STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345492	A. BUILDING _____ B. WING _____	C 06/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interviews the facility failed to notify the physician regarding urine changes and a urine culture	F 157	GOOD FAITH ATTEMPT STATEMENT This time line investigation and plan of correction constitutes a written allegation	7/14/15

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

Electronically Signed | 07/10/2015

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F 157	Continued From page 1 report obtained by a consulting Urologist which was positive for bacteria growth for one (Resident #3) of four sampled residents. The findings included: Review of the facility ' s policy regarding " Indwelling Urinary Catheter Care and Management " revealed the physician was to be notified regarding abnormal changes in urine color. Review of Resident # 3 ' s closed record revealed the resident was admitted to the facility on 7/25/14 with multiple medical diagnoses which included but were not limited to the following: Bilateral Cerebrovascular Accident, Percutaneous Endoscopic Gastrostomy Tube Placement secondary to Dysphagia, History of Urinary Tract Infection, Uremia secondary to Neurogenic Bladder and Urinary Retention. The resident was documented as needing a Foley catheter secondary to his diagnosis of Neurogenic Bladder. The resident ' s last MDS (Minimum Data Set) assessment, dated 4/23/15, coded the resident with severe cognitive impairment and as needing total assistance from staff members for his activities of daily living. Record review revealed the resident was seen by a consulting Urologist on 6/2/15 after he had been identified to have Penile Meatus Erosion and a Urethra Fistula in May 2015. Record review revealed the Urologist checked a urine culture during the consultative visit. Review of the record revealed there was no documented follow up by facility staff regarding the culture done at the Urology office until a family member informed the facility staff that they had received notification directly from the Urologist that the culture was positive and the resident needed to be on an antibiotic. Specifically, review of the nursing notes revealed that Nurse # 1 was notified on 6/10/15	F 157	of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove substantial noncompliance. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. IMMEDIATE ACTION No immediate actions taken, resident is not in the facility at the time of this plan of action METHOD TO IDENTIFY OTHERS The Clinical management team conducted a review on 6/25/15 of the 24 hour report for the last 30 days to review for change of condition. The 24 hour report audit include Residents name, type of change of condition, notification of MD and Responsible party, documentation in nurses notes, care plan updated with change in condition, and IDT notified of the change in condition. Identified issues will be reviewed with the facility physician SYSTEMIC CHANGES 1. Education began on 6/23/2015 by the Clinical Competency Coordinator and/or the clinical nurse management team, for Licensed Nurses on the identification change of condition, documentation using	

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F 157	Continued From page 2 that the Urologist had informed Family Member # 2 that the resident needed to be on an antibiotic due to the results of the culture. Nurse # 1 was interviewed on 6/22/15 at 2 PM and stated that Resident # 3 ' s family member (Family Member # 2) approached her on 6/10/15 near the end of the dayshift and made her aware that the resident needed to be on an antibiotic according to the Urology office. Nurse # 1 stated this was the first time she was made aware of the resident ' s antibiotic need. Nurse # 1 stated she called and spoke to the Urology office on 6/10/15 and requested they send the information related to the resident ' s antibiotic need so that it could be followed up on. Nurse # 1 stated that she was not in the facility on Thursday (6/11/15) and she did not know what had transpired on Friday (6/12/15) in relation to the need to obtain the faxed information. Nurse # 1 stated she had passed along the information to the hall nurse and Nurse # 2 on 6/10/15 that the Urology office would be faxing the information. On 6/22/15 at 2:30 PM Nurse # 2 was interviewed and stated she recalled Nurse # 1 talking to her about watching for the Urology fax to come into the facility. Nurse # 2 stated that she did look for it on Wednesday, 6/10/15, but it did not come. She stated she did not remember anything about follow up regarding the fax on Thursday, 6/11/15, or Friday, 6/12/15. Review of the 6/2/15 urine culture report revealed the result was faxed and received at the facility on 6/11/15. The report results showed the culture grew more than 100,000 colonies of Acinetobacter baumannii. It was verified with the facility administrator that the receiving fax number on 6/11/15 was the facility ' s admission office fax machine. There was no documentation that the attending physician was called regarding the	F 157	the Interact tools (SBAR, and Stop and Watch), use of the 24 hour report and notification of MD and RP of change of condition. All Licensed Nurses have been educated. 2. Education on the Interact tools (SBAR, and Stop and Watch), use of the 24 hour report and notification of MD and RP of change of condition has been added to orientation for licensed staff. 3. The clinical nurse manager and week end clinical manager will review the 24 hour report from the previous day for changes in condition, notification of change of condition to MD and RP, Documentation in the medical record using the interact tool, care plan updated for change of condition and IDT notified of the change of condition. MONITORING PROCESS DHS and Quality Assurance nurse will review the 24 hour report audit daily x 14 days then weekly x 4 weeks then monthly thereafter until compliance is maintained. Findings from the 24 hour audit will be presented by the Quality Assurance nurse to the monthly QAPI committee.	

