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 07/31/2015

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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to assure that the Medication Administration Record had been accurately transcribed to reflect the medical doctor ' s order for Ativan for two (Resident # 1 and Resident # 2) of two sampled residents whose medications were reviewed. The findings included: 1. 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. Record review revealed the resident had been transferred to the hospital multiple times since his initial admission to the facility. Specific dates were as follows: The resident was admitted to the hospital on 6/21/15 and readmitted to the facility on 7/7/15. The resident was admitted to the hospital on 7/8/15 and returned to the facility on 7/13/15. Also on 7/18/15 the resident was evaluated at the hospital Emergency Room and returned that same day. Upon the resident ' s return to the facility on 7/13/15 the resident was ordered to receive Ativan 0.5 mg (milligrams) every day PRN (as needed) for anxiety according to the 7/13/15 hospital discharge medication list. Review of the	F 281	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 Medication administration records were reconciled with the narcotic sheets to validate that all residents had received their medications appropriately. METHOD TO IDENTIFY OTHERS The Clinical management team conducted an audit of all new admissions/readmissions for the previous 30 days to ensure all medications were transcribed correctly was started on 8/14/2015.	9/1/15

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

Electronically Signed | 08/22/2015

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 07/31/2015

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 281	Continued From page 1 facility ' s physician orders revealed the Ativan was incorrectly transcribed as a regularly scheduled daily medication when the resident was readmitted to the facility on 7/13/15. On the resident ' s most recent July MAR the Ativan was transcribed as a scheduled medication to be given every day at 8 AM and there was no documentation to show the facility had detected the transcription error and attempted to rectify it. Also on the July MAR there were multiple days that some nurses documented they gave the Ativan and some days were blank. Specifically, on the following ten days the resident was documented as receiving the Ativan as indicated by nurses ' initials: 7/17/15, 7/19/15; 7/20/15; 7/21/15; 7/22/15; 7/23/15; 7/24/15; 7/27/15; 7/28/15; and 7/29/15. On the following dates there were blanks for the dates of 7/25/15 and 7/26/15. The initials for the date of 7/29/15 appeared to run into 7/30/15 making it difficult to distinguish if the nurse was documenting she administered it or not. On 7/18/15 the resident was documented as OOF (out of facility). On 7/30/15 at 1:35 PM Nurse # 1 was interviewed in regards to the resident ' s Ativan which still appeared on the MAR as a regularly scheduled 8 AM medication. Nurse # 1 stated she thought the medication was PRN (as needed) but offered no explanation of why it had been documented as administered some days, omitted some days, and not clarified to read correctly as a PRN medication on the resident ' s MAR. By law Ativan is considered a controlled medication and nurses are required to sign when they remove an Ativan dose from a locked storage area prior to the administration of the Ativan. The following observation and review revealed the nurses were signing on the resident ' s MAR they gave the Ativan on days on which there was no evidence	F 281	100% medication administration record audit was completed on 8/5/2015.Identified issues will be reviewed with the facility physician. SYSTEMIC CHANGES 1.Education began on 8/5/2015 by the DHS and/or the clinical nurse management team for all Licensed Nurses on medication administration. 2.Education will be conducted by the Southeastern Regional Area Health Education Center as to medication administration and ethics on 8/31/2015. 3. Education on medication administration with emphasis on documentation of medication in the Medication Record and Narcotic sheets will be conducted by United Pharmacy Services on 8/25/2015. 4.Clinical Management team will review the Medication Administration Records and Narcotic count sheets for accurate and complete documentation weekly x 4 weeks then monthly thereafter. MONITORING PROCESS Narcotic sheets are reconciled with Medication Administration Records to ensure medications are accuratley documented on the Medication Administration Record. Medication Administration Records are reviewed with the Narcotic sheets to ensure accurate and complete documentation on the Narcotic sheets. DHS and Quality Assurance nurse will review the findings from the Medication Administration Record audit. Findings from the audit will	

