55 Finis recliner watching Resident #72 againsteeth brushed took have a white substant the gum line of resident's tooth brusher visibly dry. An interview was controlled to the substant and bottom. Nurse the hadn't had his the hadn't had his the hadn't had his the hadn't had his the his the hadn't had his the hadn't had his the	and lower teeth. The resident's ral mouth care tray were athroom on the sink and were Resident #72 was made on PM. The resident remained in any televising in the living room. In stated he had not had his ay. The resident was noted to tance in between all of his teeth the upper and lower teeth. The ush and oral mouth care tray the bathroom on the sink and conducted with Nurse #7 on PM. Nurse #7 observed and confirmed she observed are on all of his teeth both top at #7 stated she was not aware seeth brushed. Nurse #7 stated tion for nurse aides (NA) to as of daily living (ADL) which shing and personal hygiene for were dependent for care. conducted with NA #7 on PM. NA #7 revealed she did not 2's teeth today. NA #7 not have time before she was rent hallway at lunch time. NA new Resident #72 was ais ADLs and she needed to senducted with Nurse #6 on PM. Nurse #6 stated she was sident #72 hadn't had his teeth	F3	12				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345558	B. WING		05/09/2014
	ROVIDER OR SUPPLIER	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 312 F 371 SS=E	brushed. Nurse #6 sta for NAs to provide all (ADL) which included personal hygiene for a dependent for care. Noto provide teeth brush every shift for all reside for care or needing as An interview was con- Nursing on 05/09/14 a her expectation oral coresidents requiring as activities of daily living 483.35(i) FOOD PRO STORE/PREPARE/Si The facility must - (1) Procure food from	ated it was her expectation activities of daily living teeth brushing and all residents who were lurse #6 added NAs needed sing after meals or at least lents who were dependent esistance. ducted with the Director of at 12:59 PM revealed it was are be provided daily for all sistance or dependent for J. CURE, ERVE - SANITARY	F 31	What corrective action will be accomplished for the residents fou have been affected by the deficient practice?	
	authorities; and (2) Store, prepare, disunder sanitary condition This REQUIREMENT by: Based on observation interviews, the facility frozen foods in 1 of 2 dispose of resident-pumanufacturer use-by rooms, to properly clean an ice:	is not met as evidenced n, record review and staff failed to properly store nourishment rooms, to urchased food past dates in 1 of 2 nourishment an 3 of 5 kitchen areas, to		Thermometers placed in the free both nourishment rooms Food disposed of and Maintenance Sign posted "out of order" Cleaned/replaced affected contained Sandwich and Tarter Sauce disposed fresh items provided by Dietary 1 was educated immediately on temperatures All areas and equipment identified for cleaning were cleaned by Dietary Maintenance Sandwich and Tarter Sauce disposed fresh items provided by Dietary 1 was educated immediately on temperatures	notified May 5, 2015 rs May 5, 2015 d of and May 5, 2015 ary at Aide # proper

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STATEMENT OF AND PLAN OF CO	5 77 1 77 77 77 77 77 77 77 77 77 77 77 7	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		345558	B. WING		05/09/2014
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NO OTATE VETERANG HOME DI ACCAMOUNTANI			62 LAKE EDEN ROAD		
NC STATE VETERANS HOME-BLACK MOUNTAIN			BLACK MOUNTAIN, NC 28711		
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F 371

Continued From page 51

food storage, and to serve a cold potentially hazardous food item at a temperature of 41 degrees Fahrenheit or below in 1 of 5 kitchen areas.

Findings included:

1. An observation on 05/07/14 at 10:58 AM of the nourishment room used for Bravo and Charlie units revealed a Daily Freezer/Refrigerator Temperature Log affixed to the door of the refrigerator/freezer. Printed instructions on this form directed a designated food service employee was to record the time, air temperature and their initials in the morning and the afternoon and "It is not necessary to check temperatures of food products but touch several products to be sure they are cold and frozen items are solid to the touch."