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F 157	Continued From page 3	F 157		

growth of bacteria on 6/11/15, 6/12/15, or on 6/13/15.
Resident # 3 ' s family member (Family member # 1) was interviewed on 6/23/15 at 10:30 AM. Family member # 1 stated that Family member # 2 had approached Nurse # 1 on Wednesday, 6/10/15, as the medical record had noted regarding the need to follow up about the resident ' s urine culture growing bacteria and need for an antibiotic. Family Member # 1 stated she and Family member # 2 thought the antibiotic would be obtained after it had been brought to Nurse # 1 ' s attention. Additionally Family Member # 1 voiced a concern that there was a notable difference in the resident ' s condition on Saturday, 6/13/15, observed and reported by Family Member # 2 to a nurse. Family Member # 1 stated that Family Member # 2 observed that the resident was having a " bad day, " " talking crazy talk, " and complained of unrelieved back pain.
Nurse # 3 was noted to be assigned to care for Resident # 3 on Saturday, 6/13/15, according to facility staffing records. Nurse # 3 was interviewed on 6/22/15 at 3 PM. The interview collaborated the statement by the family member that a nurse had been informed of family concerns on Saturday, 6/13/15. Nurse # 3 stated that on Saturday, 6/13/15, the resident ' s NA had informed her that Family Member # 2 wanted to talk to her. Nurse # 3 stated that she went to see the resident and Family Member # 2 and noted that Resident # 3 ' s urine was a " little cloudy. " Nurse # 3 stated that she told Family Member # 2 that she would give the resident extra water. Nurse # 3 also stated that Family Member # 2 reported the resident was a " little anxious. " Nurse # 3 stated that Family Member # 2 informed her that she had been called and told by

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F 157	Continued From page 4 the Urology office that Resident # 3 needed to be on an antibiotic. Nurse # 3 stated she had not received any information in nursing report about the Urology urine culture which had been positive for bacteria growth. Nurse # 3 stated she told the family that she would put the resident on the facility ' s 24 hour report so that clarification could be obtained and the resident would be monitored. Per the interview with Nurse # 3 the attending physician was not called regarding the change in urine or the need for the antibiotic which had been identified by the Urology office and faxed to the facility on 6/11/15. Review of the nursing notes for Sunday, 6/14/15, at 9:17 AM revealed Nurse # 4 had entered Resident # 3 ' s room at 7:32 AM to find the following: " rsdt (Resident) vomiting and wheezing. Head of bed was elevated. Rsdt was lying on his right side. Vital signs were obtained at this time. 80/52, 96, Resp 40, 101.8 ..... " The nurse further noted she called the RN supervisor, administered Tylenol, placed the resident on oxygen, called the physician and orders were obtained to send the resident to the emergency room (ER). Interview with Nurse # 4 on 6/22/15 at 3:20 PM revealed that she was not given any information in nursing report about Resident # 3 being unstable or having problems with his urine on 6/14/15. Nurse # 4 stated she entered the room at the first of her medication pass and found the resident was coughing, had vomited, and had a fever. Nurse # 4 stated she alerted the RN supervisor, administered Tylenol to the resident via way of his Gastrostomy tube, elevated his head further, and gave him a breathing treatment. Nurse # 4 stated orders were obtained to transfer him to the hospital, and he was transferred near the beginning of her shift.	F 157		

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F 157	Continued From page 5 Review of the record revealed the resident was transferred to the hospital on 6/14/15 at 9:17 AM. Review of the resident ' s hospital records revealed that on his 6/14/15 History and Physical the reason for admission was noted to be " Sepsis, probably related to urinary tract infection and right lower lobe pneumonia. " Review of the History and Physical revealed the physician documented that upon admission the resident ' s urine " on physical exam actually looked very purulent with pus. " An ER nurse documented on 6/14/15 at 10:26 AM, " large amount of pus noted to come from penis after patient ' s indwelling foley removed. "	F 157		
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interviews the facility failed to follow up with Urologist ' s recommendations for one (Resident # 3) of one sampled residents with an indwelling catheter. The findings included: Review of Resident # 3 ' s closed record revealed the resident was admitted to the facility on	F 315	GOOD FAITH ATTEMPT STATEMENT This time line investigation and plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the	7/14/15