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 07/31/2015

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 281	Continued From page 2 they ever removed the medication and did so. All of the resident ' s available, stored Ativan pills were observed with Nurse # 1 on 7/30/15 at 1:35 PM. There were 22 Ativan doses left on the current Ativan card in use and this matched the resident ' s " Controlled Drug Receipt and Record of Disposition Form, " which would indicate that the " Controlled Drug Receipt and Record of Disposition Form " was accurate. As noted above the nurses had signed they had administered the Ativan at 8 AM on the above noted ten days on the resident ' s MAR. Review of the resident ' s " Controlled Drug Receipt and Record Disposition Form " revealed the Ativan had been signed out from the resident ' s controlled substance card only on four of the ten days the nurses initialed they gave it. Theses dates were: 7/20/15; 7/22/15; 7/23/15; and 7/24/15. This would indicate that the nurses were initialing they administered the Ativan on the MAR when they had no record of proof they had done so. Also, on the resident ' s Ativan " Controlled Drug Receipt and Record of Disposition Form " there were initials that the Ativan was signed out on 7/25/15 at 9 AM but as noted above there was a blank on the resident ' s MAR for the 25th. Nurse # 1 stated that she thought the Ativan was PRN (as needed) and had no further explanation of the initials on the MAR not reconciling with the " Controlled Drug Receipt and Record of Disposition Form " or why the medication still appeared on the MAR as a regularly scheduled 8 AM medication. The DON (Director of Nursing) was interviewed at 7/31/15 at 11 AM and 12:50 PM about the inability to reconcile the Ativan doses on hand with the resident ' s MAR. The DON verified that nurses had been documenting they were giving the Ativan on days on which they really had not	F 281	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 07/31/2015

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 281	Continued From page 3	F 281		

administered it. The DON stated that she had talked with the nurses and the nurses were under the impression that it was a PRN medication even though it was on the MAR as an 8 AM scheduled medication. The DON was questioned why the nurses would then sign they gave the Ativan and yet not administer it. The DON was also questioned why the nurses had not clarified the order if they thought it was PRN and yet continued to see it on the MAR as a regularly scheduled medication. The DON stated she had not been aware of the problem until the survey. The DON stated that it was her expectation that as the nurses removed and prepared the medications they would somehow flag the MAR in an acceptable manner so when they returned from the administration of multiple medications they could recall and verify they had actually prepared and administered each medication.
2. Record review revealed Resident # 2 was admitted to the facility on 5/29/12. The resident had multiple diagnoses which included but were not limited to the following: Dementia, Hypertension, Depression, Severe Degenerative Joint Disease, and History of Left Hip Fracture. Review of the physician orders revealed the resident was ordered to receive Ativan 0.5 mg (milligrams) twice per day on a regularly scheduled basis. The origin of the order was dated as 4/7/15.
Review of Resident # 2 ' s July MAR on 7/31/15 at 9:15 AM revealed nurses had initialed they had administered the resident ' s Ativan twice per day every day of the month. All of the resident ' s available, stored Ativan pills were observed with Nurse # 1 on 7/31/15 at 9:15 AM. There were 24 Ativan pills left on the current Ativan card in use and this matched the resident ' s " Controlled Substance Inventory Sheet, " which would

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 07/31/2015

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 281	Continued From page 4 indicate that the " Controlled Substance Inventory Sheet, " was accurate. Review of the resident ' s " Controlled Substance Inventory Sheet " could not be reconciled with four dates on the resident ' s MAR. Nurses had initialed they had administered the Ativan on the following dates and the " Controlled Substance Inventory Sheet " contained no documentation that the nurses had removed the medication from the cart: the 8 AM dose of 7/26/15; the 8 AM dose of 7/27/15; the 8 PM dose of 7/28/15; and the 8 AM dose for 7/30/15. The inability to reconcile the resident ' s MAR with the " Controlled Substance Inventory Sheet " was brought to the attention of the DON on 7/31/15 at 9:20 AM and she stated she would look into it. The DON was interviewed at 7/31/15 at 11 AM and 12:50 PM and verified that the nurses had been documenting they were giving the Ativan on days on which they really had not administered it.	F 281		
F 329 SS=D	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	F 329		9/1/15

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 07/31/2015

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 329	Continued From page 5 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: Based on observation, record review and staff/family interviews the facility failed to provide Ativan administration monitoring to assure the doses were necessary and correctly administered for two (Resident # 1 and Resident # 2) of two sampled residents whose medications were reviewed. The findings include: 1. 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. Record review revealed the resident had been transferred to the hospital multiple times since his initial admission to the facility. Specific dates were as follows: The resident was admitted to the hospital on 6/21/15 and readmitted to the facility on 7/7/15. The resident was admitted to the hospital on 7/8/15 and returned to the facility on 7/13/15. Also on 7/18/15 the resident was evaluated at the hospital Emergency Room and returned that same day.	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 Medication administration records were reconciled with the narcotic sheets to validate that all residents had received their medications appropriately. METHOD TO IDENTIFY OTHERS	

