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 _____	10/18/2018

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

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F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 565	This plan of correction constitutes a	11/15/18

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

Electronically Signed | 11/10/2018

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F 565	Continued From page 1 facility failed to record, resolve and communicate the facility's efforts to address resident requests and/or concerns voiced during 9 of 9 Resident Council meetings. Findings included: During a Resident Council group interview conducted on 10/15/18 at 11:31 AM, residents present voiced an ongoing issue with the resolution of concerns and/or requests voiced during Resident Council meetings. They added, as a result, other residents lost interest in attending and at the July meeting, the members decided to discontinue further Resident Council meetings. The Resident Council minutes for the period September 2017 through June 2018 were reviewed and revealed the following: Resident Council minutes dated 09/06/17 indicated residents voiced concerns related to staffing, cold food and coffee. Resident Council minutes dated 10/02/17 indicated residents voiced new concerns which included the pub not being opened at designated hours or restocked often enough and rooms not being cleaned. It was noted the Administrator attended the meeting to discuss staffing issues. Resident Council minutes dated 11/06/17 indicated residents voiced an ongoing concern of cold food and coffee. It was noted residents voiced several new concerns such as bulletin boards lowered for w/c access, restorative program, and clean linen not being brought to the halls.	F 565	written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does 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. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1.The 9 residents directly affected by the deficient practice have been interviewed by the administrator on 11/5/18 and invited to a resident council meeting on 11/5/18 where their requests and concerns were voiced and documented. 2.All concerns and requests will be followed up on 11/12/18 by administrator. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1.Audits were conducted by the administrator on 11/5/18 at the resident council meeting to discover resident concerns from previous resident council meetings on that were not addressed by the facility, all concerns from the monthly meeting held on 11/5/18 will be addressed	

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F 565	Continued From page 2 Resident Council minutes dated 12/04/17 indicated residents voiced ongoing concerns which included the shortage of clean linen, rooms not getting cleaned and restorative program. It was noted residents voiced several new concerns and requests such as a grip bar at the scales for residents to weigh themselves. Resident Council minutes dated 01/08/18 indicated residents voiced ongoing concerns which included the pub not being opened at designated times, no housekeeping services on the weekends and being served sandwiches for dinner instead of a hot meal. It was noted residents voiced new concerns related to staff not wearing hair nets or gloves when serving meals. Resident Council minutes dated 02/05/18 indicated residents voiced ongoing concerns which included housekeeping services not provided on the weekends. It was noted residents voiced several new concerns and requests which included information on applying for a grant to fund a greenhouse, rough towels and dietary aides not wearing hair nets at meal times. Resident Council minutes dated 03/05/18 indicated no meeting was conducted due to illness. Resident Council minutes dated 04/02/18 indicated residents voiced ongoing concerns which included rough towels and sandwiches served for dinner instead of hot meal. It was noted residents voiced several new concerns which included Nurse Aides assisting residents to meetings.	F 565	by the administrator/designee by 11/12/18. 2.All resolutions will be formally presented to resident council (at their request) at the next scheduled council meeting December 3, 2018. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? 1.An 100% audit of resident concerns at Resident Council meetings will be held every week (beginning 11/5/18) for the next four weeks, and monthly thereafter to ensure resolutions to the resident requests/concerns. The two partners are the administrator and medical records, as requested by resident council. The stated partners have in-serviced themselves on the policy and procedure of resident council and are implementing this policy. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. 1.An audit will be conducted weekly for the next 4 weeks by administrator/designee to document that all concerns are addressed and every month thereafter. 2.The QAPI committee will review audit for completion at every monthly meeting. Date of Compliance: 11/15/18	

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F 565	Continued From page 3	F 565		

Resident Council minutes dated 05/07/18 indicated residents voiced concerns which included courtyard access and nurse aides using cellphones in resident rooms and hallways.

Resident Council minutes dated 06/04/18 indicated residents voiced ongoing concerns which included a grab bar at the scales for resident use and greenhouse for the courtyard.

Resident Council minutes dated 07/09/18 indicated residents voiced ongoing concerns which included shortage of linens, greenhouse and salad dressing variety. It was noted the residents attending voted to disband due to lack of interest.