An observation on 05/07/14 at 10:58 AM of the nourishment room used for Bravo and Charlie units revealed in the freezer 21 foam containers, each 4 ounces, of an orange cream flavored fortified food. All 21 containers had the following manufacturer's printed instructions: "store frozen, serve as ice cream or pudding consistency when thawed, use within 5 days of thawing, for creamy consistency thaw 4 hours prior to eating." Three containers were observed stored in the door of the freezer and 18 containers were observed stored on the lowest level, in the middle and back of the freezer. Pressing the sides of all the containers revealed the product to be soft. Also observed in the door of the freezer were 3 pint-sized containers partially full of ice cream with resident names and on the lowest level in the back corner were another 2 pint-sized containers partially full of ice cream with resident names. All

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All areas and equipment identified for deep May 5, 2014 cleaning were cleaned by Dietary Manager

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

Dietary Manager, provided supervisory May 5, 2014 rounds to other neighborhoods without identification of any other residents at risk

What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?

Nourishment rooms and kitchenettes to be checked by Dietary Aides daily to recordJune 6 2014 refrigerator and freezer temperatures, to check labeling and dating of food items and to check cleanliness of floors and storage containers.

Dietary supervisors to check nourishment room, kitchenettes and main kitchen on compliance rounds for clean storage une 6 2014 containers, clean ice scoops, properly dated and labeled food items, appropriate refrigerator and freezer temperatures, grease build-up near steamer and deep fryer and general dirt or grease on floors of kitchenette and main kitchen. This will be checked three times weekly for four weeks, then weekly for four months.

			(X3) DATE SURVEY COMPLETED		
		345558	B. WING		05/09/2014
	ROVIDER OR SUPPLIER VETERANS HOME-BLA	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 32 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 371	were squeezed. An interview on 05/07 Registered Dietician reitem came from the mourishment room free frozen until removed, a meal at the dining tawas checking temperashould also have been freezer was working. column on the temperatures, there we freezer but items in it is solid. An interview on 05/09 Manager revealed Matemperatures on refrigaides were expected to the foam containers of like regular nourishment containers at a time at cream. He stated the frozen until used. 2. An observation dat the nourishment room revealed the following a. In an upper cabine shredded wheat cerean name and room number the cereal was partiall and was approximatel	2/14 at 11:41 AM with the evealed the fortified food ain kitchen freezer to the ezers and were to remain then they would thaw during able. She stated whoever atures for the refrigerators in checking to make sure the She stated there was no ature log for freezer as no thermometer for the should have been frozen and the dietary intenance staff checked greators and the dietary o back them up. He stated of fortified food were stocked ent items at 12:00 noon, 8 long with containers of ice fortified food was to remain ed 05/07/14 at 10:12 AM of for Alpha and Delta units	F 371	compliance. Education will be provided to new pupon general and job specific orient on keeping floors and storage corclean, monitoring and reporting temperatures in refrigerators and frensuring all food temperatures are consuming all food temperatures.	ce are to Certified d food weekly June 6, 2014 ng of I deep- ers for of on bejune 6, 2014 eficient quality lace for ntinued partners cation ntainers g safe June 6, 2014

NAME OF PROVIDER OR SUPPLIER NC STATE VETERANS HOME-BLACK MOUNTAIN (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONT. from page 54	(X5) COMPLETION DATE
NC STATE VETERANS HOME-BLACK MOUNTAIN (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
cont. from page 54	June 6, 2014
b. In a lower cabinet were found various cans of soup labeled with another resident's name and room number. 1 can of ready-to-eat creamy broccoli soup had a printed manufacturer "recommend use by" date of 02/25/14 and another 3 cans with the date of 03/26/14. 1 can of ready-to-eat creamy chicken soup had a date of 03/06/14. c. In a lower cabinet was found a box of instant oatmeal containing 9 single serving packets of various flavors. Printed on the box was the manufacturer "best if used before" date of 02/12/14. An interview on 05/07/14 at 10:40 AM with the Registered Dietician revealed nursing staff were responsible for resident-purchased food storage. She stated the bag of cereal should not have been left open and it should have been removed by nursing when the resident passed away. She stated ready-to-eat food purchased by residents or their family with manufacturer dates should be treated no differently than ready-to-eat food purchased by the facility for resident meals, with all foods being consumed or discarded before the date printed on the container. An interview on 05/09/14 at 10:05 AM with the Dietary Manager revealed dietary aides were expected to monitor all food items stored in nourishment rooms, including those purchased by residents or their family, for proper storage, labeling and food items are within expiration dates. 3. Observation of unit kitchenettes at unit dining areas (where resident meals were plated) and the main kitchen (where food was stored and	June 6, 2014