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 07/31/2015

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 329	Continued From page 6 Review of the resident ' s current care plan revealed staff had identified " Resident is at risk for side effects from antianxiety drug use " as a problem with the onset date of 7/15/15 noted on the care plan. There were multiple care planned interventions which included but were not limited to " Administer Resident ' s medication as ordered by physician " and " monitor resident ' s behavior. " On 7/30/15 at 6:17 PM NA (Nurse Aide) # 1 was observed to go into Resident # 1 ' s room to set up his evening meal tray. The NA could be heard outside from the hallway setting the tray before Resident # 1. The NA stepped out of the room and the surveyor entered and found the resident appeared to be having a hard time staying awake and kept closing his eyes while he ate. The resident had two spoons on his tray. The resident was using one to eat and the other had been dipped down into his ice cream. The handle of the second spoon protruded upwards from the center of the ice cream cup. Using one of his two spoons the resident was attempting to scoop the ice cream out of the cup by dipping around the second spoon stuck down into the ice cream. The resident kept continuing to try to use one spoon to scoop around the other spoon, and his eyes kept closing while he attempted to do this. NA # 1 was asked about the resident at 6:30 PM and went to check on the resident. NA # 1 sat down to feed the resident and also noted him to be lethargic. NA # 1 stated she would go get a wash cloth and wash his face to see if he would awaken some. NA # 1 was asked if she had observed the resident to have any behavior issues and stated she had not. The NA stated he usually would feed himself and she would check on him periodically. Review of the resident ' s hospital discharge	F 329	The Clinical management team conducted an audit of all new admissions/readmissions for the previous 30 days to ensure all medications were transcribed correctly was started on 8/14/2015. 100% medication administration record audit was completed on 8/5/2015.Identified issues will be reviewed with the facility physician. SYSTEMIC CHANGES 1.Education began on 8/5/2015 by the DHS and/or the clinical nurse management team for all Licensed Nurses on medication administration. 2.Education will be conducted by the Southeastern Regional Area Health Education Center as to medication administration and ethics on 8/31/2015. 3. Education on medication administration with emphasis on documentation of medication in the Medication Record and Narcotic sheets will be conducted by United Pharmacy Services on 8/25/2015. 4.Clinical Management team will review the Medication Administration Records and Narcotic count sheets for accurate and complete documentation weekly x 4 weeks then monthly thereafter. MONITORING PROCESS Narcotic sheets are reconciled with Medication Administration Records to ensure medications are accuratley documented on the Medication Administration Record. Medication Administration Records are reviewed with	

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 07/31/2015

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 329	Continued From page 7 orders, facility physician orders and MARS (medication administration records) revealed the following with specific dates to be noted: Review of the resident ' s May 2015 and June 2015 monthly orders and the May 2015 and June 2015 MARS revealed the resident was ordered to receive Ativan 0.5 mg (milligrams) every day PRN (as needed) for anxiety. The PRN Ativan was documented as being administered only one time in May and June, 2015. This date was noted to be 6/21/15. Upon the resident ' s readmission date of 7/7/15 he was ordered to receive the Ativan again at the same dosage of 0.5 milligram and again on a (PRN) basis for anxiety. According to the MAR the resident was not documented as receiving any doses on 7/7/15 or 7/8/15 before he was transferred back to the hospital on 7/8/15. Upon the resident ' s return to the facility on 7/13/15 the resident was ordered the Ativan again in the same dosage and again on a PRN (as needed basis.) Specifically this order was found on the 7/13/15 hospital discharge medication list to read " Lorazepam (Ativan) 0.5 mg tablet Directions: 1 capsule oral daily as needed for anxiety. " Review of the July 2015 most recent physician orders revealed the Ativan was incorrectly transcribed as a regularly scheduled daily medication when the resident was readmitted to the facility on 7/13/15. On the resident ' s most recent July MAR the Ativan was transcribed as a scheduled medication to be given every day at 8 AM. Also on the July MAR there were multiple days that some nurses documented they gave the Ativan and some days were blank. These dates were after the facility ' s compliance date on which the facility alleged that medications were being monitored. Specific examples are on the following ten days where the resident was documented as receiving the Ativan as indicated	F 329	the Narcotic sheets to ensure accurate and complete documentation on the Narcotic sheets. 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 07/31/2015

