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 _____	03/23/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and	F 272		4/14/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/10/2017

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F 272	Continued From page 1 non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete Care Area Assessment summaries which included underlying causes, risk factors and factors to be considered in developing individualized care plan interventions for 2 of 32 residents with comprehensive assessments (Resident #25 and 158). The findings included: 1. Resident #25 was re-admitted to the facility on 8/11/15 and had diagnoses of Cerebrovascular Accident (Stroke) and Mood Disorder. Review of the physician ' s orders for August 2016 revealed Resident #25 had an order for Haldol, an antipsychotic medication. The Annual Minimum Data Set (MDS) dated 8/4/16 under section N did not indicate the resident received an antipsychotic medication. The Care Area Assessment for Psychotropic Drug Use dated 8/4/16 under Analysis of Findings provided no information regarding the need for an antipsychotic medication or that the resident was on an antipsychotic medication. On 3/23/17 at 2:15 PM, MDS Nurse #1 stated in an interview that she did the MDS Assessment	F 272	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. Step 1 Assessments with deficiency found for resident #25 and resident #158 will be modified to comply with RAI Manual/Medicaid/Federal Guidelines by 4/13/2017. Step 2 To complete 100% audit of all Comprehensive assessments for ALL	

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

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F 272	Continued From page 2 and the Care Area Assessment for Psychoactive Drug use for Resident #25. The MDS Nurse stated she checked the resident ' s chart and he did receive Haldol during the look back period for the assessment completed on 8/4/16. The MDS Nurse stated she did not know why she missed the antipsychotic medication. 2. Resident #158 was admitted to the facility on 9/22/16 and had a diagnosis of Alzheimer ' s Dementia. Review of the Care Area Assessment (CAA) Summary dated 9/22/16 revealed Nutrition triggered for Resident #158 and a CAA needed to be completed for the resident. The CAA for Nutrition provided by the facility was blank and had not been completed. On 3/23/17 at 11:37 AM MDS Nurse #1 stated in an interview she reviewed the Nutrition CAA for Resident #158 and the CAA was not done. The MDS Nurse stated the dietary manager usually did the Nutrition CAAs. The MDS Nurse stated she signed that the assessment was completed but must have been an oversight. On 3/23/17 at 1:53 PM the Dietary Manager stated in an interview she knew she was supposed to do section K of the MDS but was not aware she needed to do the CAA for nutrition also.	F 272	Active residents from 1/1/2017 to 4/9/2017 to ensure all Care Area Assessments have been completed and are accurate. Step 3 1. Education began on 4/10/2017 by the Clinical Reimbursement Coordinator and/or designee for the Interdisciplinary Team on completing Care Area Assessments with comprehensive assessments, per the RAI Manual/Federal Guidelines. 2. All new Interdisciplinary team members will be educated upon hire during orientation on completing Care Area Assessments with comprehensive assessments, per the RAI Manual/Federal Guidelines. 3. A Care Area Assessment audit tool will be implemented by the Case Mix Director (CMD), and will be completed as follows by the Interdisciplinary Team :5 times per week for 4 weeks then,2 times per week for 4 weeks, and then audit done monthly for 3 months. Step 4 Monitoring will be done by the Case Mix Director (RN) and/or Designee to ensure all Care Area Assessments are completed and accurate with each Comprehensive Assessment. Continued monitoring will then occur 5 times per week for 4 weeks, then 2 times per week for 4 weeks, and then monthly for 3 months. Results of the monitoring, with tracking and trending, will	

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F 272	Continued From page 3	F 272	be reported by Case Mix Director□s (RN) monthly to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 278		4/14/17

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F 278	Continued From page 4 (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) Assessment in section N and section K of the MDS for 3 of 32 residents reviewed (Resident #25, #143 and #151). The findings included: 1. Resident #25 was re-admitted to the facility on 8/11/15 and had a diagnosis of Alzheimer ' s Dementia and Mood Disorder. Review of the physician ' s monthly orders for August 2016 revealed an order for Haldol, an antipsychotic medication. Section N of the Annual MDS dated 8/4/16 did not show the resident received an antipsychotic medication. On 3/23/17 MDS Nurse #1 stated in an interview that Resident #25 was on Haldol during the look back period for the assessment completed on 8/4/16. The MDS Nurse stated she completed the MDS and did not know why she missed the antipsychotic medication. 2. Resident #143 was admitted to the facility on 10/15/16 and had a diagnosis of Alzheimer ' s Dementia. Review of the Admission Minimum Data Set (MDS) Assessment dated 10/28/16 under Section K revealed a dash in the space the resident ' s height was to be entered. When reviewing the resident ' s medical record, a height could not be	F 278	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. Step 1 Assessments with deficiency found for resident #25 and resident #143 will be modified on 4/10/2017 to comply with RAI /anual/Medicaid/Federal Guidelines. Step 2 To complete 100% audit of all Comprehensive assessments for ALL Active residents from 1/1/2017 to 4/9/2017 to ensure all Section N and Section K have been completed, without dashes, and are accurate. Step 3	

