| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345558 | A. BUILDING _____ B. WING _____ | C 06/26/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NC STATE VETERANS HOME-BLACK MOUNTAIN | 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 164 SS=D | 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS<br><br>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.<br><br>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.<br><br>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.<br><br>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and staff interviews, the facility failed to protect the confidentiality of a resident's private healthcare information for 1 of 1 residents during a dining observation (Resident #15).<br>The findings included: | F 164 | This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of | 7/24/15 |

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

Electronically Signed | 07/18/2015

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| F 164 | Continued From page 1<br>Resident #15 was admitted on 10/24/12. Diagnoses included dementia.<br>A medical record review revealed Resident #15 had experienced an increased cough and an increased fever beginning on 06/15/15.<br>On 06/22/15 at 6:10 PM, Nurse Aide (NA) #1 was observed to tell Resident #12's personal sitter that Resident #15 had not been feeling well lately and had had an upper respiratory infection.<br>An interview was conducted with Resident #12's personal sitter on 06/22/15 at 6:14 PM. She stated she was a private employee of Resident #12 and did not work for the facility. The sitter further stated she was not related to Resident #15, but she knew him and other residents in relation to her job as a sitter.<br>An interview was conducted with NA #1 on 06/22/15 at 6:16 PM. She stated she should not have shared information regarding Resident #15's health condition with Resident #12's sitter. NA #1 explained she had received training in Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in the past year. The HIPAA Privacy Rule is a federal law that protects the privacy and confidentiality of health information.<br>An interview was conducted with Unit Coordinator #1 on 06/25/15 at 11:42 AM. She stated all questions regarding a resident's diagnoses or condition should be directed to the nurse. The Unit Coordinator further explained an NA could share certain information with family members, such as how much a resident ate or if a resident got a shower, but it was not appropriate for NA #1 to discuss Resident #15's diagnoses or health status with Resident #12's sitter.<br>An interview was conducted with the Director of Health Services (DHS) on 06/25/15 at 2:23 PM. She stated NA #1 should not discuss Resident | F 164 | Correction is submitted to meet the requirements by State and Federal Laws.<br><br>1. a. CNA #1 on 6/22/15 was re-educated by Director of Health Services and Administrator on HIPAA standards related to Veteran #15 medical condition with Veteran #13 personal sitter.<br>b. Validation of HIPAA education on hire and yearly performed by Director of Health Services on 6/22/15<br><br>2. All Veterans at risk for breach of HIPAA confidentiality<br><br>3. a. On 6/25/15 re-education on HIPAA standards initiated for all partners by Management Team.<br>b. General in-service conducted by Administrator on 7/2/15 for all partners encompassing HIPAA standards and compliance<br>c. Any partners on vacation, FMLA, or PRN status will be educated prior to any interaction with veterans, families or visitors on next scheduled day.<br>d. New partners will be educated on initial orientation and annually per company policy<br><br>4. a. 5 Partners on 6a-6p shift and 5 Partners on 6p-6a per day according to monitoring schedule will be interviewed and observed by Administrator and/or Management Team validating HIPAA knowledge and compliance<br>5X/week for 2 weeks--> then<br>4X/week for 2 weeks--> then<br>3X/week for 2 weeks--> then | |

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| F 164 | Continued From page 2<br>#15's care or diagnoses with Resident #12's sitter. The DHS explained the NA should defer to the nurse with those types of questions. She further stated all employees were provided information related to the HIPAA Privacy Rule on hire and yearly thereafter. | F 164 | 2X/week for 2 weeks--> then 1X/week for 4 weeks<br>b. Results will be submitted to QAPI by Administrator and/or Management team monthly for review and modification as indicated until compliance deemed met | |
| F 167 SS=B | 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE<br><br>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.<br><br>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident and staff interviews, the facility failed to post a notice of availability of survey results in a place accessible to residents.<br>The findings included:<br>Observations on 06/23/15 at 8:00 AM and on 06/24/15 at 5:09 PM revealed no evidence of a posted notice of the availability and location of the survey results.<br>On 06/24/15 at 3:53 PM an interview was conducted with the Resident Council President. She revealed she did not know the location of the survey results and could not remember if the survey results had been mentioned in a resident council meeting. | F 167 | This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws.<br><br>1. Survey Results Binder was placed in visible location for unassisted access for review by veterans, families, and visitors<br><br>2. All Veterans, families and visitors are at risk to be affected with desire to review | 7/24/15 |

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| F 167 | Continued From page 3<br>On 06/25/15 at 11:44 AM an interview was conducted with the Activities Director. She stated she was the recorder for the resident council meetings. She said she had provided the residents attending the council meetings the ombudsman number but had not provided the residents the community advocacy numbers or information about the state survey results. She revealed she does not know where the state survey results are located.<br>On 06/25/15 at 5:11 PM an interview was conducted with the Administrator. She was asked if the survey results were available for review by residents. The Administrator walked over to a wall and pointed to a wooden box with a small label on the door of the box engraved, " annual survey results inside. " The sign on the door of the box was not readily visible to residents. The Administrator said she did not know the survey results had to be more accessible to residents for review. | F 167 | Survey Results<br><br>3. a. On 7/2/15 General Staff in-service by Administrator provided partner education of Survey Result Binder location<br>b. On 7/15/15 information provided to Resident Council on Survey Result Binder location for un-assisted review<br>c. On 7/1/15 Veterans, Family, visitors and interested parties were provided with education by addition to Facility July newsletter located at Sign In Roster front door location<br>d. New partners education will be provided on initial orientation of Survey Results Binder<br><br>4. a. Monitoring of data integrity and content of Survey Result Binder will be performed by Administrator or Director of Health Services weekly for 3 months<br>b. Results will be submitted to QAPI monthly by Administrator for review and modification as indicated until compliance deemed met | |
| F 168 SS=B | 483.10(g)(2) RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES<br><br>A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff | F 168 | This Plan of Correction constitutes a | 7/24/15 |

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| F 168 | Continued From page 4<br>interviews, and record review, the facility failed to post the state complaint hotline number at a level readable for one sampled resident seated in a wheelchair. (Resident #97).<br>Observation on 06/23/15 at 8:00 AM revealed a bulletin board in an alcove off from the facility lobby. The bulletin board posted a document approximately 3 feet up on the upper left hand corner of the board with the state complaint hotline number written in small print not readable for a resident in a wheel chair.<br>Resident #97 was coded on his most recent MDS dated 06/16/15 as cognitively intact with no vision problems.<br>On 06/24/15 at 10:18 AM an interview was conducted with resident #97 and he was asked if he knew where the complaints hotline number was located. He said he did not know where the number was located.<br>On 06/25/15 at 2:30 PM Resident #97 ambulated in his wheel chair to the alcove of the lobby to view the document which contained the state complaint hot line number. He observed the document, not at eye level, from his wheel chair and stated he could not read the hotline number or other information contained in the document.<br>On 06/25/15 at 5:11 PM the Administrator was shown the document with the hotline # on the bulletin board. She was asked if she thought a resident in a wheel chair would be able to read the small print complaint hot line number located several feet above eye level. She observed the document and stated a resident would not be able to read the document and she said was going to post the document at a level residents in wheel chairs would be able to read. | F 168 | written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws.<br><br>1. Compliance Advocacy Numbers were placed in visible location for unassisted access at wheel chair level for review by veterans, families, and visitors<br><br>2. All Veterans, families and visitors are at risk to be affected with desire to review Compliance Advocacy Numbers<br><br>3. a. On 7/2/15 General Staff in-service by Administrator provided partner education of Compliance Advocacy Numbers location<br>b. On 7/15/15 information provided to Resident Council on Compliance Advocacy Numbers location for un-assisted review<br>c. On 7/1/15 Veterans, Family, visitors and interested parties were provided with education by addition to Facility July newsletter located at Sign In Roster front door location<br>d. New partners education will be provided on initial orientation of Compliance Advocacy Numbers<br><br>4. a. Monitoring Compliance Advocacy Numbers will posting be performed by Administrator or Director of Health Services weekly for 3 months | |