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 329	Continued From page 8	F 329		

by nurses ' initials: 7/17/15, 7/19/15; 7/20/15; 7/21/15; 7/22/15; 7/23/15; 7/24/15; 7/27/15; 7/28/15; and 7/29/15. On the following dates there were blanks for the dates of 7/25/15 and 7/26/15. The initials for the date of 7/29/15 appeared to run into 7/30/15 making it difficult to distinguish if the nurse was documenting she administered it or not. On 7/18/15 the resident was documented as OOF (out of facility).
On 7/30/15 at 1:35 PM Nurse # 1 was interviewed in regards to the resident ' s Ativan. It was observed at this time, that the Ativan still appeared on the MAR as a regularly scheduled medication to be administered at 8 AM. As noted above the nurses had signed they had administered the Ativan at 8 AM on the above noted ten days. Review of the resident ' s Controlled Drug Receipt and Record Disposition Form revealed it had been signed out from the resident ' s controlled substance card only on four of the above ten days the nurses initialed they gave it. Theses dates were: 7/20/15; 7/22/15; 7/23/15; and 7/24/15. This review revealed the nurses ' documented administration of the resident ' s Ativan did not match the controlled Disposition Sheet where the nurses would have been required to sign for the removal of the drug from a locked narcotic/controlled substance box on the medication cart. Also, on the Controlled Drug Receipt and Record of Disposition sheet there were initials that the Ativan was signed out on 7/25/15 at 9 AM but as noted above there was a blank on the resident ' s MAR for the 25th. Nurse # 1 stated that she thought the Ativan was PRN (as needed) and had no further explanation of the initials on the MAR not reconciling with the Controlled Drug Receipt and Record of Disposition or why the medication still appeared on the MAR as a regularly scheduled 8 AM

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 07/31/2015

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 329	Continued From page 9	F 329		

medication. Nurse # 1 was interviewed again on 7/31/15 at 8:50 AM and questioned whether the resident had any behaviors. Nurse # 1 stated she had not observed the resident to have any behaviors or to be anxious.
Nurse # 2 was interviewed on 7/31/15 at 8:30 PM. Nurse # 2 stated she did help care for Resident # 1. Nurse # 2 was questioned regarding any behaviors or anxiety the resident might have and Nurse # 2 stated Resident # 1 was very pleasant and she had never known him to have any anxiety.
NA # 2 was interviewed on 7/31/15 at 8:38 PM and questioned regarding any behaviors or anxiety the resident had. NA # 2 stated the resident had no behaviors at all. Interview with NA # 2 revealed the resident was concerned over his arm which he had problems with recently but he didn ' t display anxiety over it.
Interview with the resident ' s responsible party on 7/30/15 at 4:30 PM revealed the responsible party was very knowledgeable about his condition and involved in his care. The family member stated she was concerned the resident didn ' t have " any spunk left anymore " after multiple recent hospitalizations. The responsible party was questioned about the resident ' s history of being prescribed Ativan and responded that it had always been ordered to be given on an as needed basis. The responsible party stated that the resident had been hospitalized so many times recently that she felt he might be depressed but she had not observed that he needed the PRN Ativan to be administered since he had last returned from the hospital because he was so tired all the time.
The DON (Director of Nursing) was interviewed at 7/31/15 at 11 AM and 12:50 PM about the inability to reconcile the Ativan doses on hand with the

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 07/31/2015

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 329	Continued From page 10	F 329		

resident ' s MAR and the reason why the resident was scheduled to receive the Ativan on a regular basis. The DON stated she had reviewed the record also since it had been brought to her attention by the surveyor on 7/30/15 and that the initial error had originated on 7/13/15 when the resident returned to the facility. The DON stated that the facility ' s system for admitting a resident from the hospital includes transcribing the medications twice and the steps were as follows. The staff first transcribe a resident ' s medications from the hospital discharge orders to a form entitled " NCSVH Medication Reconciliation Form. " This form is then given to the physician who will care for the resident at the facility. The physician then reviews the form and decides to either continue or discontinue the medications. The continuation or discontinuation of the medications is noted on the first form. Then a newly admitted resident ' s medications are transcribed a second time to a facility physician order sheet from the reconciliation form and signed by the physician. The DON showed the surveyor Resident # 1 ' s reconciliation form when the resident was readmitted on 7/13/15 and stated an error occurred in the first transcription of the Ativan. The nurse transcribed the Ativan as a regularly scheduled medication and not a PRN medication as the hospital discharge orders had been written. The DON stated that two nurses did not verify that the first transcription had been done correctly, and the error had gone undetected. The DON stated that she had also looked into the issue of the inability to reconcile the resident ' s number of Ativan doses on hand with the resident ' s MAR. The DON stated that two nurses had been involved. The DON verified that the nurses had been documenting they were giving the Ativan on days on which they really did