There was no evidence the facility's response to the requests and/or concerns voiced during the meetings were reviewed or discussed during the subsequent meetings.

The facility's grievance/concern logs for the period September 2017 through July 2018 were reviewed. There were no concerns recorded for the Resident Council or residents who attended the meetings except for the month of March 2018 which indicated the 5 concerns dated 03/01/18 related to Administration, Nursing and Activities were all resolved.

An interview on 10/18/18 at 2:53 PM with the Medical Records (MR) staff member revealed she attended most of the Resident Council meetings to facilitate and record the minutes. The MR confirmed the Resident Council decided

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F 565	Continued From page 4	F 565		

to disband due to the lack of participation from other residents. She recalled residents voiced a lot of the same issues month to month and explained she would just write the concerns on the minutes which were given to the Department Heads to address. She was not aware of how the resolution was communicated back to the members of the Resident Council.

An interview on 10/18/18 at 3:40 PM with the Activity Director (AD) revealed she had attended a few Resident Council meetings to facilitate and record the minutes until the members requested no Department Heads (DH) attend the meetings unless they were invited. She added they had specifically requested for the MR to attend the meetings. The AD explained when the DH attended the meetings, they discussed concerns voiced at the last meeting as well as any new concerns. She added the concerns were not written on a separate form but were included in the minutes which were reviewed at the morning staff meeting and given to the appropriate DH to address. She was unsure how the resolution was communicated back to the Resident Council members once the DH were no longer allowed to attend the meetings.

An interview was conducted on 10/18/18 at 6:10 PM with the Administrator. He stated it was his expectation for staff to listen, document and report resolutions of concerns voiced during Resident Council meetings or provide explanation when the concerns could not be resolved. He added, going forward, systems would be put into place and was hopeful the Resident Council meetings would resume.

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F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		11/15/18

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F 623	Continued From page 6 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 7 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, Regional Ombudsman and staff interviews, the facility failed to notify the Regional Ombudsman when residents discharged or transferred from the facility for 6 of 9 months (March 2018, May 2018, June 2018, July 2018, August 2018 and September 2018). Findings included: Review of the facility's discharges and transfers for the period January 2018 through September 2018 revealed residents who discharged or transferred from the facility were recorded on a monthly spreadsheet and the completed spreadsheets were filed in a 3-ring binder along with a copy of the fax communication result report which was sent to the Regional Ombudsman (RO). Further review revealed the following:	F 623	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1.Immediately upon notification that the facility had failed to comply with this regulation, the administrator faxed to the ombudsman the missing months of March through September, 2018 on 10/17/18 by the administrator. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1.The Business Manager will be responsible to gather and fax the discharge/transfer information to the ombudsman every month. The residents that could be affected are listed on resident discharge and transfer list which	

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F 623	Continued From page 8 January 2018: Fax communication result report dated 01/26/18 at 12:49 PM confirmed a successful transmission. February 2018: Fax communication result report dated 02/26/18 at 2:00 PM confirmed a successful transmission. March 2018: No evidence of a fax transmission. April 2018: Fax communication result report dated 04/27/18 at 11:46 AM confirmed a successful transmission. May 2018: Fax communication result report dated 05/08/18 at 1:32 PM indicated an unsuccessful transmission due to the line being busy. June 2018: No evidence of a fax transmission. July 2018: No evidence of a fax transmission. August 2018: No evidence of a fax transmission. September 2018: No evidence of a fax transmission. During a telephone interview on 10/16/18 at 12:38 PM, the RO indicated she had not received notification of residents who discharged or transferred from the facility since January 2018. During an interview on 10/17/18 at 6:07 PM the Administrator explained the Nurse Navigator recorded resident transfers and discharges on a spreadsheet and faxed them to the RO monthly. He was unable to provide evidence of successful fax transmissions of the discharge/transfer spreadsheets submitted to the RO for the months of March 2018, May 2018, June 2018, July 2018, August 2018, or September 2018. The Administrator was unsure where the breakdown occurred but would expect for them to be submitted monthly.	F 623	will be utilized to inform the ombudsman of discharges and transfers. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? 1.The Business Manager had previously been educated on this procedure and a refresher was conducted by the administrator on 11/8/18. This report will be sent via faxed to the ombudsman, keeping the fax confirmation at the facility. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. 1.The administrator will audit the documentation monthly before the information is disseminated to the ombudsman. 2.The audit will continue monthly for 3 months. 3.The audit information will be reviewed at each monthly QAPI meeting. Date of Compliance: 11/15/18	