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F 315	Continued From page 6 7/25/14 with multiple medical diagnoses which included but were not limited to the following: Bilateral Cerebrovascular Accident, Percutaneous Endoscopic Gastrostomy Tube Placement secondary to Dysphagia, History of Urinary Tract Infection, Uremia secondary to Neurogenic Bladder and Urinary Retention. The resident was documented as needing a Foley catheter secondary to his diagnosis of Neurogenic Bladder. On 5/14/15 the resident was further diagnosed during an Emergency Room visit as having Penile Meatus Erosion with a Urethra Fistula. The resident was also treated for a urinary tract infection on 5/14/15 when he was identified to have a urine culture growing Providencia Stuartii. The resident ' s last MDS (Minimum Data Set) assessment, dated 4/23/15, coded the resident with severe cognitive impairment and as needing total assistance from staff members for his activities of daily living Record review revealed the resident was scheduled to be seen by a consulting Urologist following the identification of his Penile Erosion and Urethra Fistula. Review of the record revealed the consult was conducted on 6/2/15 and a " Report of Consultation " was completed by the Urologist and sent back to the facility. Under " Findings " the Urologist had noted two recommendations. The first was " will need to schedule for SP (suprapubic) tube placement. " The second recommendation did not appear clear. On 6/22/15 at 2 PM Nurse # 1 was interviewed and stated that the " Report of Consultation " was the facility ' s means of communicating with consulting physicians and was sent with a resident when a resident had outside appointments. This nurse was asked if she could read the last recommendation and	F 315	provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove substantial non compliance. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. IMMEDIATE ACTION No immediate actions taken, resident is not in the facility at the time of this plan of action. METHOD TO IDENTIFY OTHERS 100% audits for all residents in the facility, which had an outside physician appointment in the last 30 day, completed by clinical managers. Audit will include review of physician consult form to ensure any new orders were completed and follow up appointments were made. Any issues identified will be addressed with the facility physician. Audit was completed by 6/25/15. SYSTEMIC CHANGES 1. Education began on 6/23/15 for 100% of licensed nurses on Resident appointment by the Clinical Competency Coordinator, and or nurse manager. Any staff not completing the education by 6/29/15 will not be permitted to work until education is completed. All Licensed Nurses have completed education. 2. Education will be added to new partner orientation for licensed nurses.	

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F 315	Continued From page 7 responded she was not sure. On 6/22/15 at 2:30 PM Nurse # 2 was interviewed. Nurse # 2 stated she was not able to read the second recommendation either and that she had not seen the consult paper. Nurse # 2 stated if she had seen the consult paper she would have called the Urology office to clarify since it was unclear. During the survey, on 6/23/15, the administrator called and spoke to the Urology office to clarify what the Urologist had written. Interview with the administrator on 6/23/15 at 3 PM revealed she had clarified the recommendation to be a notation by the Urologist that he had checked a urine culture while the resident was in the office on 6/2/15. Review of the nursing note documentation following 6/2/15 revealed no follow up regarding the consult until 6/10/15. Also record review revealed this facility follow up was initiated when it was brought to the facility staff ' s attention by the resident ' s family. Nurse # 1 had made a notation in the resident ' s record at 5:15 PM on 6/10/15 documenting, " Writer spoke with .... (family member) at 5 PM who reported received voice mail msg (message) from urology clinic regarding need for medication-she stated ' they said he needs Rx (prescription) for medicine (UTI) urinary tract infection and I can pick up from office. ' I informed (family member) that facility would contact (Urology Office) and request labs order for Dr. L ... ... (Resident ' s attending physician) to review. (Family member) voiced understanding and agreement with plan ... " Nurse # 1 further documented that she called the Urology office and spoke to the Urologist ' s nurse who told Nurse # 1 that she would fax the labs and orders in the AM to the facility fax number 822-0693. Nurse # 1 documented that she had completed a communication form and that the	F 315	Education included: a. Upon return from outside appointment packet will be review for recommendation by the charge nurse b. If no packet returns with the resident the charge nurse will call the consultant physician office to obtain recommendation c. If recommendation are provided the nurse will contact the facility physician with the recommendation. d. Any new orders will be written on a telephone order and handled per facility protocol. e. Physician Consult form will be placed in the physician box. 3. The nurse management will review the appointment from previous day to ensure packets were returned with recommendations and the recommendation were followed up pre facility process. MONITORING PROCESS The nurse management will review the appointment from previous day to ensure packets were returned with recommendations and the recommendation were followed up per facility process daily x 14 days then weekly x 4 weeks then monthly until compliance is maintained. Results from the audit will be reviewed by the Director of Health Services and/or the Quality Assurance Nurse. Finds from the appointment audit will be presented, by the Quality Assurance Nurse, to the monthly Quality Assurance Performance Improvement Committee for	