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 07/31/2015

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 329	Continued From page 11	F 329		

not administer it. The DON stated that she had talked with them and the nurses were under the impression that it was a PRN medication. The DON was questioned why the nurses would then sign they gave the Ativan and yet not administer it. The DON was also questioned why the nurses had not clarified the order if they thought it was PRN and yet continued to see it on the MAR as a regularly scheduled medication. The DON was unable to give a reason why they had done so. The DON stated the nurses were new nurses, and she had not been aware of the problem prior to the surveyor bringing it to her attention and thus she did not have an explanation why they would be documenting medication doses they did not give.

2. Record review revealed Resident # 2 was admitted to the facility on 5/29/12. The resident had multiple diagnoses which included but were not limited to the following: Dementia, Hypertension, Depression, Severe Degenerative Joint Disease, and History of Left Hip Fracture. Review of the resident ' s most recent care plan revealed the staff had identified the resident to have a history of Depression, Psychosis, Hypertension, and Anxiety. The problem onset date was noted as 3/18/15. The care plan also identified that the resident was at risk for side effects related to psychotropic medication use. Review of the physician orders revealed the resident was ordered to receive Ativan 0.5 mg (milligrams) twice per day on a regularly scheduled basis. The origin of the order was dated as 4/7/15.

The resident was observed on 7/30/15 at 8:40 AM; 9:15 AM; and 1:40 PM to be up in her wheelchair and not displaying any behaviors at the observation times. On 7/30/15 at 9:47 AM a staff member was observed as she checked

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 07/31/2015

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 329	Continued From page 12	F 329		

random rooms for clean bed linens. Resident # 2 was seated at her doorway during this time and did appear mildly anxious when asked if her room could be checked and stated she didn ' t want it to be checked. Interview with the acting DON (Director of Nursing) on 7/31/15 at 12:50 PM revealed the resident exhibited severe anxiety at times.

The following observation, interviews, and record reviews revealed the resident had not been receiving the Ativan as ordered. An observation of Resident # 2 ' s Ativan doses on hand in the medication cart was done with Nurse # 1 on 7/31/15 at 9:15 AM and the doses correlated with the Controlled Substance Inventory Sheet.

Review of Resident # 2 ' s July MAR on 7/31/15 at 9:15 AM revealed nurses had initialed they had administered the resident ' s Ativan twice per day every day of the month. Some of the days the nurses documented they administered the Ativan could not be reconciled with the Controlled Substance Inventory Sheet to show the nurses actually administered it as their initials on the MAR would indicate. Some specific examples are as follows: Nurses had initialed they had administered the Ativan on the following dates: the 8 AM dose of 7/26/15; the 8 AM dose of 7/27/15; the 8 PM dose of 7/28/15; and the 8 AM dose for 7/30/15. There was no documentation that the Ativan was ever removed from the locked narcotic/controlled substance drawer of the medication cart at those four times in order that the medication be given.

The inability to reconcile the resident ' s MAR with the Controlled Substance Inventory Sheet was brought to the attention of the DON on 7/31/15 at 9:20 AM and she stated she would look into it.

The acting DON was interviewed at 7/31/15 at 11 AM and 12:50 PM and verified that the nurses

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 07/31/2015

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 329	Continued From page 13 had been documenting they were giving the Ativan on days on which they really did not administer it.	F 329		
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 observation, record review, and staff interviews the facility failed to assure two (Resident # 1 and Resident # 2) of four sampled residents ' medical records were accurate and complete in relation to their medications. The findings included: 1. 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. Record review revealed the resident had been	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	9/1/15