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| F 168 | Continued From page 5 | F 168 | b. Results will be submitted monthly to QAPI by Administrator for review and modification as indicated until compliance deemed met | |
| F 248 SS=D | 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and resident and staff interviews, the facility failed to provide a program of activities designed to meet the mental and psychosocial needs of 1 of 2 residents reviewed for participation in activities (Resident #51).<br>The findings included:<br>Resident #51 was admitted to the facility on 10/12/12. Diagnoses included macular degeneration and depression.<br>The last documented activities assessment dated 12/18/12 indicated Resident #51 would enjoy having someone read to him.<br>An annual Minimum Data Set (MDS) dated 12/12/14 indicated the resident felt it was somewhat important to have books, newspapers, and magazines to read. The MDS also indicated the resident felt it was somewhat important to listen to music, do things with groups of people, and go outside when the weather was nice.<br>A review of Resident #51's care plan dated 03/12/15 identified a problem area of recreation | F 248 | This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws.<br><br>1. a. On 6/26/15 Annual Activity assessment was performed and completed by Activity Director for Veteran # 51<br>b. "likes" and individualized Care Plan was updated on 6/26/15 by Activity Director<br><br>2. All Veterans have potential to be affected.<br>a. On 7/16/15 Audit of all veterans to ensure Annual assessment has been performed by Activity Director | 7/24/15 |

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| F 248 | Continued From page 6<br>related to decreased vision and hearing. The identified goal was the resident would participate in preferred activities twice a week to maintain quality of life. Interventions included going outside when the weather was nice, participation in a gardening group, reminiscent discussion, and staff to verbally inform him of daily activities.<br>An interview was conducted with Resident #51 on 06/23/15 at 8:48 AM. He stated the facility did not provide things for him to do in his room on his own, like books or cards. The resident explained he loved to read but could not anymore due to being legally blind. He stated he would be interested in audiobooks but the option had never been offered.<br>On 06/24/15 at 10:48 AM, Resident #51 was observed to be asleep in a wheelchair in his room.<br>A review of the Activities Calendar revealed Golf Cart Rides were scheduled to start at 11:00 AM.<br>On 06/24/15 at 11:14 AM, Resident #51 was observed to be asleep in a wheelchair in his room.<br>On 06/24/15 at 11:29 AM, an activities assistant was observed to enter the room next to Resident #51 and invite him to the Golf Cart Ride. The activities assistant did not invite Resident #51.<br>An interview was conducted with Resident #51 on 06/24/15 at 11:33 AM. He stated no one had invited him to any activities that day and did not know about the Golf Cart Ride. The resident explained he had ridden the golf cart before and did not want to today. He stated his wife took him outside from time to time and that was enough.<br>An interview was conducted with the Activities Director (AD) on 06/25/15 at 4:57 PM. She stated she did an activities assessment when a resident was admitted and then quarterly. The AD explained she was aware Resident #51 | F 248 | b. On 7/20/15 Audit of all veterans assessment "likes" of activities have been updated with addition to individualized Care Plan by Activity Director<br><br>3. Activity Director re-educated with expectations of completion of comprehensive assessments quarterly, annually and with Significant Change in Status<br><br>4. a. Activity Director will provide Administrator written validation of quarterly "likes": review, individualized Care Plan update, and Annual Assessment and/or Significant Change in Status Assessment completion Weekly for 3 Months<br>b. Results will be submitted monthly to QAPI by Activity Director for review and modification as indicated until compliance deemed met | |

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| F 248 | Continued From page 7<br>enjoyed reading but was not sure if he had ever been offered any of the audiobooks owned by the facility.<br>An interview was conducted with the Administrator on 06/26/15 at 2:39 PM. She stated the AD was responsible for assessing residents for their preferences and interests related to activities and updating the care plan related to activities as necessary. She further explained the AD changed at the time Resident #51's activities assessment was due and so the assessment was not completed. | F 248 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced | F 279 | | 7/24/15 |

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| F 279 | Continued From page 8<br>by:<br>Based on observations, record reviews, and resident and staff interviews, the facility failed to develop a comprehensive care plan for 1 of 2 residents reviewed for activities (Resident #51) and 1 of 2 residents reviewed for nutrition (Resident #19).<br>The findings included:<br>1) Resident #51 was admitted to the facility on 10/12/12. Diagnoses included macular degeneration and depression.<br>The last documented activities assessment dated 12/18/12 indicated Resident #51 would enjoy having someone read to him.<br>An annual Minimum Data Set (MDS) dated 12/12/14 indicated the resident felt it was somewhat important to have books, newspapers, and magazines to read. The MDS also indicated the resident felt it was somewhat important to listen to music, do things with groups of people, and go outside when the weather was nice.<br>A review of Resident #51's care plan dated 03/12/15 identified a problem area of recreation related to decreased vision and hearing. The identified goal was the resident would participate in preferred activities twice a week to maintain quality of life. Interventions included going outside when the weather was nice, participation in a gardening group, reminiscent discussion, and staff to verbally inform him of daily activities.<br>There was no mention of Resident #51's interest in reading or any interventions to support his interest in reading.<br>An interview was conducted with Resident #51 on 06/23/15 at 8:48 AM. He stated the facility did not provide things for him to do in his room on his own, like books or cards. The resident explained he loved to read but could not anymore due to being legally blind. He stated he would be | F 279 | This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws.<br><br>1. a. Veteran #51 Care Plan was updated by Activity Director on 6/25/15 reflecting updated likes and intervention of taped books<br>b. Veteran #19 Care Plan was updated by Registered Dietitian on 6/25/15 to reflect interventions assigned related to weight loss<br><br>2. All Veterans have the risk to be affected with Comprehensive Care Plan updates<br>a. Audit performed by Activity Director on 7/20/15 for Veterans who require update of care plan for "likes"<br>b. Audit performed by Registered Dietitian on 6/25/15 for Veterans who require update of care plan for weight variance<br><br>3. a. Comprehensive Assessments Activities<br>1. Activities Director will identify veterans with activity needs based on quarterly, annual and/or Significant change in status assessment's<br>2. Likes and dislikes will be updated quarterly by Activity Director<br>3. Any changes of Likes or dislikes | |

