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 06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		7/23/18

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

Electronically Signed | 07/23/2018

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F 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the failed to notify the resident's responsible party after a fall (Resident #1) and failed to notify the resident's physician and responsible party (Resident #2) for 2 of 3 residents sampled for falls. Findings included: 1. Resident #1 was admitted to the facility on 04/07/16 with diagnoses which included dementia, generalized muscle weakness, lack of coordination, osteoporosis, osteoarthritis and heart disease. A review of a care plan with an onset date of 08/11/17 indicated Resident #1 was at risk for falls due to lower extremity weakness, poor balance, often attempted to transfer self, dementia and osteoporosis. The goal revealed Resident #1 would not experience any serious injuries related to falls and the approaches and interventions indicated in part to monitor for changes in resident's condition that may warrant increased supervision or assistance and notify physician, keep room and surrounding area free of clutter, keep frequently used items within	F 580	This 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 the deficiency. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. Process that lead to the Deficiency: Resident was admitted to the facility on 4/7/2016. Root Cause Analysis. Failure to notify Responsible party/MD of incident. Charge nurse did not immediately notify families per policy. On 6/2/18 Resident #1 had an unwitnessed fall without injuries at 5:00 am. Charge nurse on shift did not	

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F 580	Continued From page 2	F 580		

reach, provide cueing and re-direction as needed for safety and landing strips to bedside.

A review of the most recent quarterly Minimum Data Set (MDS) dated 05/11/18 indicated Resident #1 was severely impaired in cognition for daily decision making. The MDS also indicated Resident #1 required limited assistance with bed mobility and transfers.

A review of an incident report dated 06/02/18 at 5:00 AM indicated Nurse #1 saw NA #1 going to Resident #1's room and followed her. The report further indicated Nurse #1 saw Resident #1 sitting on the floor mat with his back resting against the bed and Resident #1 stated he was trying to go back to bed and he slid onto the floor. A section labeled actions taken indicated the physician was notified on 06/02/18 but the section labeled family notified was blank.

A review of nurse's progress notes dated 06/02/18 at 6:09 AM indicated Nurse #1 saw NA #1 going to Resident #1's room and followed her. The notes revealed Resident #1 was sitting on the fall mats on the floor and his back was resting on the bed and Resident #1 stated he was trying to go back to bed and slid on the floor. The notes further revealed Resident #1 denied pain or discomfort, there were no injuries and neurological checks were started. The notes also revealed a body audit was done and there was no new redness, discoloration or open areas seen and a House Supervisor was notified and Nurse #1 let the incoming shift know to call Responsible Party (RP) on normal waking hours.

A review of nurse's progress notes dated 06/03/18 at 2:41 PM by Nurse #2 revealed immediately notify RP/MD and passed to oncoming shift who did not notify RP. At 8:00am on 6/2/18 IDT team and DHS reviewed incident report but did not follow up on notifications of RP/MD. On 5/12/18 Resident #2 had an unwitnessed fall without injuries at 4:00pm. Charge nurse on shift failed to notify RP/MD of fall.

Process for implementing the acceptable plan of correction for specific deficiency.

On 7/3/2018 Staff was in-serviced by Staff Educator on fall policy/procedures as well as nursing documentation and notifications of Responsible party and Medical Director. On 7/22/18 a 100% audit was completed on all falls to ensure proper documentation and reporting was completed.

Monitoring procedure to ensure that the plan of correction is effective.

As of 7/3/18 a fall avoidance book will be kept by Director of Health Services and reviewed daily for 4 weeks, then weekly for 6 weeks thereafter to ensure fall policies and procedures were conducted and documented per CMS standards. DHS will complete a log showing daily review and Administrator will initial daily showing review of compliance. Performance Improvement plan was implemented 7/22/18 to ensure daily audits are being completed by IDT and DHS and reviewed daily by Administrator.

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Resident #1 voiced severe pain to right lower back which was unrelieved by scheduled Tylenol. The notes further revealed a call was placed to a Nurse Practitioner (NP) and new orders were received for Percocet 2.5 milligrams (mg) by mouth now but if unrelieved give 2.5 mg again by mouth and family was in to visit with resident.

During an interview on 06/27/18 at 2:53 PM, the House Supervisor explained she thought Resident #1 had a fall on a weekend. She stated if a resident had a fall without injury during night shift, staff usually waited until the end of shift to call the RP but if there was injury they called the RP immediately. She further stated the nurse who assessed the resident was responsible for completion of the incident report and confirmed Nurse #1 documented Resident #1's fall on an incident report.