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 07/31/2015

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 514	Continued From page 14 transferred to the hospital multiple times since his initial admission to the facility. Specific dates were as follows: The resident was admitted to the hospital on 6/21/15 and readmitted to the facility on 7/7/15. The resident was admitted to the hospital on 7/8/15 and returned to the facility on 7/13/15. Also on 7/18/15 the resident was evaluated at the hospital Emergency Room and returned that same day. The following information to be noted below with specific details revealed four problems with the accuracy and completeness of Resident #1 ' s medical record: An Ativan transcription error on the resident ' s medical record had gone undetected; the resident ' s MAR (Medical Administration Record) had multiple documented times when the resident received Ativan when he did not do so; an old MAR (Medical Record Administration Record) which was no longer intended to be in use had documentation on days when it had been replaced by a more current MAR, and there were multiple blanks for multiple medications on the resident ' s current MAR. The following was found in regards to the resident ' s undetected Ativan transcription error: Upon the resident ' s return to the facility on 7/13/15 the resident was ordered to receive Ativan 0.5 mg (milligrams) every day PRN (as needed) for anxiety according to the 7/13/15 hospital discharge medication list. Review of the facility ' s physician orders revealed the Ativan was incorrectly transcribed as a regularly scheduled daily medication when the resident was readmitted to the facility on 7/13/15. The DON (Director of Nursing) was interviewed at 7/31/15 at 11 AM and 12:50 PM about the reason why the transcription error had occurred. The acting DON stated she had reviewed the record also since it had been brought to her attention by the	F 514	continue to improve the quality of care and services to our residents. IMMEDIATE ACTION Medication administration records were reconciled with the narcotic sheets to validate that all residents had received their medications appropriately. METHOD TO IDENTIFY OTHERS The Clinical management team conducted an audit of all new admissions/readmissions for the previous 30 days to ensure all medications were transcribed correctly was started on 8/14/2015. 100% medication administration record audit was completed on 8/5/2015.Identified issues will be reviewed with the facility physician. SYSTEMIC CHANGES 1.Education began on 8/5/2015 by the DHS and/or the clinical nurse management team for all Licensed Nurses on medication administration. 2.Education will be conducted by the Southeastern Regional Area Health Education Center as to medication administration and ethics on 8/31/2015. 3. Education on medication administration with emphasis on documentation of medication in the Medication Record and Narcotic sheets will be conducted by United Pharmacy Services on 8/25/2015. 4.Clinical Management team will review the Medication Administration Records and Narcotic count sheets for accurate	

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 07/31/2015

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 514	Continued From page 15 surveyor on 7/30/15 and that the initial error had originated on 7/13/15 when the resident returned to the facility. The acting DON stated that the facility ' s system for admitting a resident from the hospital includes transcribing the medications twice and the steps were as follows. The staff first transcribe a resident ' s medications from the hospital discharge orders to a form entitled " NCSVH Medication Reconciliation Form. " This form is then given to the physician who will care for the resident at the facility. The physician then reviews the form and decides to either continue or discontinue the medications. The continuation or discontinuation of the medications is noted on the first form. Then a newly admitted resident ' s medications are transcribed a second time to a facility physician order sheet from the reconciliation form and signed by the physician. The DON showed the surveyor Resident # 1 ' s reconciliation form when the resident was readmitted on 7/13/15 and stated an error occurred in the first transcription of the Ativan. The nurse transcribed the Ativan as a regularly scheduled medication and not a PRN medication as the hospital discharge orders had been written. The DON stated that two nurses did not verify that the first transcription had been done correctly, and the error had gone undetected The following details are in regards to a nurse documenting on the resident ' s old MAR which was no longer in use on the day which the nurse was documenting on it: The resident ' s previous July MAR was reviewed with the DON. This MAR was for the resident ' s 7/7/15 facility admission when the resident was sent back to the hospital within 24 hours. It was confirmed with the DON that this MAR should have only been in use for the date of 7/7/15 and a new MAR had been made when the resident returned on 7/13/15.	F 514	and complete documentation weekly x 4 weeks then monthly thereafter. MONITORING PROCESS Narcotic sheets are reconciled with Medication Administration Records to ensure medications are accuratley documented on the Medication Administration Record. Medication Administration Records are reviewed with the Narcotic sheets to ensure accurate and complete documentation on the Narcotic sheets. 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 07/31/2015

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 514	Continued From page 16	F 514		

Review of the old 7/7/15 MAR revealed that on the date of 7/27/15 a nurse initialed off on the resident ' s old MAR in addition to the current MAR that she had given medications at 8 PM. The nurse had marked through her initials on the old MAR where she had signed off nine different orders. The DON was questioned why the nurse would have been signing on two different MARs and she responded that she did not know. The DON stated that the old MAR typically was kept on the current MAR book, turned backwards, and stapled and the nurse would have had to turn it forwards and unstaple the pages.