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| F 279 | Continued From page 9<br>interested in audiobooks but the option had never been offered.<br>An interview was conducted with the Activities Director (AD) on 06/25/15 at 4:57 PM. She stated she did an activities assessment when a resident was admitted and then quarterly. She stated she was responsible for updating the care plan with information gathered from assessments. The AD explained she was aware Resident #51 enjoyed reading but was not sure if he had ever been offered any of the audiobooks owned by the facility. She could not explain why there was no activities assessment completed since 12/18/12 nor why Resident #51's care plan did not include interventions to support his interest in reading.<br>An interview was conducted with the Administrator on 06/26/15 at 2:39 PM. She stated the AD was responsible for assessing residents for their preferences and interests related to activities and updating the care plan related to activities as necessary. She further explained the AD changed at the time Resident #51's activities assessment was due and so the assessment was not completed.<br><br>2. Resident #19 was admitted on 01/13/14 with diagnoses including Alzheimer's disease and depression. Abnormal weight loss was added to the diagnosis list on 05/19/15.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 04/06/15 revealed Resident #19 had short and long-term memory loss and was severely impaired in making daily decisions. The quarterly MDS further revealed Resident #19 required extensive assistance with eating and significant weight loss had not occurred. The quarterly MDS noted Resident #19 was 72 inches tall and | F 279 | will have intervention at time of identification with update of Care Plan by Activity Director<br>4. Interdisciplinary team will be advised of changes at next scheduled care plan meeting unless otherwise indicated<br><br>b. Comprehensive Assessments Nutritional<br>1. Registered Dietitian will identify veterans with nutritional needs based on quarterly, annual and/or Significant change in status assessment's<br>2. Upon identification Registered Dietitian will implement interventions as indicated to prevent further nutritional variance.<br>3. Intervention will be initiated at time of identification with update of Care Plan by Registered Dietitian<br>4. Interdisciplinary team will be advised of changes at next scheduled care plan meeting unless otherwise indicated<br><br>4. a. All Comprehensive Care Plans will be monitored for updates and interventions by the Interdisciplinary Team weekly according to the RAI Assessment Schedule for 3 months<br>b. Results will be submitted to QAPI by Activity Director and Registered Dietitian for review and modification as indicated until compliance deemed met | |

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| F 279 | Continued From page 10 | F 279 | | |

weighed 154 pounds.

Review of Resident #19's recorded weights revealed the following:
- 02/09/15- 162.3 pounds
- 03/04/15- 156.0 pounds
- 04/14/15- 151.6 pounds
- 04/27/15- 152.3 pounds
- 04/30/15- 155.6 pounds
- 05/11/15- 152.4 pounds
- 05/18/15- 147.2 pounds

Review of a quarterly dietary assessment dated 04/06/15 revealed Resident #19's current weight was 156 pounds and noted a 3.5% weight loss in 1 month, a 5.5% weight loss in 3 months, and a 9.4% weight loss in 6 months. His current intake was 75% to 100% of meals. The Dietitian recommended 120 cc's (cubic centimeters) of a high calorie nutritional supplement to be given twice a day for weight stability.

Review of a significant weight loss checklist form dated 05/13/15 revealed the Dietitian noted Resident #19 had significant weight loss in the last 180 days. His current intake was 25% to 50% of meals. The recommendation was to continue the supplements.

Review of Resident #19's physician's orders revealed on 05/19/15 an order was written for a high calorie nutritional shake three times a day with meals and on 06/02/15 an order was written for staff to offer pudding twice a day as a snack.

Further review of the medical record revealed there was no care in place that addressed Resident #19's significant weight loss which was identified by the Dietitian on 05/13/15.

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| F 279 | Continued From page 11<br><br>During an interview on 06/25/15 at 3:45 PM the Dietitian stated he was responsible for and typically wrote care plans for weight loss after completing the significant weight loss form. The Dietitian could not explain how Resident #19's care plan for weight loss was missed.<br><br>An interview with the Director of Health Services (DHS) on 06/25/15 at 4:54 PM revealed the facility identified new resident problems or the need to update care plans during clinical rounds and when a new problem was identified she would expect the care plan to be in place within 24 hours. | F 279 | | |
| F 318 SS=D | 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and staff interviews, the facility failed to provide restorative nursing services for range of motion, transfers, or brace assistance for 2 of 4 residents reviewed for restorative nursing services (Residents #21 and #11).<br>The findings included:<br>1) Resident #21 was readmitted to the facility on 03/27/15. Diagnoses included stroke and | F 318 | This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws. | 7/24/15 |

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| F 318 | Continued From page 12<br>hemiplegia.<br>An admission Minimum Data Set (MDS) dated 04/03/15 indicated Resident #21 had short-term and long-term memory deficits and was severely impaired in making daily decisions. The MDS also indicated the resident had an impairment in one upper extremity and both lower extremities. In addition, the MDS indicated Resident #21 received physical and occupational therapy services and restorative nursing services for passive range of motion and splint or brace assistance.<br>A medical record review revealed a Restorative Nursing Referral from physical therapy dated 05/05/15. The referral outlined the goals and instructions to provide passive range of motion for fifteen minutes per day for six days per week and brace assistance for one hour per day to Resident #21.<br>A review of the care plan dated 06/22/15 for Resident #21 revealed a problem area of decreased range of motion in the right leg and to provide restorative nursing for passive range of motion and a knee brace to prevent further contractures. The goal was to provide passive range of motion to the right leg for fifteen minutes every day for six days every week and to apply a knee brace to the right leg for one hour every day. Interventions included instructions to staff on how to perform passive range of motion and apply the knee brace.<br>Review of the Restorative Log from 05/26/15 - 06/26/15 indicated Resident #21 received passive range of motion services on 06/10/15, 06/18/15, 06/19/15, and 06/23/15. The Restorative Log also indicated Resident #21 received splint/brace assistance on 06/18/15, 06/19/15, and 06/23/15.<br>On 06/25/15 at 10:50 AM, Resident #21 was observed in the bed in his room. The knee brace | F 318 | 1. a. Residents #21 is provided ROM per Restorative Care plan. Splint had been discontinued on 5/27/15 (had not been removed from room)<br>b. Resident #11 is provided sit to stand transfers with increased safety, posture and increased knee extension to both legs. Restorative care plan updated with how many days a week this is to be performed and the duration of each exercise<br><br>2. a. On 6/29/15 Audit performed of Veterans on Restorative Nursing to identify any other Veterans at risk by Restorative Coordinator<br>b. Residents identified given ROM, Splint, and restorative task assigned per Restorative Nursing Care Plan<br><br>3. a. All CNA Core Staff will be crossed trained as Restorative CNA's<br>b. In the event there is not a scheduled Restorative Team, every CNA is assigned to perform Veteran Restorative care<br>c. General Staff education provided by Administrator on 7/2/15 of integration of Restorative CNA's and Core CNA Staff<br>d. Education for Restorative Tasks, and Documentation initiated on 7/7/2015 by Clinical Systems Review Coordinator<br>e. Education for new partners will be performed during job specific orientation<br>f. Any Core CNA staff on vacation, FMLA or PRN status will be educated prior to any restorative interaction with veterans on next scheduled day<br><br>4. a. Restorative Documentation will be | |

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| F 318 | Continued From page 13<br>was on the dresser.<br>On 06/26/15 at 10:56 AM, Resident #21 was observed in a chair in his room. The knee brace was placed in another chair.<br>An interview was conducted with Nurse Aide (NA) #2 on 06/26/15 at 1:49 PM. He stated Resident #21 had significant contractures. He stated the restorative aide normally put the resident's knee brace on in the morning so the hall NAs did not do that. NA #2 further stated he was not sure who was supposed to provide passive range of motion services or brace assistance when there was no restorative aide scheduled.<br>An interview was conducted with NA #3 on 06/26/15 at 1:54 PM. She stated she was not sure who was responsible for doing restorative exercises or applying braces or splints where there was no restorative aide scheduled.<br>An interview was conducted with Restorative Aide #1 on 06/26/15 at 2:53 PM. She stated Resident #21 was no longer receiving restorative nursing services because he was receiving physical and occupational therapy services. Restorative Aide #1 explained when a resident started receiving physical or occupational therapy services, he or she was automatically discharged from restorative nursing services. She stated she was unable to provide restorative services when she was reassigned to a hall so restorative services were not completed when there was no restorative aide scheduled.<br>An interview was conducted with the Occupational Therapist (OT) on 06/26/15 at 4:23 PM. She stated Resident #21 was not receiving any services from physical, occupational, or speech therapy. She explained Resident #21 was discharged from therapy to restorative nursing in May 2015.<br>An interview was conducted with Nurse #1 | F 318 | monitored by Restorative Nurse/MDS Team<br>5X/week for 2 weeks --> then<br>4X/week for 2 weeks --> then<br>3X/week for 2 weeks --> then<br>2X/week for 2 weeks --> then<br>1X/week for 4 weeks<br>b. Results will be submitted monthly by Nursing Administration to QAPI for review and modification as indicated until compliance deemed | |