During an interview on 06/27/18 at 5:56 PM, Nurse #1 stated on 06/02/18 he was giving medications and saw NA #1 running down the hall and he followed her into Resident #1's room. He explained Resident #1 was sitting on the fall mat with his back against the bed but Resident #1 did not complain of pain. He further explained he assessed Resident #1 and did neurological checks and filled out an incident report. He stated since Resident #1 was not complaining of pain he reported to Nurse #2 who was the day shift nurse and confirmed he did not call the physician on call or the RP. He explained he considered the gravity of the fall and if there was no pain or injury he let the day shift nurse call the physician and RP during normal waking hours.

During an interview on 06/28/18 at 10:50 AM, Nurse #3 explained she was not working when

Title of Person Responsible for implementing the acceptable plan of correction.

The Administrator is responsible for implementing the acceptable plan of correction.

Date of Compliance: 07/23/2018

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Resident #1 had a fall on 06/02/18. She stated she came to work on Monday 06/04/18 and Resident #1's fall was reported to her. She further stated nursing staff were supposed to notify the physician and RP at the time of an incident such as a fall. She explained she normally tried to call the RP as soon as it happened but she was aware night shift nurses passed it on to the day shift to call the RP if the resident was not injured and the nurse who called the RP should make a note that they notified them.

During an interview on 06/28/18 at 11:38 AM, Nurse Practitioner #1 stated she saw Resident #1 on 06/07/18 for pain management due to a fall. She further stated it was her expectation the RP should be notified after a resident had a fall.

During a telephone interview on 06/28/18 at 1:05 PM, Nurse #2 confirmed she received a report from Nurse #1 that Resident #1 slid out of bed on 06/02/18 when he attempted to take himself to the bathroom. She stated she did not call the RP after report on 06/02/18 because she thought Nurse #1 had tried to call them. She further stated she talked with the RP on Sunday 06/03/18 and the RP had reported to her that no one had called her about Resident #1's fall.

During an interview on 06/28/18 at 12:38 PM, the Interim Director of Health Services explained it was her expectation when a resident had a fall, the nurse should do a body audit, pain assessment and assess for injury. She stated she expected for the nurse to notify the physician and RP. She further stated someone should have called the RP on 06/02/18 after Resident #1's fall and it should have been documented and

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F 580	Continued From page 5	F 580		

the contact date and time with the physician was supposed to be documented on the incident report.

During an interview on 06/28/18 at 12:50 PM, the Administrator stated it was his expectation for nursing staff to follow the steps that needed to be done after a fall and to make all notifications with the physician and RP they needed to make. He further stated if staff had questions he expected for them to call the Interim Director of Health Services.

2. Resident #2 was admitted to the facility on 11/10/17 with diagnoses which included kidney disease, Type 2 diabetes, anxiety, depression and a history of a stroke.

A review of the most recent quarterly Minimum Data Set dated 04/11/18 revealed Resident #2 was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #2 required extensive assistance with bed mobility and transfers.

A review of a care plan dated 01/09/18 indicated Resident #2 was at high risk for falls due to attempts to stand with an unsteady gait. The goal revealed Resident #2 would will not experience any serious injuries related to falls and the interventions indicated in part to monitor for changes in condition that may warrant increased supervision or assistance, keep room and surrounding areas free of clutter, keep frequent used item within reach, non-skid socks on while in bed, attempt to keep resident in high traffic areas and when resident showed increased attempts to stand alone or had increased restlessness and agitation and have staff provide

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F 580	Continued From page 6	F 580		

1:1 visits for distraction and call family so he may speak with them on the phone.

A review of nurse's progress notes dated 05/12/18 at 12:10 AM indicated Resident #2 needed frequent reminders and redirection to use call light for assistance but redirection was effective short term.

A review of an incident report dated 05/12/18 at 4:00 PM completed by Nurse #4 revealed a Nurse Aide (NA) walked by Resident #2's room and observed him sitting on floor in front of a recliner. The report indicated Resident #2 had no apparent injury, an assessment was performed and he was alert and oriented. A section labeled notification of physician and family were blank.

During an interview on 06/28/18 at 11:00 AM, Nurse #4 stated she was being oriented by Nurse #5 and recalled a NA reported she found Resident #2 on the floor in front of his recliner. She explained she and Nurse #5 assessed Resident #2 and he had no apparent injury so they assisted Resident #2 back into his recliner. She stated Nurse #5 said she would call the physician and family so Nurse #4 stated she did not call the physician or family.

During a telephone interview on 06/28/18 at 12:30 PM, Nurse #5 stated she did not recall Resident #2's fall on 05/12/18 but did remember orienting a new nurse. She explained it was protocol when a resident had a fall to assess the resident and notify the physician and family and complete an incident report and the physician and family should have been notified after Resident #2's fall.