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F 623	Continued From page 9 The Nurse Navigator was out of the facility and unavailable for an interview.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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) regarding tobacco use for 1 of 1 residents (Resident #65) and failed to accurately code the MDS regarding a urostomy for 1 of 1 residents (Resident #37). Findings included: 1. Resident #65 was readmitted to the facility on 03/01/2018 with diagnoses that included: chronic obstructive pulmonary disease (COPD) and alcohol dependence with alcohol-induced persisting dementia. A review of the quarterly MDS, dated 09/06/2018, revealed Resident #65 had severe cognitive impairment and displayed no rejection of care. The MDS further revealed Resident #65 was not coded for tobacco use. A review of the care plan (CP), dated 09/06/2018, indicated Resident #65 needed supervision with smoking. An interview was conducted with the Licensed Practical Nurse (LPN)-MDS Coordinator (MDSC)	F 641	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1.An immediate 100% audit of all smokers and residents with ostomies in facility and their assessments was completed on 10/17/18 with no other errors identified. 2.Resident #65, MDS coordinator immediately corrected the smoking observation assessment, and corrected appropriate MDS assessment and resubmitted said assessment on October 17, 2018 3.Resident # 37 , MDS coordinator immediately opened and corrected urostomy status on all affected MDS assessments and resubmitted corrected MDS assessments on October 18, 2018 How will you identify other residents having the potential to be affected by the same practice and what corrective action will be taken? 1.MDS Coordinator(s) created and implemented a teaching tool on October 19, 2018 for all Nursing Supervisors and	11/15/18

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F 641	Continued From page 10 on 10/17/2018 at 09:10 AM. She indicated that the quarterly 09/06/2018 MDS under the Health Conditions Section should have been coded as tobacco use. An interview was conducted with the Director of Health Services (DHS) on 10/18/2018 at 02:00 PM. She indicated that her expectation was that tobacco use should have been coded on the quarterly 09/06/2018 MDS. An interview was conducted with the Interim Administrator on 10/18/2018 at 05:47 PM. He stated that his expectation was that tobacco use should have been indicated on the MDS since Resident #65 was a smoker. 2. Resident # 37 admitted to the facility on 02/13/17 with diagnoses that included history of bladder cancer, obstructive uropathy (structural or functional hindrance of normal urine flow) and encounter for attention to other artificial openings of urinary tract. Review of a care plan initiated on 02/12/18, with a recent review date of 08/13/18, indicated Resident # 37 had a urostomy (surgical opening near the surface of the skin to allow the passage of urine outside of the body) due to history of bladder cancer and obstructive uropathy. Review of the annual Minimum Data Set (MDS) dated 02/12/18, quarterly MDS dated 05/14/18 and quarterly MDS dated 08/13/18 all indicated, under section H0100, Resident # 37 had an indwelling catheter. Further review revealed ostomy, which included urostomy, was not coded.	F 641	Unit Nurses to update the daily 24hour report with any changes/additions to smoking status on new, readmitted residents or long term residents 2.MDS and IDT will identify Ostomy appliance use on Admission and Readmission for Accuracy when entering information into MDS section H0100 3.Smoking Observation Forms will be utilized on new admissions, readmissions, quarterly□s, Annuals and Significant changes. MDS will utilize this form to validate MDS accuracy of coding of section J1300 4.The IDT Team will review all new orders on daily morning rounds for new developments that could affect MDS assessment coding accuracy 5.Information from the 24hour report will be reviewed daily during IDT rounds to identify any changes to smoking and ostomy assessments What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? 1.MDS Coordinator(s) and IDT members on daily rounds will review daily orders for changes/additions of smokers and uro/genital appliance and will use this information to correctly code MDS sections J1300 and H0100 2.Uro/genital appliance list/audit tool will be referred to by MDS coordinators for accuracy when entering information into section H0100 on MDS assessments 3.The current/new smoker audit tool will be utilized to ensure accuracy in coding	