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06/26/15 at 4:30 PM. She stated she was responsible for the restorative nursing program. Nurse #1 explained she received a referral from therapy, she wrote an order for restorative nursing, and made the care plan according to therapy's recommendations. She further explained the NAs assigned to the halls were responsible for providing restorative nursing services when there was no restorative aide scheduled.
An interview was conducted with the Administrator on 06/26/15 at 6:17 PM. She stated a weekend restorative aide was not really in the facility's budget, but they worked around that by staggering the two current restorative aides so one was usually available on the weekend. She further stated the facility's goal was to train all NAs in restorative nursing but that was not done yet.
An interview was conducted with the Director of Health Services (DHS) on 06/26/15 at 6:37 PM. She stated NAs were supposed to pick up restorative tasks and incorporate them into daily resident care when there was no restorative aide scheduled.
2) Resident #11 was admitted on 10/17/12 with diagnoses including abnormal posture, difficulty in walking, generalized muscle weakness, and paralysis agitans.

Review of the medical record revealed a Physician's order dated 03/06/15 for restorative nursing to perform sit to stand transfers with increased safety, increased upright posture upon stand, and increase knee extension both legs. Increase ability to stand and practice sit to stand in front of rail with verbal cues to stand up tall upon standing.

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Review of the annual Minimum Data Set (MDS) dated 05/11/15 revealed Resident #11 had short and long-term memory deficits and was severely impaired in making daily decisions. The annual MDS indicated Resident #11 had impaired range of motion on both lower extremities and was provided active range of motion exercises by the restorative nursing program 1 day during the last 7 calendar days.

Review of a restorative nursing care plan dated 05/11/15 revealed Resident #11 required restorative nursing services due to muscle weakness and unsteady lower extremities. The goals were for Resident #11 were to perform sit to stand/from stand transfers with increased safety, increased upright standing posture, and increased knee extension to both legs to increase ability to stand upright until next review. The approaches included for Resident #11 to practice sit to/from stand transfers in front of a rail with verbal cues to stand tall upon standing and to sit in a chair with one or both legs on a chair in front of him to assist him to maintain legs in this position for as long as possible to achieve maximum stretch. The care plan did not include how many days a week or the duration of each exercise.

Review of Resident #11's restorative log from 05/11/15 through 06/26/15 revealed he received restorative services 4 times during the week of 05/10/15, 3 times the week of 05/17/15, 1 time the week of 05/24/15, 1 time the week of 05/31/15, 2 times the week of 06/07/15, 2 times the week of 06/14/15 and on 06/23/15.

An interview was conducted with Nurse Aide (NA) #2 on 06/26/15 at 1:49 PM. NA #2 stated he was

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not sure who was responsible for providing restorative services when there was no restorative aide scheduled.
An interview was conducted with NA #3 on 06/26/15 at 1:54 PM. NA #3 stated she was not sure who was responsible for providing restorative services when there was no restorative aide scheduled.
An interview was conducted with Restorative Aide (RA) #1 on 06/26/15 at 2:48 PM. RA #1 indicated Resident #11 restorative services included upper and lower body stretches. RA #1 stated there were two RAs and they both worked 5 days a week and split the facility. RA #1 stated she was frequently pulled to the floor to work a resident assignment due to call outs. RA #1 explained when there was only one RA on the schedule it was difficult to provide restorative services to all of the residents on the restorative nursing list. RA #1 indicated when she was pulled to the floor to take an assignment she provided restorative services to her assigned residents only. The interview further revealed RA #1 entered the number of minutes the resident performed each exercise into the computer.
An interview was conducted with Nurse #1 06/26/15 at 4:30 PM. During the interview Nurse #1 confirmed she was responsible for the restorative nursing program and when she received a referral for the restorative nursing program she put the information into the computer kiosk and completed a care plan. Nurse #1 further stated referrals were typically for 6 days a week and the restorative aides documented the number of minutes each exercise was performed into the computer. The interview further revealed when the restorative aides were not scheduled or pulled to a resident assignment the nurse aides (NAs) were expected

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| F 318 | Continued From page 17<br>to provide restorative services.<br>An interview was conducted with the Administrator on 06/26/15 at 6:17 PM. She stated a weekend restorative aide was not really in the facility's budget, but they worked around that by staggering the two current restorative aides so one was usually available on the weekend. The Administrator further stated the facility's goal was to train all nurses aides in restorative nursing by July 2015 and staff the Alpha and Bravo units for the nurse aides to provide restorative services to their residents.<br>An interview was conducted with the Director of Health Services (DHS) on 06/26/15 at 6:37 PM. She stated NAs were supposed to pick up restorative tasks and incorporate them into daily resident care when there was no restorative aide scheduled. | F 318 | | |
| F 322 SS=D | 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that --<br><br>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and<br><br>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. | F 322 | | 7/24/15 |

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This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interviews the facility failed to check for placement of a gastrostomy feeding tube before flushing with water and administration of medications for 1 of 2 residents observed for administration of medications in a gastrostomy tube during medication pass observations (Resident #92). The findings included:

Review of a facility policy titled: "Medication Administration: Enteral Tubes" dated as revised on 06/18/15 revealed the following instructions: "Verify tube placement using the following procedures: inject 15-20 cubic centimeters (cc) of air into the tube with the syringe and listen to stomach with stethoscope for distinct "whooshing" sound. Aspirate stomach contents with syringe."

Resident #92 was admitted to the facility on 03/09/15 with diagnoses which included Parkinson's disease, dysphagia (difficulty swallowing), hypertension and gastro-esophageal reflux disease. The most recent Minimum Data Set (MDS) dated 06/11/15 indicated Resident #92 had modified independence with daily decision making and short term memory problems.

A physician's progress note dated 05/15/15 read in part: "Nurses give medications by feeding tube because he doesn't like the taste of them."

This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws.

1. a. Nurse #3 was re-educated on facility protocol for placement check of Gastrostomy Tube and competency check performed on 6/24/15
b. Resident #92 was subsequently checked for placement with + placement check by Nurse on 6/24/18

2. Any Veteran with Gastrostomy Tube is at risk to be affected
a. Audit for all Gastrostomy Tube Veterans by Nursing 6Administration
b. Placement check for all Veterans identified performed by Nursing Administration

3. a. Gastrostomy Flush and medication administration via Gastrostomy tube added to Medication Administration Sheet for process accountability
b. Policy and Procedure re-education for Gastrostomy placement checks and competency evaluations performed by