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION IG	(X	3) DATE SURVEY COMPLETED
		345558	B. WING _			05/09/2014
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F 371	a. On 05/08/14 at 11 Alpha Unit kitchenett inch wide strip of dirt cabinet baseboards a steam table. Food deleft side of steam table. Food deleft side of steam table b. On 05/09/14 at 9: main kitchen reveale the side of the steam the vicinity of a small the steamer unit and c. On 05/09/14 at the main kitchen with revealed a large plas parts for a mixer and lower metal shelf und counter. On the lid a observed debris and d. On 05/09/14 at the main kitchen with revealed an approximalong the length of a sthe meat slicer. An Interview on 05/09 Dietary Manager revealed surrounding the deep surrounding the deep	2:53 AM, observation of the e revealed approximately 6 build-up on the floor, along and along the length of the ebris was noted along the le. 40 AM, observation of the d accumulation of grease on er unit and on the tile floor in metal table located between the deep fryer. at 9:48 AM, observation of the Dietary Manager tic container holding extra food processor, placed on a ler a food preparation and inside the container was crumbs. at 9:48 AM, observation of the Dietary Manager nate 6 inch wide dirt build-up 2 compartment sink next to	F3	71		
	revealed the lid and of for a mixer and food	container holding extra parts processor should have been Further interview with the				

			3) DATE SURVEY COMPLETED			
		345558	B. WING			05/09/2014
	ROVIDER OR SUPPLIER EVETERANS HOME-BLA	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 371	stated everything sto containers were to be containers and cabin this responsibility was. The Dietary Manager on the night shift were the unit kitchenette flet technician would deckitchenettes and main stated floor technician their machines to per 4. An observation was obtaining food tempe kitchen on 05/09/14 at temperatures of the fetable were obtained by 12:20 PM another DA a wrapped pimento of Charlie Hall refrigerat. At 12:48 PM DA #1 we pimento cheese sand The sandwich was unplate with the intent of server to be given to a obtain the temperature was delivered to the kan interview at that timmake the sandwich at temperatures of any server to the kitchen. DA the temperature of the by inserting a thermore	assigned to unit sponsible for cleaning. He red in cabinets in dirty se swapped out with clean et shelving wiped down and so noted on their cleaning list. It stated Housekeeping staff er responsible for mopping pors each day and the floor exp clean the floors in the unit in kitchen once a month. He in should have been using form the floor deep cleaning. It is conducted of staff ratures in the Charlie Hall it 12:07 PM. The pods placed on the steam by Dietary Aide (DA) #1. At a from the kitchen delivered the ese sandwich to the or. It is observed removing the wich from the refrigerator. It is observed on a finanding the plate to the a resident. DA #1 did not be of the sandwich when it sitchen or before plating. In the, DA #1 stated she did not	F 37			

PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTI			(X3) DATE SURVEY COMPLETED		
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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			CK MOUNTAIN		62 LAKE EDEN ROAD		
F 371 Continued From page 56	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
Fahrenheit. DA#1 stated she did not make the pimento cheese sandwich and was unaware she should obtain the temperature of cold sandwiches that come from the kitchen. An interview with the Dietary Manger was conducted 05/09/14 at 1:19 PM. He stated all foods, cold or hot, had temperatures obtained before they left the kitchen and again before being served in the neighborhood kitchens. The expected temperature of cold foods was 41 degrees Fahrenheit or below and should be maintained when served from the tray line. 5. An observation of the Charlie Hall neighborhood kitchen was conducted 05/07/14 at 3:39 PM wift the Registered Dietician (RD). Five 2 quart clear plastic containers were observed in a cabinet. The containers held raisin bran, corn flakes, and rice cereals, thickner, and brown sugar. The containers were observed with finger prints and smudges on the plastic and they were sticky to the touch. The RD checked the cleaning schedule for this kitchen. The containers were not listed for cleaning. The RD stated the containers should be kept clean and without grime. Further observation at this time revealed a holder for an ice scoop mounted on the wall next to the ice machine. An ice scoop was observed in holder at this time and the scoop rested on the bottom of the cholder. The inside of the holder container. An ice scoop was observed in holder at this time and the scoop rested on the bottom of the choltom of the cholder. The linside of the holder container a black substance observed around the seams of the bottom of the container. The RD checked the cleaning schedule and did not find the ice scoop or holder on the schedule. The RD stated the ice scoop holder on the schedule. The RD stated the ice scoop or holder on the schedule. The RD stated the ice scoop or holder on the schedule. The RD stated the ice scoop or holder on the schedule. The RD stated the ice scoop or holder on the schedule. The RD stated the ice scoop or holder should be clean and	F 371	pimento cheese sand should obtain the tem that come from the kit. An interview with the land conducted 05/09/14 at foods, cold or hot, had before they left the kit being served in the ne expected temperature degrees Fahrenheit of maintained when served. 5. An observation of the neighborhood kitchen 3:39 PM with the Reg 2 quart clear plastic of a cabinet. The containflakes, and rice cereal sugar. The containers prints and smudges of sticky to the touch. The schedule for this kitch not listed for cleaning containers should be grime. Further observation at for an ice scoop mour ice machine. An ice scholder at this time and bottom of the holder. To contained a black sub seams of the bottom of checked the cleaning the ice scoop or holder at the stime and checked the cleaning the ice scoop or holder.	ated she did not make the wich and was unaware she perature of cold sandwiches chen. Dietary Manger was at 1:19 PM. He stated all demperatures obtained chen and again before eighborhood kitchens. The experimental of the cold foods was 41 or below and should be eved from the tray line. The Charlie Hall was conducted 05/07/14 at instered Dietician (RD). Five containers were observed in mers held raisin bran, corn as, thickener, and brown as were observed with finger on the plastic and they were the RD checked the cleaning en. The containers were are RD stated the kept clean and without at this time revealed a holder and the scoop was observed in the scoop was observed in the scoop rested on the The inside of the holder stance observed around the of the container. The RD schedule and did not find aron the schedule. The RD	F 37			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345558	B. WING		05/09/2014
	ROVIDER OR SUPPLIER VETERANS HOME-BLA	CK MOUNTAIN	9	STREET ADDRESS, CITY, STATE, ZIP CODE 82 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 371	was the evening serve kitchen. DA #2 explai condition of the cereal holder. He added the used the ice scoop to An interview was cond Manager (DM) on 05/6 stated the dietary aide was in charge of ensu were kept clean. If co should be changed for stated the ice scoops taken to the kitchen with dish cleaning machine holder should be checalways clean. 