The following details are in regards to the nurses documenting Ativan administration with no evidence they administered the Ativan: By law Ativan is considered a controlled medication and nurses are required to sign when they remove an Ativan dose from a locked storage area prior to the administration of the Ativan. The following observation and review revealed the nurses were signing on the resident ' s MAR they gave the Ativan on days on which there was no evidence they ever removed the medication and did so.

All of the resident ' s available, stored Ativan pills were observed with Nurse # 1 on 7/30/15 at 1:35 PM. There were 22 Ativan doses left on the current Ativan card in use and this matched the resident ' s " Controlled Drug Receipt and Record of Disposition Form, " which would indicate that the " Controlled Drug Receipt and Record of Disposition Form " was accurate. As noted above the nurses had signed they had administered the Ativan at 8 AM on the above noted ten days on the resident ' s MAR. Review of the resident ' s " Controlled Drug Receipt and Record Disposition Form " revealed the Ativan had been signed out from the resident ' s controlled substance card only on four of the ten

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 07/31/2015

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 514	Continued From page 17	F 514		

days the nurses initialed they gave it. Theses dates were: 7/20/15; 7/22/15; 7/23/15; and 7/24/15. This would indicate that the nurses were initialing they administered the Ativan on the MAR when they had no record of proof they had done so. Also, on the resident ' s Ativan " Controlled Drug Receipt and Record of Disposition Form " there were initials that the Ativan was signed out on 7/25/15 at 9 AM but as noted above there was a blank on the resident ' s MAR for the 25th. The DON (Director of Nursing) was interviewed at 7/31/15 at 11 AM and 12:50 PM about the inability to reconcile the Ativan doses on hand with the resident ' s MAR. The DON verified that nurses had been documenting they were giving the Ativan on days on which they really had not administered it.

In addition to the Ativan blanks on the resident ' s current MAR there were multiple blanks observed when the MAR was reviewed on 7/30/15 at 1:15PM for other non- controlled medications. Specific medications and times that were blank were as follows: Lasix (40 mg dose ordered twice per day)--blanks were observed for 8 AM doses on 7/25/15, 7/26/15, 7/27/15, and 7/28/15; the anticonvulsant medication of Keppra (1000 mg ordered twice per day)---a blank was observed for the 8 AM dose on 7/25/15; Potassium Chloride (10 mill equivalents to be administered daily)-a blank was observed on the MAR for the 8 AM dose of 7/25/15; Magnesium Oxide (400 mg to be administered twice per day)-a blank was observed for the 8 AM dose of 7/25/15; Vitamin D2 (50,000 Units to be given twice per day)-a blank was observed for the 8 AM dose of 7/25/15; also the nurse circled her initials for the administration of the Vitamin D2 on the 8 PM doses of 7/18/15, 7/19/15, and the 8 AM dose of 7/26/15 without noting the reason why the

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 07/31/2015

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 514	Continued From page 18	F 514		

medication was not given (the circled initials would have indicated that the medication was not given or it was held and the reason documented on the back of the MAR). No reason was documented.
2. Record review revealed Resident # 2 was admitted to the facility on 5/29/12. The resident had multiple diagnoses which included but were not limited to the following: Dementia, Hypertension, Depression, Severe Degenerative Joint Disease, and History of Left Hip Fracture. Review of the physician orders revealed the resident was ordered to receive Ativan 0.5 mg (milligrams) twice per day on a regularly scheduled basis. The origin of the order was dated as 4/7/15.
Review of Resident # 2 ' s July MAR on 7/31/15 at 9:15 AM revealed nurses had initialed they had administered the resident ' s Ativan twice per day every day of the month. All of the resident ' s available, stored Ativan pills were observed with Nurse # 1 on 7/31/15 at 9:15 AM. There were 24 Ativan pills left on the current Ativan card in use and this matched the resident ' s " Controlled Substance Inventory Sheet, " which would indicate that the " Controlled Substance Inventory Sheet, " was accurate. Review of the resident ' s " Controlled Substance Inventory Sheet " could not be reconciled with four dates on the resident ' s MAR. Nurses had initialed they had administered the Ativan on the following dates and the " Controlled Substance Inventory Sheet " contained no documentation that the nurses had removed the medication from the cart: the 8 AM dose of 7/26/15; the 8 AM dose of 7/27/15; the 8 PM dose of 7/28/15; and the 8 AM dose for 7/30/15.
The inability to reconcile the resident ' s MAR with the " Controlled Substance Inventory Sheet "