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F 315	Continued From page 8 primary nurse, unit manager, and MD were informed. Nurse # 1 was interviewed on 6/22/15 at 2 PM and stated that Resident # 3 ' s family member had approached her on 6/10/15 near the end of the dayshift and made her aware that the resident needed to be on an antibiotic according to the Urology office. Nurse # 1 stated this was the first time she was made aware of the resident ' s antibiotic need. Nurse # 1 stated she called and spoke to the Urology office on 6/10/15 and requested they send the information related to the resident ' s antibiotic need so that it could be followed up on. Nurse # 1 stated that she was not in the facility on Thursday (6/11/15) and she did not know what had transpired on Friday (6/12/15) in relation to the need to obtain the faxed information. Nurse # 1 stated she had passed along the information to the hall nurse and Nurse # 2 on 6/10/15 that the Urology office would be faxing the information. On 6/22/15 at 2:30 PM Nurse # 2 was interviewed and stated she recalled Nurse # 1 talking to her about watching for the Urology fax to come into the facility. Nurse # 2 stated that she did look for it on Wednesday, 6/10/15, but it did not come. She stated she did not remember anything about follow up regarding the fax on Thursday, 6/11/15, or Friday, 6/12/15. Review of the record revealed that the urine culture was faxed to the facility on Thursday, 6/11/15, to the fax number 910-822-0979. Interview with the administrator on 6/23/15 at 1 PM revealed this fax number was the facility ' s admission office fax machine. Resident # 3 ' s family member (Family member # 1) was interviewed on 6/23/15 at 10:30 AM. Family member # 2 was listed on the resident ' s record as the Responsible party and Family Member # 1 was listed as the next available	F 315	recommendation.	

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F 315	Continued From page 9	F 315		

family member for contact. Family member # 2 was not available for interview on 6/23/15. Family member # 1 stated that Family member # 2 had approached Nurse # 1 on Wednesday, 6/10/15, as the medical record had noted. Family Member # 1 stated she and Family member # 2 thought the antibiotic would be obtained after it had been brought to Nurse # 1 ' s attention. Additionally Family Member # 1 voiced a concern that there was a notable difference in the resident ' s condition on Saturday, 6/13/15, observed and reported by Family Member # 2 to a nurse. Family Member # 1 stated that Family Member # 2 observed that the resident was having a " bad day, " " talking crazy talk, " and complained of unrelieved back pain.

Review of the nursing notes revealed no nursing notes on 6/11/15, 6/12/15, or 6/13/15. Nurse # 3 was noted to be assigned to care for Resident # 3 on 6/13/15 according to facility staffing records.

Nurse # 3 was interviewed on 6/22/15 at 3 PM. The interview collaborated the statement by the family member that a nurse had been informed of family concerns on Saturday, 6/13/15. Nurse # 3 stated that on Saturday, 6/13/15, the resident ' s NA had informed her that Family Member # 2 wanted to talk to her. Nurse # 3 stated that she went to see the resident and Family Member # 2 and noted that the resident had some congestion which she felt was normal for him. Nurse # 3 stated Resident # 3 ' s urine was a " little cloudy. " Nurse # 3 stated that she told Family Member # 2 that she would give the resident extra water. Nurse # 3 also stated that Family Member # 2 reported the resident was a " little anxious. " Nurse # 3 stated that Family Member # 2 informed her that she had been called and told that Resident # 3 needed to be on an antibiotic. Nurse # 3 stated she reviewed the record with

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F 315	Continued From page 10	F 315		

Family Member # 2 and showed the family member that the resident had received an antibiotic in May, 2015 and therefore Nurse # 3 stated she was not sure if that was the antibiotic to which the family member was referring. Nurse # 3 stated she told the family that she would put the resident on the facility ' s 24 hour report so that clarification could be obtained and the resident would be monitored.
Review of the nursing notes for Sunday, 6/14/15 at 9:17 AM revealed Nurse # 4 had entered Resident # 3 ' s room at 7:32 AM to find the following: " rsdt (Resident) vomiting and wheezing. Head of bed was elevated. Rsdt was lying on his right side. Vital signs were obtained at this time. 80/52, 96, Resp 40, 101.8 ..... " The nurse further noted she called the RN supervisor, administered Tylenol, placed the resident on oxygen, called the physician and orders were obtained to send the resident to the ER.
Interview with Nurse # 4 on 6/22/15 at 3:20 PM revealed that she was not given any information in nursing report about Resident # 3 being unstable or having problems with his urine on 6/14/15. Nurse # 4 stated she entered the room at the first of her medication pass and found the resident was coughing, had vomited, and had a fever. Nurse # 4 stated she alerted the RN supervisor, administered Tylenol to the resident via way of his Gastrostomy tube, elevated his head further, and gave him a breathing treatment. Nurse # 4 stated orders were obtained to transfer him to the hospital, and he was transferred near the beginning of her shift.
Review of the record revealed the resident was transferred to the hospital on 6/14/15 at 9:17 AM.
Review of the resident ' s hospital records revealed that on his 6/14/15 History and Physical the reason for admission was noted to be "