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F 641	Continued From page 11 During an interview on 10/17/18 at 3:13 PM the MDS RN confirmed Resident # 37 had a urostomy and no indwelling catheter. The MDS RN reviewed the MDS assessments dated 02/12/18, 05/14/18 and 08/13/18 and acknowledged all had been inaccurately coded as indwelling catheter instead of ostomy. She added modifications would be submitted. During an interview on 10/17/18 at 5:47 PM the Director of Nursing stated it was her expectation for MDS assessments to be accurately coded to reflect the resident's status at the time of the assessment.	F 641	MDS section J1300 4.MDS coordinator(s) immediately developed and implemented a teaching tool for Nursing Supervisors and Unit Nurses that smoking status on all new admissions and readmissions be documented on the daily 24hour report on October 19, 2018 How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. 1.Results from the Smoking and Uro/genital tools will be brought forward to the Quality Assurance Performance Improvement Meeting (QUAPI) on a monthly and ongoing basis for review by the QUAPI team. 2.People responsible for implementing Plan of correction are: Administrator, MDS and IDT members Date of Compliance: 11/15/18	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		11/15/18

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 _____	10/18/2018

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

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F 656	Continued From page 12 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop care plans for antipsychotic (Resident #22) and hypnotic (Resident #26) medication use for 2 of 5 residents reviewed for unnecessary medications.	F 656	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1.Affected resident #22 antipsychotic care plan was immediately updated and	

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F 656	Continued From page 13 Findings included: 1. Resident #22 admitted to the facility on 07/15/15 with multiple diagnoses that included dementia with lewy body and major depressive disorder. Review of the CAA (Care Area Assessment) associated with the annual MDS (Minimum Data Set) dated 02/02/18 indicated Resident #22 received antipsychotic medication for dementia and a care plan would be developed. Review of the quarterly MDS dated 08/03/18 indicated Resident #22 received antipsychotic medication during the 7-day look back assessment period. Review of Resident #22's current care plans, last reviewed on 08/07/18, revealed no care plan for antipsychotic medication use. During an interview on 10/17/18 at 11:26 AM the MDS RN explained a care plan was typically developed any time they coded medication use on the MDS. She confirmed Resident #22 received antipsychotic medication and stated a care plan should have been developed. During an interview on 10/18/18 at 1:59 PM the Director of Nursing stated it was her expectation for care plans to be comprehensive and	F 656	corrected on 10/18/18 2.Affected resident #26 hypnotic care plan was immediately updated and corrected on 10/18/18. 3.The MDS coordinator (s) will use an audit tool beginning 11/5/18 to compare existing medications to current pharmacy listing of residents on medications weekly X 3 months. Discrepancies identified will be corrected immediately 4. All care plans will be reviewed and updated by the MDS Coordinator(s) and the IDT members during care plan meetings per quarterly MDS calendar. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1.MDS did an immediate 100% review of all residents in facility that use psychotropic/hypnotic medications in any classification on October 18, 2018. There were no other missing psychotropic/hypnotic use care plans identified. 2. The process for the 100% audit was to review the care plans of all residents listed on the Pruitt Pharmacy generated psychotropic/hypnotic medication list for accuracy; the Pharmacy List was also compared to current MD orders for accuracy in dosing, timing, route also performed on October 18, 2018, there were no further discrepancies found. 3.MDS Coordinator(s) developed and implemented a teaching tool on October 19, 2018 for all Nursing Supervisors and Unit Nurses to update the daily 24 hour	