During an interview on 06/28/18 at 12:38 PM, the

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F 580	Continued From page 7 Interim Director of Health Services explained it was her expectation when a resident had a fall, the nurse should do a body audit, pain assessment and assess for injury. She stated she expected for the nurse to notify the physician and RP. She further stated someone should have called the RP on 06/02/18 after Resident #1's fall and it should have been documented and the contact date and time with the physician was supposed to be documented on the incident report. During an interview on 06/28/18 at 12:50 PM, the Administrator stated it was his expectation for nursing staff to follow the steps that needed to be done after a fall and to make all notifications with the physician and RP they needed to make. He further stated if staff had questions he expected for them to call the Interim Director of Health Services.	F 580		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 842		7/23/18

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(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;

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F 842	Continued From page 9 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the failed to complete documentation on an incident report after a fall (Resident #1) and failed to document a resident fall in the nurse's progress notes and complete documentation on an incident report (Resident #2) for 2 of 3 residents sampled for falls. Findings included: 1. Resident #1 was admitted to the facility on 04/07/16 with diagnoses which included dementia, generalized muscle weakness, lack of coordination, osteoporosis, osteoarthritis and heart disease. A review of a care plan with an onset date of 08/11/17 indicated Resident #1 was at risk for falls due to lower extremity weakness, poor balance, often attempted to transfer self, dementia and osteoporosis. The goal revealed Resident #1 would not experience any serious injuries related to falls and the approaches and interventions indicated in part to monitor for changes in resident's condition that may warrant increased supervision or assistance and notify physician, keep room and surrounding area free	F 842	Process that lead to the Deficiency: Root Cause Analysis. Failure to notify Responsible party/MD of incident. Charge nurse did not immediately notify families per policy. On 6/2/18 Resident #1 had an unwitnessed fall without injuries at 5:00 am. Charge nurse on shift did not immediately notify RP/MD and passed to oncoming shift who did not notify RP. At 8:00am on 6/2/18 IDT team and DHS reviewed incident report but did not follow up on notifications of RP/MD. On 5/12/18 Resident #2 had an unwitnessed fall without injuries at 4:00pm. Charge nurse on shift failed to notify RP/MD of fall. Process for implementing the acceptable plan of correction for specific deficiency. On 7/3/2018 Staff was in-serviced by Staff Educator on fall policy/procedures as well as nursing documentation and notifications of Responsible party and Medical Director. On 7/22/18 a 100% audit was completed on all falls to ensure	

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F 842	Continued From page 10	F 842		

of clutter, keep frequent used items within reach, provide cueing and re-direction as needed for safety and landing strips to bedside.

A review of the most recent quarterly Minimum Data Set (MDS) dated 05/11/18 indicated Resident #1 was severely impaired in cognition for daily decision making. The MDS also indicated Resident #1 required limited assistance with bed mobility and transfers.

A review of an incident report dated 06/02/18 at 5:00 AM indicated Nurse #1 saw NA #1 going to Resident #1's room and followed her. The report further indicated Nurse #1 saw Resident #1 sitting on the floor mat with his back resting against the bed and Resident #1 stated he was trying to go back to bed and he slid onto the floor. A section labeled actions taken indicated the physician was notified on 06/02/18 but there was no time documented when the physician was notified and the section labeled family notified was blank.

A review of nurse's progress notes dated 06/02/18 at 6:09 AM indicated Nurse #1 saw NA #1 on duty going to Resident #1's room and followed her. The notes revealed Resident #1 was sitting on the fall mats on the floor and his back was resting on the bed and Resident #1 stated he was trying to go back to bed and slid on the floor. The notes further revealed Resident #1 denied pain or discomfort, there were no injuries and neurological checks were started. The notes also revealed a body audit was done and there was no new redness, discoloration or open areas seen and a House Supervisor was notified and Nurse #1 let incoming shift know to call Responsible Party (RP) on normal waking hours. The notes further revealed there was no proper documentation and reporting was completed.

Monitoring procedure to ensure that the plan of correction is effective.

As of 7/3/18 a fall avoidance book will be kept by Director of Health Services and reviewed daily for 4 weeks, then weekly for 6 weeks thereafter to ensure fall policies and procedures were conducted and documented per CMS standards. DHS will complete a log showing daily review and Administrator will initial daily showing review of compliance. Performance Improvement plan was implemented 7/22/18 to ensure daily audits are being completed by IDT and DHS and reviewed daily by Administrator.

Title of Person Responsible for implementing the acceptable plan of correction.

The Administrator is responsible for implementing the acceptable plan of correction.

Date of Compliance: 07/23/2018

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F 842	Continued From page 11	F 842		

documentation the physician was notified.