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	345492	A. BUILDING _____ B. WING _____	C 06/23/2015

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F 315	Continued From page 11	F 315		

Sepsis, probably related to urinary tract infection and right lower lobe pneumonia. " Review of the History and Physical revealed the physician documented that upon admission the resident ' s urine " on physical exam actually looked very purulent with pus. " An ER nurse documented on 6/14/15 at 10:26 AM, " large amount of pus noted to come from penis after patient ' s indwelling foley removed. " An infectious disease consult was noted to be done on 6/15/15 and this physician noted that the admission urine cultures were growing the bacteria Proteus and Klebsiella. The infectious disease physician also made a notation that she had noted the urine culture results of 6/2/15 which had shown Acinetobacter and documented that since all three were susceptible to the antibiotic of Meropenum it should be the plan of treatment.
Further review of the resident ' s facility medical record revealed that after the resident had been discharged to the hospital on 6/14/15 that an order was obtained and written in the record on 6/15/15 to treat the resident with an antibiotic. A telephone order was received on 6/15/15 for Doxicillin 100 mg (milligrams) BID (twice per day) with 8 oz. of water for 5 days. Nurse # 5 who took the telephone order was interviewed on 6/22/15 at 3:40 PM. Nurse # 5 stated that routinely supervisors were given a stack of abnormal labs to call to the physician. Nurse # 5 stated that as the 3-11 shift supervisor Resident # 3 ' s urine culture was in her stack of abnormal labs to call to the physician when she reported to work on Monday, 6/15/15. Nurse # 5 stated that she did not realize the resident was in the hospital when she obtained the orders because she was just calling about the entire stack of labs and Resident # 3 ' s urine culture report was among the others.
Interview with Nurse # 1 on 6/22/15 at 3:50 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345492	A. BUILDING _____ B. WING _____	C 06/23/2015

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F 315	Continued From page 12 revealed the facility staff used a 24 hour report to communicate among themselves regarding acutely ill residents and things needing to be referred to the physician. Nurse # 1 stated that Resident # 3 had appeared on the 24 hour report only on the date of 6/13/15 between the period of 6/2/15 through 6/14/15.	F 315		
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		7/14/15

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F 329	Continued From page 13 Based on observation, record review and staff interviews the facility failed to provide Dilantin administration monitoring to assure the doses were necessary for one (Resident # 1) of four sampled residents. The findings include: Review of the facility ' s " Medication Administration: General Guidelines " policy revealed it included the instructions: " If a dose seems excessive considering the patient/resident ' s age and condition, or a medication order seems to be unrelated to the patient/resident ' s current diagnosis or condition, the physician is contacted for clarification prior to the administration of the medication. " Record review revealed Resident # 1 was admitted to the facility on 4/17/15 with multiple diagnoses which included but were not limited to the following: Cerebrovascular Accident, Atrial Fibrillation, Vascular Dementia, and a Seizure Disorder. The resident was coded on his MDS (Minimum Data Set) assessment, dated 4/24/15 as having impaired cognitive abilities. The resident ' s care plan, last reviewed on 5/20/15, included the information that the resident had a seizure disorder and three of the care planned interventions were: meds (medications) as ordered; labs as ordered; and to notify the physician of abnormal findings. Review of documentation within the record revealed that from his admission date of 4/17/15 until his hospitalization on 6/21/15 the resident had three different physician ordered Dilantin dosages. They were as follows: upon the admission date of 4/17/15 the resident ' s dosage was prescribed as 200 mg (milligrams) EX (extended release) twice per day; on 5/15/15 the Dilantin order was changed to 50 mg twice per day; and on 6/13/15 the Dilantin order was changed to 100 mg twice per day. Review of the	F 329	GOOD FAITH ATTEMPT STATEMENT This time line investigation and plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove substantial noncompliance. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. IMMEDIATE ACTION No immediate actions taken, resident is not in the facility at the time of this plan of action. METHOD TO IDENTIFY OTHERS DHS will review the June pharmacy report to the completed physician recommendations are complete and signed. 100% lab audits for all residents in the facility was completed by clinical managers on 6/23/15. The lab audit include Residents name, lab order identified in master lab book / Pending log and resulted lab is in the chart. Clinical mangers reviewed the physician orders from 6/1/2015 through current for lab orders. SYSTEMIC CHANGES	