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

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F 656	Continued From page 14 resident's receiving antipsychotic medications to have a care plan. 2. Resident #26 admitted to the facility on 11/20/17 with multiple diagnoses that included panic disorder, anxiety disorder and PTSD (Post Traumatic Stress Disorder). Review of the quarterly MDS (Minimum Data Set) dated 08/07/18 indicated Resident #26 received antidepressant and hypnotic medications during the 7-day look-back assessment period. Review of Resident #26's current care plans, last reviewed on 09/10/18, revealed no care plan for hypnotic medication use. During an interview on 10/17/18 at 11:26 AM the MDS RN explained a care plan was typically developed any time they coded medication use on the MDS. She confirmed Resident #26 received hypnotic medication and stated a care plan should have been developed. During an interview on 10/18/18 at 1:59 PM the Director of Nursing stated it was her expectation for care plans to be comprehensive and resident's receiving hypnotic medications to have a care plan.	F 656	report with any changes/additions to psychotropic medications. All telephone orders will be reviewed during morning rounds for any changes/additions to psychotropic medications. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? 1.MDS Coordinator(s) will review the weekly pharmacy generated psychotropic medication list and compare it to current MD orders for accuracy and then compare both orders and the pharmacy list to resident care plans for accuracy in and presence of applicable care plans this will start on 11/5/18 and continue quarterly following the MDS calendar. 2. MDS Coordinator(s) and IDT members on rounds will review daily orders for changes/additions to psychotropic medications. 3.As noted previously MDS Coordinator(s) and IDT members on rounds will review the 24 hour report for changes/additions to psychotropic medications 4.Any identified errors/omissions will be corrected on the care plans by the MDS coordinator(s) How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. 1.The persons responsible for monitoring corrective action:	

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

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F 656	Continued From page 15	F 656	MDS Coordinator(s) IDT members on rounds and during care plan meetings 2.Review of compliance with auditing tools will occur daily at IDT meeting. Audits will begin 11/5/18 and continue quarterly by following the MDS calendar, any discrepancies will be rectified immediately. 3.QAPI oversight with review of audit tools will be at the monthly meeting Date of Compliance: 11/15/18	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		11/15/18

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F 657	Continued From page 16 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update a care plan to indicate fluid restriction for 1 of 1 sampled resident for dialysis (Resident #63)) and failed to update care plan to reflect weight loss for 1 of 1 sampled resident reviewed for nutrition (Resident #6). Findings included: 1. Resident #63 was admitted to the facility on 02/27/18 and diagnoses included end stage renal disease (ESRD). A review of a care plan with onset date 02/28/18 indicated a problem that Resident #63 required hemodialysis and was at risk for fluid overload and compromised nutrition related to disease state. A review of a care plan with onset date 03/12/18 indicated a problem that Resident #63 required renal dialysis 3 times per week Monday, Wednesday, and Friday. A review of a physician's order dated 04/25/18 indicated Resident #63 was to have fluid restriction of 1000 milliliters (ml) per day for ESRD. A further review of updated care plan of 06/05/18 with identified problem for hemodialysis with	F 657	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1.MDS Coordinator(s) immediately developed a list of all residents in facility with fluid restrictions, reviewed orders and care plans and corrected any identified care plan deficiencies on October 17, 2018. 2.Quality Measures Nurse did immediate in-service for Nursing Supervisors, Unit Nurses, CNA□s and Dietary Aides on monitoring resident□s on fluid restrictions on October 17, 2018. 3.On each resident that was identified to be on a fluid restriction a Fluid Intake Monitoring tool was placed on the MAR. 4.Care planning for a history of weight loss and weight review completed with no significant weight loss detected for resident #6. Care plans will be updated when significant weight variances detected. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