483.65 INFECTION CONTROL SPREAD, LINENS The facility must establinfection Control Progsafe, sanitary and com to help prevent the devor disease and infection (a) Infection Control Program under which (1) Investigates, control the facility; (2) Decides what processing the condition of the control program under which (1) Investigates, control the facility; (2) Decides what processing the condition of the condition of the control program under which (1) Investigates, control the facility; (2) Decides what processing the condition of th	ary Aide (DA) #2 was 4 at 3:40 PM. He stated he er for the Charlie Hall ned he was unaware of the 1 containers or the ice scoop nurse aides on the hall obtain ice for the residents. Illucted with the Dietary 09/14 at 10:05 AM. He assigned to that kitchen ring the kitchen contents ntainers were soiled, they r clean ones. The DM and holders should be eekly to run through the e. He added the ice scoop ked daily to ensure it was ONTROL, PREVENT Illish and maintain an ram designed to provide a nfortable environment and velopment and transmission n. rogram lish an Infection Control	F 371	What corrective action will accomplished for the residents for have been affected by the depractice? Nurse #2 educated on appropriate time for glucometers following cowith germicidal wipes	und to eficient drying May 9, 2014
		of incidents and corrective			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	7 6		CONSTRUCTION	(X3) DATE SU COMPLE	
		345558	B. WING			05/09	/2014
VAC-6000000000000000000000000000000000000	ROVIDER OR SUPPLIER	CK MOUNTAIN		6	TREET ADDRESS, CITY, STATE, ZIP CODE 2 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
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F 441	prevent the spread of isolate the resident. (2) The facility must p communicable diseas from direct contact will direct contact will trans. (3) The facility must rehands after each direct hand washing is indicaprofessional practice. (c) Linens Personnel must handle	I of Infection Control Program dent needs isolation to infection, the facility must rohibit employees with a e or infected skin lesions h residents or their food, if smit the disease. equire staff to wash their t resident contact for which ated by accepted	F		Continued from page 58 How will you identify other resider the potential to be affected by deficient practice and what correct will be taken? Medication observation on performed by Registered Nursadditional nurse practice of gl cleaning, no further risks were ident to assure that the deficient practic reoccur, i.e., what quality a program will be put in place for m to assure continued compliance? Manufacturers Instructions for gl	the same ive action al units ses with ucometer ified. nonitored e will not assurance ionitoring ucometer	May 9, 2014
	by: Based on observation interviews the facility f glucose meters (gluco policy and the manufa 1 of 1 observations of disinfected. The findings included: A facility policy entitled Devices dated Septem to disinfect the glucom germicidal wipe and the and disinfecting process.	meters) according to facility cturer's instructions during a glucometer being I Blood Glucose Testing aber 2012 specified in part			cleaning to be posted at each nursing station and reviewed with nursing staff. Clinical Competency Coordinates designated licensed nurse will glucometer cleaning for two resistence unit twice weekly for four we weekly for four weeks then monthly months. Immediate training will be to any nurse not following manufunctions for adequate cleaning attimes. Education will be provided to new upon general and job specific orients glucometer cleaning and drying.	ator or monitor dents on eks, then y for four provided facturer's and trying	June 6, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345558	B. WING _		05	/09/2014	
	ROVIDER OR SUPPLIER	CK MOUNTAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711			
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F 441	devices would be clear and after each reside and after each reside and after each reside. A review of the Instrumanufacturer of the gutilized by the facility directions specified to a hard surface the trevisibly wet. Use enough to remain visibly wet or remain visibly or remain visible or rem	ter blood sugar monitoring aned and disinfected before in use. ctions provided by the ermicidal disposable wipe was conducted. The accomplish disinfection of ated surface must remain gh wipes for treated surface for 3 minutes then let air dry. conducted on 05/07/14 at obtaining finger stick blood go for a resident. Nurse # 2 ing equipment, entered and followed the proper ag the FSBS reading. Upon a returned to the medication is emeter (glucometer) with a sed the wipe into the trash sucometer into a plastic bag. The glucometer was to the bag after less than 1 inceed by Nurse # 2. Nurse # 2 cometer remained wet for a in let air dry. 105/07/14 at 7:05 AM glucometer cleaning Nurse # procedure after utilizing a end glucometer down with a general plucometer to air end again. Nurse # 2 stated	F 44	All reports from compliance ro submitted to Quality Assurance Performance Improvement Comonthly for validation of compupdate/change as indicated	e and mmittee	June 6, 2014	