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F 329	Continued From page 14 resident ' s labs revealed results drawn during the months of May 2015 and June 2015 ranging from 3.9 to 37.8; with 37.8 being documented as a critical value and 3.9 documented as sub therapeutic. Therapeutic lab ranges were noted to be 10 to 20 according to the lab reports. Following the resident ' s initial facility admission, review of the record revealed the resident was hospitalized from 5/11/15 until 5/15/15 and upon hospital admission he was diagnosed with Dilantin Toxicity. After his return to the facility an order was written on 6/10/15 to obtain a Dilantin level, CMP (Complete Metabolic Panel) and a CBC (Complete Blood Count) with differential. Interview with a facility nurse consultant on 6/22/15 at 4:30 PM revealed Nurse # 2 had called the physician and obtained the lab orders on 6/10/15 based on the pharmacist recommendations. Review of the " Consultant Pharmacist Communication to Physician, " dated 6/10/15, revealed the pharmacist was recommending the labs be done to " reassess drug levels and drug monitoring. " Review of the record on 6/22/15 revealed no Dilantin level or CBC since the order had been written on 6/10/15. Interview with the facility nurse consultant on 6/22/15 at 4:30 PM revealed only the CMP had been completed and it was confirmed that the Dilantin level and CBC had not been done. The nurse consultant also stated that the facility had procedures in place to do routine lab draws Monday through Friday, but these two labs were missed. Record review further revealed that following the completion of his hospitalization care on 5/15/15, the resident was readmitted to the facility with orders to administer 50 mg of Dilantin twice per day. According to the resident ' s facility MAR (Medication Administration Record) this dosage of	F 329	1. Education began on 6/25/2015 by the Clinical Competency Coordinator and/or DHS for Clinical Management team on the process of completing pharmacy recommendations. The Process will include: a. The physician will provide a written response to the facility within 30 days b. Medical Records will check physician folder and submit the singed recommendations to the DHS c. DHS will review recommendation against pharmacy report d. DHS will submit recommendations to the Clinical Management Team to complete the recommendation within 3 working days e. The clinical team will review pharmacy recommendations with current medication orders to identify any prior medication dosage changes and inform the physician if dosages have changed between the origin of pharmacy recommendation and physician review. f. Clinical Management nurse will notify the DHS of completion of the recommendations then recommendation are filed in the medical record. 2. Education related to completion of pharmacy recommendation has been added to the orientation for Clinical Managers. 3. DHS will monitor the completion of the recommendations monthly. 4. Education began on 6/23/2015 for Licensed Nurses on the process of completing laboratory order, to include ensuring labs are ordered, drawn, returned and followed through with as	

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F 329	Continued From page 15 50 mg was continued from 5/15/15 until the date of 6/13/15 when a nurse documented a telephone order to " 1) Discontinue Dilantin 200 mg by mouth twice daily 2) Dilantin 100 mg by mouth twice daily 3) Repeat Dilantin level & Albumin level in 10 days. " The facility nurse consultant was interviewed on 6/22/15 at 4:30 PM and questioned regarding the origin of the order given that the resident ' s Dilantin dose was not 200 mg when the nurse obtained the order to " discontinue Dilantin 200 mg ... " Interview with the nurse consultant revealed the order was based on the previous month ' s pharmacy recommendation and not on the resident ' s most recent dosage. The nurse consultant provided the surveyor with the report upon which the 6/13/15 order was based. Review of this 5/15/15 " Consultant Pharmacist Communication to Physician " report revealed the pharmacist was making recommendations based on a Dilantin dosage of 200 mg EX twice per day; which had been his prescribed dose prior to his hospitalization for Dilantin Toxicity. The communication form included the notation, " RE: Phenytoin EX Cap 100 mg 2 caps (200 mg) BID (twice per day). " The pharmacist documented that she was asking the physician to consider a decreased Dilantin dosage of 100 mg every twelve hours. Interview with the consultant nurse on 6/22/15 at 4:30 PM revealed Nurse # 2 had called the recommendations to the physician on 6/13/15 and obtained the order without updating or reminding the physician that the Dilantin dosage had already been changed to 50 milligrams. Review of the record revealed the new order of 100 mg twice per day was transcribed to the June 2015 MAR on 6/13/15. During a medication pass observation on 6/21/15	F 329	prescribed by the physician. 5. Unit supervisors will ensure that all ordered labs are received back and followed through appropriately, during clinical rounds M-F, Week end supervisor and week end clinical manager on duty will also do clinical round and audit ordered labs if any on S/Su to ensure completion. 6. Education on the lab process will be added to new hire orientation for licensed nurse. 7. The Director of Health Services and/or Clinical Managers will correlate the Daily Lab Audits and forwarded results to the QAPI Committee for any recommendations and follow through. 8. The facility has established a Lab committee that will meet once weekly on Mondays to discuss all labs ordered for the prior week. This meeting will stand as a triple check process to ensure that all components of follow through took place. First meeting will be held on 6/29/2015. 9. DHS or clinical nurse manager will collect daily lab tracking sheet for the prior week and bring them to the meeting for discussion and triple checking. This lab triple check process will be documented on the last column of daily lab tracking logs and correct any discrepancies as appropriate. MONITORING PROCESS DHS and Quality Assurance nurse will review the findings from physician recommendation. Findings from the audit will be presented by the Quality Assurance nurse to the monthly QAPI committee.	