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| F 322 | Continued From page 19<br>During observations of medication administration on 06/24/15 at 10:26 AM Nurse #3 crushed Resident #92's medications and mixed them in a cup with a small amount of sterile water then carried them into Resident #92's room. Nurse #3 did not have a stethoscope and removed the cap from the gastrostomy tube then placed a syringe into the end of the tube. She then poured 45 milliliters (ml) sterile water into the syringe and allowed it to flow by gravity into the tube. Next, she poured the container of crushed and liquid medication into the syringe and allowed it to flow by gravity into the tube. After the medications had flowed into the tube, Nurse #3 poured 45 ml sterile water into the syringe and allowed it to flow by gravity into the tube to flush the tube.<br><br>During an interview with Nurse #3 on 06/24/15 at 4:14 PM she stated she should have checked placement of the gastrostomy tube by auscultation (listening with a stethoscope) or aspiration of stomach contents before she flushed it with water or gave medications. She verified she did not check the tube for placement and knew she should have checked it before she gave the medications.<br><br>During an interview on 06/26/15 at 2:53 PM with the Director of Health Services, she stated it was her expectation that the nurses follow the facility policy and check the placement of the gastrostomy tube by auscultation and aspiration before flushing the tube or giving medications. | F 322 | Director of Health Services on 6/24/15<br>c. Licensed Nurse on vacation, FMLA, or PRN status will be re-educated and competency checked by Clinical Competency Coordinator/Nursing Management<br>d. New licensed Nurse partners education and competency will be performed prior to accessing Gastrostomy Tubes upon hire by Clinical Competency Coordinator/Nursing Management<br><br>4. a. Two (2) Gastrostomy Tube placement check will be monitored by Clinical Competency Coordinator/Nursing Management (One on 6a-6p and one on 6p-6a)<br>5X/week for 2 weeks --> Then<br>4X/week for 2 weeks --> then<br>3X/week for 2 weeks --> then<br>2X/week for 2 weeks --> then<br>1X/week for 4 weeks<br>b. Results will be submitted monthly to QAPI by Nursing Administration for review and modification as indicated until compliance deemed met | |
| F 332 SS=E | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>The facility must ensure that it is free of medication error rates of five percent or greater. | F 332 | | 7/24/15 |

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| NC STATE VETERANS HOME-BLACK MOUNTAIN | 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 332 | Continued From page 20 | F 332 | | |

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interview the facility failed to flush a gastrostomy tube (a tube placed through the abdomen into the stomach to provide food or medication) prior to and after administration of medication through the tube and by not administering medication one at time through a gastrostomy tube. This resulted in 2 errors out of 29 opportunities for error resulting in a medication error rate of 6.89% for 2 of 6 residents observed during medication pass. (Residents #92 and #131). The findings include:

Review of a facility policy titled: "Medication Administration: Enteral Tubes" ( a tube placed through the abdomen into the stomach to provide food or medication) dated as revised on 06/18/15 revealed the following instructions: "Tablets are crushed separately and capsules opened separately to facilitate administration. Enteral tubes will be flushed before administering medications with 15 ml of water, with 5 ml of water after each medication and with 15 ml at completion of medication administration."

1. Resident #92 was admitted to the facility on 03/09/15 with diagnoses which included Parkinson's disease, dysphagia (difficulty swallowing), hypertension and gastro-esophageal reflux disease. The most recent Minimum Data Set (MDS) dated 06/11/15 indicated Resident #92 had modified independence with daily decision making and short term memory problems.

A review of the June 2015 monthly recapitulation

This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws.

1. a. Nurses #3 and #4 were re-educated on facility protocol for placement check of Gastrostomy Tube, and administration of medication separately and not crushed/administered together performed on 6/24/15 by Director of Health Services
b. Resident #92 was subsequently checked for placement with + placement check and administered medications correctly by Nurse on 6/24/15
c. Resident #131 was subsequently checked for placement with + placement check and administered medications correctly by Nurse on 6/24/15

2. Any Veteran with Gastrostomy Tube is at risk to be affected
a. Audit for all Gastrostomy Tube Veterans by Nursing Administration
b. Placement check correct administration for for all Veterans identified performed by Nursing Administration

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| F 332 | Continued From page 21<br>of physician's orders revealed orders for the following medications to be given every morning:<br>Oxybutynin 5 milligrams (mg)/5 milliliters (ml) 2.5 ml<br>Seroquel (Quetiapine) 25 mg, 1 tablet<br>Sinemet (Carbidopa/Levodopa) 25/100 mg, 2 tablets<br>Lasix (Furosemide) 20 mg, 1 tablet<br>Tylenol (Acetaminophen) 325 mg, 2 tablets<br><br>During observation of medication administration on 06/24/15 at 10:26 AM Nurse #3 was observed as she prepared medications at a medication cart to administer through Resident # 92's gastrostomy tube. Nurse #3 poured 2.5 ml Oxybutynin into a medication cup. She then placed the Seroquel, Sinemet, Lasix and Tylenol into another medication cup. Nurse #3 then placed all the tablets in a plastic bag and crushed the medications and mixed them in a cup with 90 ml of sterile water and added the liquid Oxybutynin to the mixture. Nurse #3 then carried the cup with the medication solution into Resident #92's room. Nurse #3 did not have a stethoscope and removed the cap from the gastrostomy tube then placed a syringe into the end of the tube. She then poured 45 milliliters (ml) sterile water into the syringe and allowed it to flow by gravity into the tube. Next, she poured the container of crushed and liquid medication into the syringe and allowed it to flow by gravity into the tube. After the medications had flowed into the tube, Nurse #3 poured 45 ml sterile water into the syringe and allowed it to flow by gravity into the tube to flush the tube.<br><br>During an interview with Nurse #3 on 06/24/15 at 4:14 PM she was asked about the facility policy for administering medications through a | F 332 | 3. a. Gastrostomy Flush and medication administration via Gastrostomy tube added to Medication Administration Sheet for process accountability<br>b. Policy and Procedure re-education for Gastrostomy placement checks performed by Clinical Competency Coordinator on 6/24/15<br>c. Licensed Nurse on vacation, FMLA, or PRN status will be re-educated and competency checked by Clinical Competency Coordinator/Nursing Management<br>d. New licensed Nurse partners education will be performed prior to accessing Gastrostomy Tubes upon hire by Clinical Competency Coordinator/Nursing Management<br><br>4. a. Two (2) Gastrostomy Tube placement check will be monitored by Clinical Competency Coordinator/Nursing Management (One on 6a-6p and one on 6p-6a)<br>5X/week for 2 weeks --> Then<br>4X/week for 2 weeks --> then<br>3X/week for 2 weeks --> then<br>2X/week for 2 weeks --> then<br>1X/week for 4 weeks<br>b. Results will be submitted monthly to QAPI by Nursing Administration for review and modification as indicated until compliance deemed met | |

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| F 332 | Continued From page 22 | F 332 | | |

gastrostomy tube. Nurse #3 stated she did not know until the Director of Health Services told her today that she should have given the medications separately and flushed the tube after each one.

During an interview on 06/26/15 at 2:53 PM with the Director of Health Services, she stated it was her expectation that the nurses follow the physician's orders for administration of medications through a gastrostomy tube and flush between medications with the ordered amount of water. She stated if there wasn't a specific physician's order, she expected the nurse to follow the facility policy for flushing the tube before giving medication, between each medication and after giving medications.

2. Resident #131 was admitted to the facility on 05/29/15 with diagnoses which included atrial fibrillation, hypertension and diabetes mellitus. The most recent Minimum Data Set (MDS) assessment dated 06/05/15 indicated Resident #131 was cognitively intact for daily decision making.

A review of Resident #131's current physician's orders revealed an order for Coumadin 5.5 milligrams (mg) every day.