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F 278	Continued From page 5 found in the record. The facility provided a document from restorative nursing that revealed on 10/15/16 the resident ' s height was 67 inches. On 3/23/17 at 1:56 PM the Dietary Manager stated in an interview that she tried to stay ahead on her MDS assessments and if she got the chart before the restorative nursing staff (who obtained the height on residents), the height was not available when she did the assessment and she did not go back and complete the assessment after restorative nursing documented the height. 3. Resident #151 was admitted to the facility on 10/17/16 and had a diagnosis of Alzheimer ' s Dementia. Review of the Admission Minimum Data Set (MDS) Assessment dated 10/24/16 under Section K revealed a dash in the space the resident ' s height was to be entered. Review of the Admission Nursing Assessment and the resident ' s weight sheet revealed the space to enter the resident ' s height was blank. The facility ' s consultant dietician provided the FL2 that accompanied the resident on admission to the facility and listed the resident ' s height. A FL2 is a form that is filled out by the attending physician that gives a summary of the resident ' s medical requirements and reflects the physician ' s recommendation for the level of care needed in an institutional setting. On 3/23/17 at 12:20 PM MDS Nurse #1 stated in an interview the dietary manager did section K of the MDS Assessment.	F 278	1. Education began on 4/10/2017 by the Clinical Reimbursement Coordinator and/or designee for the Case Mix Director and Interdisciplinary Team on completing Section N and Section K with comprehensive assessments, per the RAI Manual/Federal Guidelines. 2. An Assessment audit tool for Section N and Section K of the MDS will be implemented by the Case Mix Director (CMD), and will be completed as follows by the Interdisciplinary Team :5 times per week for 4 weeks then,2 times per week for 4 weeks, and then audit done monthly for 3 months. Step 4 Monitoring will be done by the Case Mix Director (RN) and/or Designee to ensure Section N and Section K of the MDS are completed and accurate Assessment. Continued monitoring will then occur 5 times per week for 4 weeks, then 2 times per week for 4 weeks, and then monthly for 3 months. Results of the monitoring, with tracking and trending, will be reported by Case Mix Director□s (RN) monthly to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes.	

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F 278	Continued From page 6 On 3/23/17 at 1:56 PM the Dietary Manager stated in an interview that she tried to stay ahead on her MDS assessments and if she got the chart before the restorative nursing staff (who obtained the height on residents), the height was not available when she did the assessment and she did not go back and complete the assessment after restorative nursing documented the height.	F 278		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data	F 356		4/14/17

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F 356	Continued From page 7 specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of staff schedules, the facility failed to post accurate staffing data on the Daily Staffing Posting for 7 of 174 days reviewed. A review of the Daily Staffing Posting for the dates of 10/16/2016 - evening shift, 10/20/2016 - night shift, 10/22/2016 - evening shift, 12/30/2016 - evening shift, 12/31/2016 - night shift, and 02/09/2017 - night shift, and 03/18/2017 - night shift revealed no documentation of census and nursing staff. An interview on 3/22/2016 at 10:45 AM with the Administrator was done regarding no posting of the census and nursing staff. Interview revealed the Daily Staffing Posting should have been	F 356	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.	

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F 356	Continued From page 8 completed for the identified shifts. The Administrator stated it was her expectation that the staff was to accurately complete the Daily Staffing Posting on each shift. Copies of the nursing schedules and time sheets were provided by the Administrator indicated nursing staff were on duty.	F 356	Step 1 Reviewed current staffing sheets to ensure all were complete and posted per regulation. Step 2 All staffing needs were met per regulation. There were no residents at risk. Step 3 1. Education began on 3/22/2017 by the Clinical Competency Coordinator for all Registered Nurse□s on completing and posting nursing staffing data daily. 2. All new Registered Nurses will be educated upon hire during orientation on completing and posting nursing staffing data daily. 3. A Nursing Staffing audit tool for will be implemented by the Administrator and will be completed as follows by the Director of Nursing (RN) :5 times per week for 4 weeks then,2 times per week for 4 weeks, and then audit done monthly for 3 months. Step 4 Monitoring will be done by the Director of Nursing (RN) and/or Designee to ensure that nursing staffing data is posted daily. Continued monitoring will then occur 5 times per week for 4 weeks, then 2 times per week for 4 weeks, and then monthly for 3 months. Results of the monitoring, with tracking and trending, will be reported	

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F 356	Continued From page 9	F 356	by Director of Nursing (RN) monthly to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes.	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to discard abraded dome plate lids that could cause possible food contamination for 36 of 36 dome lids observed. The findings	F 371	This time line investigation and plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation	4/14/17

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F 371	Continued From page 10 included: On 3/23/17 at 9:15 AM an observation of the kitchen revealed drying racks with dome lids used to cover plates of food to keep the food warm until served to the residents. The interior surface of the dark red dome lids was abraded with some raw edges on the inner surface of the dome lids. On 3/23/17 at 9:20 AM the Dietary Manager stated for the past several months she had been replacing 1-2 cases (12 per case) of dome lids per month as her budget allowed. On 3/23/17 at 4:00 PM the Administrator stated they started a fine dining program and as part of that they had started to replace the dome lids to improve the looks of the table.	F 371	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. Step 1 36 dome plate lids were ordered on 3/23/2017. Step 2 A 100% audit of dome plate lids was done to ensure satisfactory condition by federal, state, and local authorities. Step 3 1. Education began on 3/23/2017 by the Dietary Manager for all Dietary Aides on discarding materials that could potentially cause food contamination. 2. All new Dietary partners will be educated upon hire during orientation on discarding materials that could potentially cause food contamination. 3. A dietary materials audit tool for will be implemented by the Registered Dietitian (RD) and Dietary Manager and will be completed as follows by the Cooks :5 times per week for 4 weeks then, 2 times	

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F 371	Continued From page 11	F 371	per week for 4 weeks, and then audit done monthly for 3 months. Step 4 Monitoring will be done by the Registered Dietitian (RD) and Dietary Manager to ensure that we are not using dietary materials that could potentially cause food contamination. Continued monitoring will then occur 5 times per week for 4 weeks, then 2 times per week for 4 weeks, and then monthly for 3 months. Results of the monitoring, with tracking and trending, will be reported by Dietary Manager monthly to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes.	