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F 329	Continued From page 16 at 9:45 AM Nurse # 6 was observed to prepare to administer Dilantin 100 milligrams during the resident ' s morning medications. The resident was observed to be lethargic and would not arouse to take his medication. Nurse # 6 and other staff members were observed to be in his room on 6/21/15 at 10:40 AM caring for him. At 11:15 AM medical transport staff were observed in the facility preparing to transfer the resident to the hospital. Interview with Nurse # 6 on 6/21/15 at 2:!5 PM revealed the resident ' s NA (nursing assistant) had observed the resident twitching and that the resident had some seizure activity and " panicked. " Review of the resident ' s record revealed the nurse had documented that the resident had seizure activity at 10:40 AM on 6/21/15. Record review revealed the resident was admitted to the hospital on 6/21/15. On 6/22/15, the facility obtained a faxed copy of the resident ' s Dilantin level which was drawn at 1:24 PM when the resident was transferred to the hospital. The Dilantin level was 3.9. Review of the record on 6/22/15 revealed no documented clarification efforts made by the facility staff in regards to the Dilantin order which was obtained on 6/10/15.	F 329	The Clinical Nurse Managers will ensure ordered lab results are filled in resident¿s clinical records daily M-F, week end supervisor and/or weekend clinical manager on duty will monitor on Saturdays and Sunday. DHS and/or clinical manager will monitor compliance occur daily for 14 days, then weekly for 4 weeks, then monthly x 3 months then PRN afterwards, unless recommended otherwise by Quality assurance performance improvement committee.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services	F 425		7/14/15

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F 425	Continued From page 17 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that their pharmacy policy clearly addressed the disposition of discontinued medications in a manner which resulted in destroyed medications being able to be tracked. The findings included: A closed record review revealed Resident # 3 was admitted to the facility on 7/14/14 and discharged on 6/14/15. Record review revealed the resident was not anticipated to return to the facility. The resident had multiple diagnoses which included a history of Urinary Tract Infections. Review of the resident ' s record revealed he was ordered to receive the antibiotic Bactrim DS (Double Strength) twice per day for 10 days for a urinary tract infection on 5/14/15. The order was transcribed on the May MAR as scheduled to begin on the 15th. There were no documented nurse ' s initials signifying that the resident received his antibiotic on the morning of May 20, 2015 or May 24, 2015 when it was due. These areas were blank. There was no documentation related to the omitted doses. A facility nurse consultant was interviewed on	F 425	GOOD FAITH ATTEMPT STATEMENT This time line investigation and plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove substantial noncompliance. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. IMMEDIATE ACTION No immediate actions taken, resident is not in the facility at the time of this plan of action. METHOD TO IDENTIFY OTHERS	

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F 425	Continued From page 18 6/23/15 at 5:20 PM regarding the disposition of any unused medications that had been in the facility for Resident # 3 since he was not anticipated to return. The nurse consultant stated there would not have been a record of the unused medications because all medications, excluding controlled medications, were placed in a sharps container and no record of the destruction had been kept. The nurse consultant was questioned how staff reconciled the medications sent by the pharmacy versus what medications were actually administered if there was ever a question regarding whether a resident received their medication. The nurse consultant stated the policy and procedure of destroying the medications without recording their destruction did not allow for this reconciliation to be done. The nurse consultant provided a copy of the pharmacy policy on " Discontinued Medications " which was last revised on 1/23/15. Under " Patient/Resident Discharge with Return Not Anticipated, " the policy directed " If orders to send medications with the patient/resident are not received, refer to policy ' Disposal of Medications ' for appropriate disposition of medications. " The policy did not direct that the discharged resident ' s discontinued medications be logged. The nurse consultant provided the " Advantange RX (prescription) FAQ (Frequently Asked Questions) " information and stated it had the policy instructions for disposition of unused medications. The " question " was noted to be " How do I dispose of discontinued medications from the cycle packs? " The " Answer " was " Waste all doses of medications in the hazardous waste containers on the med cart at the time of medication administration; place empty pouches in a drawer on the cart until the end of the med pass. Then discard these in a secure shred	F 425	No Residents are at risk SYSTEMIC CHANGES 1. Education began on 6/25/2015 by the Clinical Competency Coordinator and/or DHS for Licensed Nurses on the policy of D/C medications Multi-dose packages and Disposal of medications. The Process will include: a. The staff will follow the policy for single dose disposal the medication will be logged on the inventory sheet. Single pill will be written up on the destruction sheet Medication will be placed in a biohazard container. b. For residents that are d/c and return is not anticipated the facility will follow the policy Disposal of medications. Medications still on wheel roll will be written up on the destruction sheet. The destruction sheet will be wrapped around the medication and placed in the tote for return to pharmacy. A copy of the destruction sheet will be maintained by the facility. 2. The Clinical management team will review the single dose and multi dose disposal forms daily MONITORING PROCESS DHS and Quality Assurance nurse will review the findings from disposal forms. Findings from the audit will be presented by the Quality Assurance nurse to the monthly QAPI committee.	