During observation of medication administration on 06/24/15 at 4:38 PM Nurse #4 was observed as she prepared medications at a medication cart to administer through Resident #131's gastrostomy tube. Nurse #4 placed Coumadin 2.5 mg, one tablet and Coumadin 3.0 mg, one tablet into a medication cup. Nurse #3 then placed both tablets in a plastic bag and crushed the medications and mixed them in a cup with 120 ml of water. Nurse #4 then carried the cup with the

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| F 332 | Continued From page 23 | F 332 | | |

medication solution into Resident #131's room. Nurse #4 disconnected the feeding infusing into the tube, checked the tube for placement by inserting air through the tube and listening to the stomach with a stethoscope. Nurse #4 then placed a syringe into the end of the tube. She then poured the medication solution into the syringe and allowed it to flow by gravity into the tube. Nurse #4 then reconnected the tube to the feeding solution. Nurse #4 was not observed to flush the tube with water before or after administering the medication.

During an interview with Nurse #4 on 06/24/15 at 4;45 PM, she was asked about the facility policy for administering medications through a gastrostomy tube and whether the tube should be flushed before and after medication administration. Nurse #4 stated she didn't know what the facility policy was about flushing before and after medication administration. Nurse #4 stated she referred to the Medication Administration Record (MAR) for instructions on flushing the gastrostomy tube and the MAR didn't specify to flush the tube before and after giving medications so she didn't flush it. Nurse #4 stated the tube was clogged earlier today but she had gotten it unclogged.

During an interview on 06/26/15 at 2:53 PM with the Director of Health Services, she stated it was her expectation that the nurses follow the physician's orders for administration of medications through a gastrostomy tube and flush before and after administration of medications with the ordered amount of water. She stated if there wasn't a specific physician's order, she expected the nurse to follow the facility policy for flushing the tube before giving

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| F 332 | Continued From page 24<br>medication, between each medication and after giving medications. | F 332 | | |
| F 353 SS=D | 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS<br><br>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.<br><br>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br><br>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.<br><br>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and staff interviews, the facility failed to provide restorative nursing services for range of motion, transfers, or brace assistance for 2 of 4 residents reviewed for restorative nursing services due to insufficient nursing staff (Residents #21 and #11).<br>The findings included:<br>This tag is cross-referred to: | F 353 | This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws. | 7/24/15 |

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| F 353 | Continued From page 25<br>1) F 318 : "Based on observations, record reviews, and staff interviews, the facility failed to provide restorative nursing services for range of motion, transfers, or brace assistance for 2 of 4 residents reviewed for restorative nursing services (Residents #21 and #11)."<br>Review of daily staffing assignment sheets from 06/03/15 through 06/26/15 (24 days) revealed the following coverage for restorative nursing services:<br>- three days had no restorative aides (RA) scheduled<br>- six days had no RA due to staff being pulled to the floor to take an assignment<br>- twelve days had 1 RA and on four of the twelve days 2 RAs were scheduled and 1 RA was pulled to the floor for an assignment<br>- one day the 1 scheduled RA was pulled to the floor from 8:00 AM to 11:00 AM<br>- two days with two RAs<br>An interview was conducted with the Director of Health Services (DHS) on 06/26/15 at 6:37 PM. She stated NAs were supposed to pick up restorative tasks and incorporate them into daily resident care when there was no restorative aide scheduled. The DHS noted there had been staffing challenges in November and December of 2014 due to illness and also in May and June of 2015 due to vacations. The DHS noted the schedule is posted at the time clock so staff can sign up for additional shifts for coverage.<br>Interview further revealed when an NA called out for the 6:00 AM to 2:00 PM shift the night supervisor started making calls to replace the NA. There were currently 4 NAs that worked prn (as needed) for the facility and if they were not available the restorative aides, nurses, and the DHS take a resident assignment when needed. The DHS noted there were 4 NAs in orientation | F 353 | 1. a. Residents #21 is provided ROM per Restorative Care plan. Splint had been discontinued on 5/27/15 (had not been removed from room)<br>b. Resident #11 is provided sit to stand transfers with increased safety, posture and increased knee extension to both legs. Restorative care plan updated with how many days a week this is to be performed and the duration of each exercise<br>c. CNA Core Staff crossed trained with Restorative skills<br>d. All CNA's are assigned to ensure Restorative nursing care is provided<br><br>2. a. On 6/29/15 Audit performed of Veterans on Restorative Nursing to identify any other Veterans at risk by Restorative Coordinator<br>b. Residents identified Restorative care as assigned by Restorative Nursing Care Plan<br>c. c. CNA Core Staff crossed trained with Restorative skills<br>d. All CNA's are assigned to ensure Restorative nursing care is provided<br><br>3. a. All CNA Core Staff will be crossed trained as Restorative CNA's<br>b. Every CNA is assigned to perform Veteran Restorative care<br>c. General Staff education provided by Administrator on 7/2/15 of integration of Restorative CNA's and Core CNA Staff<br>d. Education for Restorative Tasks, and Documentation initiated on 7/7/2015 | |

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| F 353 | Continued From page 26<br>and the facility had NA positions posted in the facility and on web sites. | F 353 | by Clinical Systems Review Coordinator<br>e. Education for new partners will be performed during job specific orientation<br>f. Any Core CNA staff on vacation, FMLA or PRN status will be educated prior to any restorative interaction with veterans on next scheduled day<br><br>4. a. 5 Veterans who are on Restorative Nursing per monitoring schedule, will be observed during restorative task and documentation by Restorative Nurse/MDS Team to ensure adequate staffing provided for completion of Restorative care<br>5X/week for 2 weeks --> then<br>4X/week for 2 weeks --> then<br>3X/week for 2 weeks --> then<br>2X/week for 2 weeks --> then<br>1X/week for 4 weeks<br>b. Results will be submitted monthly by Nursing Administration to QAPI for review and modification as indicated until compliance deemed | |
| F 371 SS=D | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions | F 371 | | 7/24/15 |

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| F 371 | Continued From page 27<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to cover an opened item and discard food items opened to air and expired for stored foods, ready for use, in the kitchen refrigerator, walk-in refrigerator, and freezer.<br>The findings included:<br>1. Observation of the facility's kitchen refrigerator on 06/22/15 at 2:31 PM revealed the following problems with a food item stored opened to air. Visual inspection of the refrigerator revealed one 5 lb American cheese slices open to air.<br>An interview on 06/22/15 at 2:31 PM with the kitchen cook revealed he was responsible for labeling and dating foods stored in the refrigerator. He said he should have covered the American cheese when opened.<br><br>2. Observation of the facility's walk-in refrigerator on 06/22/15 at 2:40 PM revealed a box of head lettuce with 2 heads completely open to air ready for use with brown discoloration.<br>An interview on 06/22/15 at 2:40 PM with the facility's Registered Dietician revealed the head lettuce should have been sealed, not opened to air and should now be discarded.<br><br>3. Observation of the facility's freezer on 06/22/15 at 2:49 PM revealed a pan of sour kraut ready for use, dated 05/04/15, open to air with freezer burn and a used by date of 06/04/15.<br>An interview on 06/22/15 at 2:49 PM with the facility's Registered Dietician revealed the sour kraut should have been sealed and discarded after 06/04/15. | F 371 | This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws.<br><br>1. Food items identified in dietary refrigerator were discarded on 6/22/15<br><br>2. All cold food storage areas at risk to be affected<br>a. Audit of all cold food storage areas for food not dated or outdated performed on 6/22/15 by Dietary Team<br>b. All food items identified as undated or outdated discarded on 6/22/15 by Dietary Team<br><br>3. a. On 7/9/15 dietary staff educated on dating of all items placed in cold storage by Registered Dietitian<br>b. On 7/9/15 dietary staff educated on disposing of outdated food items by Registered Dietitian<br>c. Dietary staff on vacation FMLA, or PRN status will be educated on dating, storage and disposal of outdated food items prior to next scheduled shift<br>d. New dietary partners will be educated during job specific orientation to Dietary<br><br>4. a. Dating, storage and disposal of | |