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 07/31/2015

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 514	Continued From page 19 was brought to the attention of the DON on 7/31/15 at 9:20 AM and she stated she would look into it. The DON was interviewed at 7/31/15 at 11 AM and 12:50 PM and verified that the nurses had been documenting on the MAR they were giving the Ativan on days on which they really had not administered it.	F 514		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 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. 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. 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. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520		9/1/15

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 07/31/2015

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 520	Continued From page 20 Based on observations, record reviews and staff interviews the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in June 2015. This was for two recited deficiencies which were originally cited on a complaint investigation completed on 6/23/15 and were recited on a survey completed on 7/31/15. The deficiencies were in the areas of medication administration monitoring and maintenance of complete and accurate medical records. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1a. F 329: Based on observation, record review and staff/family interviews the facility failed to provide Ativan administration monitoring to assure the doses were necessary and correctly administered for two (Resident # 1 and Resident # 2) of two sampled residents whose medications were reviewed. The facility was recited for F 329 for failing to provide Ativan medication monitoring for Resident # 1 who was identified in the June 23, 2015 complaint investigation to have a lack of medication monitoring in relation to his Dilantin. Additionally on the follow up survey the facility failed to monitor Ativan medication administration monitoring for Resident # 2.	F 520	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 Medication administration records were reconciled with the narcotic sheets to validate that all residents had received their medications appropriately. METHOD TO IDENTIFY OTHERS The Clinical management team conducted an audit of all new admissions/readmissions for the previous 30 days to ensure all medications were transcribed correctly was started on 8/14/2015. 100% medication administration record audit was completed on 8/5/2015.Identified issues will be reviewed with the facility physician. SYSTEMIC CHANGES 1.Education began on 8/5/2015 by the	

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 07/31/2015

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 520	Continued From page 21 1b. F 514: Based on observation, record review, and staff interviews the facility failed to assure two (Residents # 1 and Resident # 2) of four sampled residents ' medical records were accurate and complete in relation to their medications. The facility was recited for F 514 for failing to maintain accurate and complete medical records. During a complaint investigation of June 23, 2015 the facility was cited for F 514 for failing to assure medical records were complete regarding documentation of medication administration. During the complaint follow up survey of 7/31/2015 the facility failed to assure Resident # 1 ' s and Resident # 2 ' s MAR were accurate and complete. The acting DON was interviewed on 7/31/15 at 12:50 PM and questioned about the facility ' s quality assurance efforts to correct the deficient practices cited during the facility ' s complaint investigation of 6/23/15. The DON stated that she had been in the facility only for the past two weeks and that the facility had implemented the plan of correction but she had discovered that there was more involved than just in servicing the staff to correct the problem and doing quality assurance audits. The DON stated since she had been in the building she had been busy developing methods to take more of the work load off of the hall nurses so that they could have more time to be attentive to their medication administration and documentation. The DON stated she had held in services on a regular basis and that she perceived that time was a factor in the facility ' s failure to correct the deficient	F 520	DHS and/or the clinical nurse management team for all Licensed Nurses on medication administration. 2.Education will be conducted by the Southeastern Regional Area Health Education Center as to medication administration and ethics on 8/31/2015. 3. Education on medication administration with emphasis on documentation of medication in the Medication Record and Narcotic sheets will be conducted by United Pharmacy Services on 8/25/2015. 4.Clinical Management team will review the Medication Administration Records and Narcotic count sheets for accurate and complete documentation weekly x 4 weeks then monthly thereafter. MONITORING PROCESS Narcotic sheets are reconciled with Medication Administration Records to ensure medications are accuratley documented on the Medication Administration Record. Medication Administration Records are reviewed with the Narcotic sheets to ensure accurate and complete documentation on the Narcotic sheets. 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 07/31/2015

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 520	Continued From page 22 practice. The DON stated that although routines had been developed to decrease the medication nurses ' workload and the staff had been in serviced, she perceived they needed someone to actually follow along with them on a daily basis and stand by them as they learned to correct some of the deficient practice observed.	F 520		