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F 425	Continued From page 19 container. " The nurse consultant validated that this was what the facility did for all discontinued medications that were not controlled medications.	F 425		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure accurate and complete medical records regarding catheter changes and antibiotic/Tylenol administration were maintained for one (Resident # 3) of four sampled residents who had multiple diagnoses related to his urinary system. The findings included: Review of Resident # 3 ' s closed record revealed the resident was admitted to the facility on 7/25/14 with multiple medical diagnoses which included but were not limited to the following: History of Urinary Tract Infection, Uremia secondary to Neurogenic Bladder and Urinary Retention. The resident was documented as needing a urinary catheter secondary to his	F 514	GOOD FAITH ATTEMPT STATEMENT This time line investigation and plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove substantial noncompliance. It also demonstrates our good faith and desire to	7/14/15

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F 514	Continued From page 20 diagnosis of Neurogenic Bladder. Record review revealed nurses initialed they had changed the resident ' s catheter five times in May, 2015. Specifically, a review of the May 2015 MAR (Medication Administration Record) included an order, " Foley Catheter #18 Fr (French) 10 ml (milliliter) bulb change monthly 25th and PRN (as needed). " Nurses had initialed they had changed the resident ' s catheter on the 1st, 2nd, 3rd, 4th, and 6th of May 2015. Two of the initials were clear; three appeared as possibly having a line through them; and none of the five were circled to indicate that the catheter had not been changed and the initials were an error. There was no documentation in the nursing notes related to reasons for a PRN (as needed) catheter change on these dates. Interview with Nurse # 1 on 6/23/15 at 4:35 PM revealed she had obtained statements from two of the nurses that they had not actually changed the catheter as indicated by their initials. The resident was also ordered to receive the antibiotic Bactrim DS (Double Strength) twice per day for 10 days for a urinary tract infection on 5/14/15. The order was transcribed on the May MAR as scheduled to begin on the 15th. There were no documented nurse ' s initials signifying that the resident received his antibiotic on the morning of May 20, 2015 or May 24, 2015 when it was due. These areas were blank. There was no documentation related to the omitted doses. Also prior to the resident ' s hospitalization on 6/14/15 a nurse documented in a nursing note written at 9:17 AM that 650 mg of Tylenol was administered to the resident. Interviews with Nurse # 4 and a family interview revealed conflicting information related to how Tylenol was administered to the resident. A family member stated during an interview on 6/23/15 at 10:30 AM	F 514	continue to improve the quality of care and services to our residents. IMMEDIATE ACTION No immediate actions taken, resident is not in the facility at the time of this plan of action. METHOD TO IDENTIFY OTHERS The Clinical management team conducted a review on 6/25/15 of the MAR for the last 30 days to review for accurate documentation. Identified issues will be reviewed with the facility physician. SYSTEMIC CHANGES 1. Education began on 6/25/2015 by the Clinical Competency Coordinator and/or the clinical nurse management team, for Licensed Nurses on the policy Errors, Omissions and Late Entries. Education will be added to orientation for licensed staff. 2. Clinical Management team will review the Medication Administration Records for accurate and complete documentation weekly x 4 weeks then monthly thereafter. MONITORING PROCESS DHS and Quality Assurance nurse will review the findings from the Medication Administration Record audit. Findings from the audit will be presented by the Quality Assurance nurse to the monthly QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345492	A. BUILDING _____ B. WING _____	C 06/23/2015

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

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F 514	Continued From page 21 that the resident vomited a whole Tylenol when he arrived at the emergency room. Interview with Nurse # 4 on 6/22/15 at 3:20 PM revealed she had crushed and placed Tylenol through the resident ' s gastrostomy tube prior to his transfer to the hospital on 6/14/15. Further review of the medical record revealed it was incomplete. There was no route of documentation related to the Tylenol administration.	F 514		