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| F 371 | Continued From page 28 | F 371 | outdated food items will be monitored by Registered Dietitian/Certified Dietary Manager/Designee<br>5X/week for 2 weeks --> Then<br>4X/week for 2 weeks --> then<br>3X/week for 2 weeks --> then<br>2X/week for 2 weeks --> then<br>1X/week for 4 weeks<br>b. Results will be submitted monthly by Dietary Department to QAPI for review and modification as indicated until compliance deemed met | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff and pharmacist interviews the facility failed to act upon a pharmacist recommendation to assess a resident for adverse side effects (tardive dyskinesia) for 1 of 1 sampled resident prescribed an antipsychotic medication (Resident #106).<br><br>The findings included: | F 428 | This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws. | 7/24/15 |

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| F 428 | Continued From page 29<br><br>Resident #106 was admitted on 04/09/15 with diagnoses including dementia, unspecified psychosis, and mood disorder. Physician's admission orders dated 04/09/15 included Geodon (antipsychotic medication) 40 mg (milligrams) by mouth after lunch and Geodon 60 mg by mouth after dinner.<br><br>Review of a progress note dated 04/14/15 revealed Resident #106 was evaluated by the Physician due to aggressive behavior and his Geodon dose was increased.<br><br>Review of the admission Minimum Data Set (MDS) dated 04/15/15 revealed Resident #106 had severely impaired cognition and received an antipsychotic medication daily during the 7 day assessment period.<br><br>Review of a care plan dated 04/15/15 revealed Resident #106 was at risk for side effects from antipsychotic and antidepressant medications. Interventions included monitoring Resident #106 for side effects.<br><br>Review of Resident #106's June 2015 Physician's order revealed he was prescribed Geodon 40 mg (milligrams) by mouth daily after lunch and Geodon 80 mg by mouth daily at bedtime.<br><br>Continued review of the medical record revealed a Dyskinesia Identification System: Condensed User Scale (DISCUS) had not been completed since Resident #106 was admitted to the facility. The DISCUS is used to detect tardive dyskinesia which is a common adverse side effect of antipsychotic medications. | F 428 | 1. Anti-psychotic Drug Monitoring Discus was completed on 6/30/15 by Director of Health Services<br><br>2. a. Audit of veterans on Anti-psychotic medications to identify if other veterans at risk by Nursing Administration on 7/13/15<br>b. Discus evaluations completed on any veteran identified with risk by Nursing Administration on 7/13/15<br><br>3. a. Re-education provided to Interdisciplinary Team by Administrator on 7/1/15 on Regulation requirement of Veterans on Antipsychotic Medication to have DISCUS Assessment every 6 months<br>b. Director of Health Services, and/or Social Worker will lead weekly review of anti-psychotic medication assessment compliance<br>c. Monthly Pharmacy Consultant compliance review will be submitted to facility with recommendations as indicated for completion of Discus Assessment if indicated<br>d. Licensed Nursing team will complete these assessments per recommendation within 10 days of receipt from Pharmacy Consultant visit<br>e. Partners on vacation, FMLA, or PRN status will be re-educated prior to serving meals on next scheduled shift<br>f. New Licensed Nurse partners will be educated during initial job specific orientation for compliance of Anti-psychotic Medication Assessment/Discus | |

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| NC STATE VETERANS HOME-BLACK MOUNTAIN | 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711 |

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| F 428 | Continued From page 30<br>Review of monthly pharmacy reviews revealed the Pharmacist reviewed Resident #106's medications and medical record on 04/30/15, 05/27/15, and 06/22/15.<br><br>During an interview on 06/26/15 at 7:00 PM the Director of Nursing (DON) stated a DISCUS should be completed on admission for residents prescribed antipsychotic medications, when a resident is started on an antipsychotic medication, and every 6 months thereafter. The DON further stated the Pharmacist typically reminded the facility when a DISCUS was due for a resident in the monthly recommendations.<br><br>An telephone interview was conducted with the Pharmacist on 06/26/15 at 7:21 PM. The Pharmacist reviewed her recommendations for Resident #106 and confirmed she had recommended a DISCUS on 04/30/15 and 06/22/15.<br><br>During a follow up interview on 06/26/15 at 7:24 PM the DON stated she gave the monthly pharmacy recommendations to the weekend supervisor for review and could not explain how the recommendation for Resident #106's DISCUS had not been completed. | F 428 | 4. a. Discus Assessments will be monitored weekly for 3 months by Interdisciplinary Team/MDS Team for compliance<br>b. Results will be submitted monthly by Nursing Administration and/or Social Worker to QAPI for review and modification as indicated until compliance deemed met | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically | F 431 | | 7/24/15 |

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| F 431 | Continued From page 31<br>reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interview the facility failed to removed expired or out of date medications from 1 of 4 medication carts and from 1 of 4 medication refrigerators. The findings include:<br><br>Review of manufacturer recommendations for Tuberculin Purified Protein Derivative (PPD) Diluted Aplisol vials indicated any unused solution should be discarded 30 days after opening. | F 431 | This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws.<br><br>1. a. Expired Purified Protein Derivative | |

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| F 431 | Continued From page 32<br>Review of manufacturer recommendations for Novolog insulin revealed it should be refrigerated until opened and could remain in use for 28 days after opening, if it had been refrigerated.<br><br>Observation on 06/26/15 at 11:14 AM of the A Hall Medication Cart revealed 1 unopened bottle Novolog insulin labeled for a specific resident with a dispense date of 04/20/15. The pharmacy label indicated: "Refrigerate until opened."<br><br>Observation of the A Hall Medication Refrigerator revealed it contained a partially used vial of Tuberculin PPD Diluted Aplisol with a manufacturer expiration date of September 2016. The vial was approximately half full. The date opened, which was written on the vial, was April 2015.<br><br>An interview on 06/26/15 at 11:35 AM with Nurse #3, who was the medication nurse for A Hall, revealed the Novolog insulin had been discontinued and should have been returned to the pharmacy. Nurse #3 verified that insulin should be stored in the refrigerator until placed into use.<br>Nurse #3 was asked when the PPD solution was last used and she stated the most recent admission to A Hall was on 06/18/15 and the resident was given a tuberculin skin test on 06/18/15. Nurse #3 was asked who was responsible for checking for out of date medications in the refrigerator and she stated all the nurses were responsible for checking and the night shift nurses were specifically responsible for checking for out of date medications. Nurse #3 was asked how long the PPD solution could remain in use after opening and she stated she would have to check the reference guide. Nurse | F 431 | (PPD) discarded on 6/26/15<br>b. Un-opened non-refrigerated Novolog insulin bottle discarded on 6/26/15<br>c. Nurse #3 was educated on checking cart and medication refrigerator during her assigned shift<br><br>2. a. Storage of all biologicals at risk to be affected<br>b. All Medication carts, medication refrigerators and medications rooms checked by Nursing Administration on 6/26/15<br>3. a. Re-education to licensed nurses on 7/20/15 by Nursing Administration on Policy and procedure of expired/outdated biological items<br>b. Licensed Nurse signature validating review and understanding of the Policy and Procedure for Storage and disposal of Biologicals completed on 7/20/15 by Nursing Administration<br>c. Licensed Nurses on vacation FMLA, or PRN status will be educated on next scheduled day<br>d. New Licensed nurses will be educated during job specific orientation to nursing duties<br><br>4. a. Discarding of biologicals by nursing Administration will be performed<br>5X/week for 2 weeks --> then<br>4X/week for 2 weeks --> then<br>3X/week for 2 weeks --> then<br>2X/week for 2 weeks --> then<br>1X/week for 4 weeks<br>b. Results will be submitted monthly by Nursing Administration to QAPI for review | |