During an interview on 06/27/18 at 2:53 PM, the House Supervisor explained she thought Resident #1 had a fall on a weekend. She stated the nurse who assessed the resident was responsible for completing the incident report.

During an interview on 06/27/18 at 5:56 PM, Nurse #1 stated on 06/02/18 he was giving medications and saw NA #1 running down the hall and he followed her into Resident #1's room. He explained Resident #1 was sitting on the fall mat with his back against the bed but Resident #1 did not complain of pain. He further explained he assessed Resident #1 and did neurological checks and filled out an incident report. He stated it was expected for the incident report to be completed with the date and time the physician and RP were notified but he did not call them and reported to Nurse #2 he had not called them.

During an interview on 06/28/18 at 10:50 AM, Nurse #3 explained she was not working when Resident #1 had a fall on 06/02/18. She stated the nurse who called the physician and RP should make a note that they notified them and document the date and time they were notified on the incident report. She further explained the nurse who assessed the resident after a fall was expected to complete the incident report and it had a section to document notification of the RP and nurses were expected to document the date and time the RP was notified.

During a telephone interview on 06/28/18 at 1:05 PM, Nurse #2 confirmed she received a report from Nurse #1 that Resident #1 slid out of bed on 06/02/18 when he attempted to take himself to

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 06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 842	Continued From page 12	F 842		

the bathroom. She stated she did not call the RP after report on 06/02/18 because she thought Nurse #1 had tried to call them and she did not document that information on the incident report.

During an interview on 06/28/18 at 12:38 PM, the Interim Director of Health Services explained it was her expectation for the nurse to complete progress notes and an incident report and to notify the physician and RP and document the date and time when they were notified.

During an interview on 06/28/18 at 12:50 PM, the Administrator stated it was his expectation for nursing staff to follow the steps that needed to be done after a fall and to make all notifications with the physician and RP they needed to make and document them.

2. Resident #2 was admitted to the facility on 11/10/17 with diagnoses which included kidney disease, Type 2 diabetes, anxiety, depression and a history of a stroke.

A review of the most recent quarterly Minimum Data Set dated 04/11/18 revealed Resident #2 was moderately impaired in cognition for daily decision making. The MDS also revealed Resident #2 required extensive assistance with bed mobility and transfers.

A review of a care plan dated 01/09/18 indicated Resident #2 was at high risk for falls due to attempts to stand with an unsteady gait. The goal revealed Resident #2 would will not experience any serious injuries related to falls and the interventions indicated in part to monitor for changes in condition that may warrant increased supervision or assistance, keep room and

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F 842	Continued From page 13	F 842		

surrounding areas free of clutter, keep frequent used item within reach, non-skid socks on while in bed, attempt to keep resident in high traffic areas and when resident showed increased attempts to stand alone or had increased restlessness and agitation and have staff provide 1:1 visits for distraction and call family so he may speak with them on the phone.

A review of nurse's progress notes dated 05/12/18 at 12:10 AM indicated Resident #2 needed frequent reminders and redirection to use call light for assistance but redirection was effective short term. Further review of nurse's notes on 05/12/18 revealed there was no documentation of Resident #2's fall at 4:00 PM.

A review of an incident report dated 05/12/18 at 4:00 PM completed by Nurse #4 revealed a Nurse Aide (NA) walked by Resident #2's room and observed him sitting on floor in front of a recliner. The report indicated Resident #2 had no apparent injury, an assessment was performed and he was alert and oriented times. A section labeled notification of physician and family were blank.

During an interview on 06/28/18 at 11:00 AM, Nurse #4 stated she was being oriented by Nurse #5 and recalled an NA reported she found Resident #2 on the floor in front of his recliner. She explained she and Nurse #5 assessed Resident #2 and he had no apparent injury so they assisted Resident #2 back into his recliner. She stated Nurse #5 said she would call the physician and family so Nurse #4 stated she did not call the physician or family or document in the nurse's notes or on the incident report.

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F 842	Continued From page 14 During a telephone interview on 06/28/18 at 12:30 PM, Nurse #5 stated she did not recall Resident #2's fall on 05/12/18 but did remember orienting a new nurse. She explained it was protocol when a resident had a fall to assess the resident and notify the physician and family and complete an incident report and nurse's progress notes. During an interview on 06/28/18 at 12:38 PM, the Interim Director of Health Services explained it was her expectation for the nurse to complete progress notes and an incident report and to notify the physician and RP and document the date and time when they were notified. During an interview on 06/28/18 at 12:50, the Administrator stated it was his expectation for nursing staff to follow the steps that needed to be done after a fall and to make all notifications with the physician and RP they needed to make and document them.	F 842		