MMICO PROVIDER OR SUPPLIER NC STATE VETERANS HOME—BLACK MOUNTAIN SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICENCES) SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCY MUST IS REPRICEDED BY PILL, RECOLLATORY OR LSC IDENTIFYING INFORMATION) FROUDT STATE Continued From page 60 further stated her understanding was the glucometers needed to be well for only 30 seconds to a minute. Nurse #2 revealed she was unaware of the procedure of ensuring that the glucometer mental between the instructions or his germicidal solution for 3 minutes and then let air dry. During an interview on 0507/14 7-45 AM the Director of Nursing (DON) stated have sure more instructed to clean the glucometers with a germicidal wipe according to manufacturer's directions before used for resident blood glucose monitoring. The DON stated she was unaware of ensuring the glucometer remained well with germicidal wipe according to manufacturer's directions before used for resident blood glucose monitoring. The DON stated she was unaware of ensuring the glucometer remained well with germicidal solution for 3 minutes and allowed to air dry to complete the disinfecting process. The DON confirmed the instructions read that the surface must remain sixtilly well for 3 minutes and then let air dry. To DON confirmed the instructions read that the surface must remain sixtilly well for 3 minutes and then let air dry. The DON confirmed the instructions read that the surface must remain sixtilly well for 3 minutes and then let air dry. The DON confirmed the instructions read that the surface must remain sixtilly well for 3 minutes and then let air dry. The DON confirmed the instructions read that the surface must remain sixtilly well for 3 minutes and then let air dry. The DON confirmed the instructions read that the surface must remain sixtilly well for 3 minutes and the germicidal solution for	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED	
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FA41 Continued From page 60 further stated her understanding was the glucometers needed to be wet for only 30 seconds to a minute. Nurse # 2 revealed she was unaware of the procedure of ensuring that the pistructions on the germicidal wipe according to manufacturer's direction sortion. The DON stated she was unaware of the sinfecting process and to allow at instructions on the germicidal wipe and verified to air dry to complete the disinfecting process were to sanitize and disinfect glucometers with a germicidal wipe according to manufacturer's directions orbitation of minutes and allowed to air dry to complete the disinfecting process. The DON confirmed the instructions on the germicidal wipe and verified to air dry to complete the disinfecting process. The DON confirmed the instructions on the germicidal wipe and verified the murses were on this infecting process. The DON confirmed the instructions on the germicidal wipe and verified the instructions read that the surface must remain visibly wet for 3 minutes and then let air dry. The DON verified the nurses were not disinfecting the glucometers per manufacturer were not disinfecting the glucometers per manufacturer.	ñ.				STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD			
further stated her understanding was the glucometers needed to be wet for only 30 seconds to a minute. Nurse # 2 revealed she was unaware of the procedure of ensuring that the glucometer remained wet with germicidal solution for 3 minutes to complete the disinfecting process and to allow air drying. Nurse # 2 then read the instructions on the germicidal wipe and verified the instructions read that the surface must remain visibly wet for 3 minutes and then let air dry. During an interview on 05/07/14 7:45 AM the Director of Nursing (DON) stated nurses were instructed to clean the glucometers before and after each use. The DON further stated nurses were to sanitize and disinfect glucometers with a germicidal wipe according to manufacturer's directions before used for resident blood glucose monitoring. The DON stated she was unaware of ensuring the glucometer remained wet with germicidal solution for 3 minutes and allowed to air dry to complete the disinfecting process. The DON confirmed the instructions on the germicidal wipe and verified the instructions read that the surface must remain visibly wet for 3 minutes and then let air dry. The DON verified the nurses were not disinfecting the glucometers per manufacture	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
	F 441	further stated her und glucometers needed to seconds to a minute. Unaware of the proceed glucometer remained for 3 minutes to compand to allow air drying instructions on the get the instructions read to visibly wet for 3 minute. During an interview or Director of Nursing (Dinstructed to clean the after each use. The Dowere to sanitize and digermicidal wipe accordirections before used monitoring. The DON ensuring the glucomet germicidal solution for air dry to complete the DON confirmed the inswipe and verified the insurface must remain withen let air dry. The Donot disinfecting the glucomet glucometer and the plant of the	erstanding was the o be wet for only 30 Nurse # 2 revealed she was dure of ensuring that the wet with germicidal solution lete the disinfecting process. Nurse # 2 then read the micidal wipe and verified that the surface must remain less and then let air dry. 105/07/14 7:45 AM the ON) stated nurses were glucometers before and ON further stated nurses isinfect glucometers with a ding to manufacturer's for resident blood glucose stated she was unaware of ler remained wet with a dinfecting process. The structions on the germicidal instructions read that the risibly wet for 3 minutes and ON verified the nurses were	F 4	41			