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| F 431 | Continued From page 33<br>#3 then looked at a reference guide, which was located in the front of the Medication Administration Records (MARs,) and stated the PPD solution could remain in use for 30 days after opening.<br><br>An interview on 06/26/15 at 2:53 PM with the Director of Health Services (DHS) about the facility system for checking for expired medications revealed every nurse was expected to check expiration dates before administering medication. The DHS stated the night shift nurses were responsible for checking the medication refrigerators, rooms and carts every Wednesday night. She stated the consultant pharmacist also checked for expired medications during her monthly visits. The DHS stated her expectation was for expired medications to be removed from medication carts, medication rooms and medication refrigerators. | F 431 | and modification as indicated until compliance deemed met | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections. | F 441 | | 7/24/15 |

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| F 441 | Continued From page 34<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to follow proper handwashing techniques during 1 of 8 observed meal services. The findings included:<br>During the dinner meal service on 06/22/15 at 5:17 PM, Nurse Aide (NA) #1 was observed to assist Resident #12 reposition in his wheelchair and then provide assistance to replace his shoe. NA #1 was wearing gloves during the interaction. NA #1 then began serving beverages to other residents and was not observed to replace her gloves or wash her hands before beginning. She was observed to open a container of chocolate milk and insert her thumb into the pour spout of the container to open it fully. She then served the | F 441 | This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws.<br><br>1. Hand Hygiene during meals. CNA #1 acknowledged hand hygiene with glove changing required after repositioning Veteran #12 and having contact with food item. | |

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| F 441 | Continued From page 35<br>chocolate milk to Resident #50.<br>An interview was conducted with NA #1 on 06/22/15 at 6:16 PM. She stated she should have washed her hands and changed her gloves after making contact with Resident #12.<br>An interview was conducted with the Director of Health Services (DHS) on 06/26/15 at 2:33 PM. She stated she expected staff to wash their hands before and after providing care to residents and to use gloves when there was potential for contact with bodily fluids. She stated staff should wash their hands and change gloves in between touching residents and serving food. | F 441 | 2. All Veterans have the potential to be affected during meal service<br><br>3. a. Re-education provided to all staff by Administrator on 7/2/15 with hand hygiene policy during meal service<br>b. Clinical Competency/Nursing administration will validate competency and knowledge of partners who serve, feed and/or reposition veterans during meals<br>b. Partners serving, feeding and/or repositioning veterans during meals will review policy and procedure for hand hygiene during meals and provide signed acknowledgement of understanding<br>c. Partners on vacation, FMLA, or PRN status will be re-educated prior to serving meals on next scheduled shift<br>c. New partners will be educated, competency checked and sign acknowledgement of understanding the Policy and Procedure of Hand Hygiene during meals on initial orientation prior to serving meals to veterans.<br><br>4. a. Meal hand hygiene will be monitored by Nursing Administration Team<br>5X/week for 2 weeks --> Then<br>4X/week for 2 weeks --> then<br>3X/week for 2 weeks --> then<br>2X/week for 2 weeks --> then<br>1X/week for 4 weeks<br>b. Results will be submitted monthly by Nursing Administration to QAPI for review and modification as indicated until compliance deemed met | |

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| F 520 | Continued From page 36 | F 520 | | |
| F 520 SS=D | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and staff and resident interviews, the facility's Quality Assessment and Assurance Committee (QAA Committee) failed to maintain implemented procedures and monitor these interventions related to developing comprehensive care plans, food storage and labeling, and infection control the Committee put into place in June 2014. This | F 520 | This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws. | 7/24/15 |

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| F 520 | Continued From page 37<br>citation is related to three citations on the current survey. The three deficiencies were in the areas of: 1) developing comprehensive care plans; 2) food procurement, storage, and preparation; and 3) infection control.<br>The findings included:<br>This tag is cross-referred to:<br>1) F 279 : "Based on observations, record reviews, and resident and staff interviews, the facility failed to develop a comprehensive care plan for 1 of 2 residents reviewed for activities (Resident #51) and 1 of 2 residents reviewed for nutrition (Resident #19)."<br>F 279 was cited on the current survey for the facility's failure to develop a comprehensive care plan to address one resident's interest in reading books but had low visual acuity due to a medical diagnosis of macular degeneration and to address one resident's significant weight loss.<br>An interview was conducted with the Administrator on 06/26/15 at 7:35 PM. She stated the QAA Committee met every month to discuss areas of concern identified through a variety of sources, including various computerized quality monitoring programs, results of state survey agency visits, and corporate complaint calls. The Administrator stated the facility has monitoring tools in place for nurse staffing and falls.<br>This tag is cross-referred to:<br>2) F 371 : "Based on observations and staff interviews, the facility failed to discard food items open to air and expired and failed to label and date stored foods in the kitchen refrigerator and walk-in refrigerator."<br>F 371 was cited on the current survey for the facility's failure to label and date stored foods in the kitche's refrigerator. The facility also failed to dispose of a box of lettuce that was open to air | F 520 | 1. a. Veterans #51 and #19 Comprehensive Care Plan's were updated with interventions indicated by Activity Director on 6/26/15 and Registered Dietitian on 6/22/15<br>b. Food items identified disposed of 6/22/15 Registered Dietitian and Dietary Team<br>c. Hand Hygiene education provided to CNA #1 on identification of infection control risk 6/22/15 by Nursing Administration. Additional facility education provided on 7/1/15 and 7/2/15 by Nursing Administration and Administrator<br><br>2. Previous and current citations at risk to be affected<br><br>3. a. Administrator education to Department Heads on 7/1/15 related to ongoing systems review and effectiveness of systems in place<br>b. Administrator education with General Staff on 7/2/15 of ongoing practice and compliance with systems in place and Value of following Policy and Procedure<br>c. Education to General staff on 7/2/15 by Administrator regarding re-citation of tags upon additional Survey visits for areas of non-compliance identified<br>d. Systems Review Monthly of citations to validate continuity of compliance<br><br>4. a. QA&A compliance will be monitored by Administrator/Designee monthly for 3 months | |

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| F 520 | Continued From page 38<br>and expired, as evidenced by browning observed on the lettuce leaves.<br>An interview was conducted with the Administrator on 06/26/15 at 7:35 PM. She stated the QAA Committee met every month to discuss areas of concern identified through a variety of sources, including various computerized quality monitoring programs, results of state survey agency visits, and corporate complaint calls. The Administrator stated the facility has monitoring tools in place for nurse staffing and falls.<br>This tag is cross-referred to:<br>3) F 441 : "Based on observations and staff interviews, the facility failed to follow proper handwashing techniques during 1 of 8 observed meal services."<br>F 441 was cited on the current survey for the facility's failure to follow proper handwashing techniques in relation to providing resident care and then returning to serve resident meals without washing hands or changing gloves in between.<br>An interview was conducted with the Administrator on 06/26/15 at 7:35 PM. She stated the QAA Committee met every month to discuss areas of concern identified through a variety of sources, including various computerized quality monitoring programs, results of state survey agency visits, and corporate complaint calls. The Administrator stated the facility has monitoring tools in place for nurse staffing and falls. | F 520 | b. Results will be submitted monthly by Administrator and/or Director of Health Services to QAPI for review and modification as indicated until compliance deemed met. | |