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F 657	Continued From page 17 onset date 02/27/18 and identified problem renal dialysis with onset date of 03/12/18 did not indicate Resident #63 was to have fluid restriction of 1000 ml per day for ESRD. A review of the most current quarterly Minimum Data Set (MDS) assessment dated 09/04/18 indicated Resident #63 was cognitively intact and had diagnoses of heart failure and ESRD and received dialysis.. On 10/17/18 at 3:18 PM an interview was conducted with the Licensed Practical Nurse (LPN) MDS Coordinator who verified Resident #63 had an order for fluid restriction 1000 ml per day that was written on 04/25/18. The LPN MDS Coordinator stated the care plan had not been updated and should have been updated when the physician wrote the order for fluid restriction to reflect Resident #63 required a fluid restriction of 1000 ml per day. The LPN MDS Coordinator stated she received a copy of physician orders daily and stated she missed updating the care plan to reflect Resident #63 was on a fluid restriction. The LPN MDS Coordinator stated she would immediately update the care plan to reflect Resident #63 required fluid restriction. On 10/17/18 at 3:28 PM an interview was conducted with the RN MDS Coordinator who stated she missed updating the care plan to reflect Resident #63 was on a fluid restriction 1000 ml per day. The RN MDS Coordinator stated Resident #63's care plan should have been updated and at the time the physician wrote an order for fluid restriction for Resident #63. On 10/17/18 at 3:48 PM an interview was conducted with Director of Nursing (DON) who	F 657	1.MDS and Dietician will coordinate and develop list of all residents with any type of fluid restriction -fluid restriction care plans will be developed on all residents with any type of fluid restriction 2.On residents w/o dialysis intervention MDS/Dietician will review MD orders daily for changes in fluid restrictions and will coordinate to update care plan accordingly and to update dietary and nursing interventions 3.On residents with dialysis interventions MDS/Dietician will coordinate to contact dialysis unit weekly to discuss resident status especially r/t fluid restrictions and will obtain information on new orders, changes in fluid restrictions, fluid overload, fluid deficit, weight issues 4.Dietician/MDS will coordinate to write appropriate orders based on above information and update care plans based on above orders 5.The RD will review 100% of residents for significant weight variance each month and update any resident□s care plan with significant weight variance when detected. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? 1.Dialysis communication book will be reviewed 3 times a week (Monday, Tuesday and Friday) for additional orders, weights and information and care plans/orders will be updated accordingly 2.DHS/Nursing will be responsible for the implementation of I&O documentation on MAR/TAR for residents on fluid restriction	

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

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F 657	Continued From page 18 stated her expectation was that the care plan would have been updated when the physician's order was received in April 2018 to reflect Resident #63 was on 1000 ml per day fluid restriction. The DON stated her expectation was that the care plan would be updated immediately to reflect Resident #63 was on 1000 ml per day fluid restriction. The DON stated the interdisciplinary team met each morning and physician orders were discussed and stated disciplines in the facility knew Resident #63 was on a fluid restriction and the care plan should have been updated. On 10/17/18 at 4:04 PM an interview was conducted with the Administrator who stated his expectation was that Resident #63's care plan would have been updated by MDS personnel to reflect Resident #63 was on 1000 ml per day fluid restriction. The Administrator stated his expectation was that Resident #63's care plan would immediately be updated by MDS personnel to reflect Resident #63 was on a fluid restriction. On 10/17/18 at 5:20 PM an interview was conducted with the Dietary Manager (DM) who stated she was not responsible for updating Resident #63's nutritional care plan to reflect fluid restriction. The DM stated the registered dietician (RD) was responsible for updating Resident #63's nutritional care plan to reflect fluid restriction. On 10/17/18 at 5:25 PM a telephone interview was conducted with the RD who stated he was responsible to update the nutrition care plan for Resident #63. The RD stated he had not updated the care plan to indicate Resident #63 was on 1000 ml per day fluid restriction.	F 657	3.MDS, Dietician and IDT members on rounds will utilize an audit tool to track resident□s on any type of fluid restriction, changes in fluid restriction orders to capture information and update fluid restriction care plans. Significant weight losses are monitored weekly times 4 weeks beginning 11/14/18 and then reviewed the following month through 1/1/19 for any additional significant weight variance. The RD will document resident□s weekly weights utilizing the weekly weight list/weekly weight meeting form tool and any significant variances will be monitored and care planned monthly. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. 1.A daily audit tool has been developed to capture any fluid restrictions for any resident. 2.The daily audits will also cover dialysis book review, any order changes and compliance. 3.The weekly weight list/weekly weight meeting tool will be reviewed and discussed weekly at the IDT team clinical meeting. 4.The audits will be reviewed daily with IDT team. 5.Audits will be reviewed monthly with the QAPI committee Date of Compliance:	

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F 657	Continued From page 19	F 657	11/15/18	

2. Resident #6 was admitted to the facility 4/6/18 and readmitted 4/16/18 with diagnoses which included anemia, diabetes, hyperparathyroidism, dementia with behavioral disturbance, depression and traumatic brain injury. The admission Minimum Data Set (MDS) dated 4/23/18 noted Resident #6 needed supervision with set up help for eating, height of 70", weighed 191 pounds, had a significant weight loss and was not on a weight loss regimen.

The Care Area Assessment associated with the admission MDS in the area of nutrition noted, No chewing or swallowing problems at this time. Resident with significant weight loss from previous discharge to readmission. Is receiving 2.0 calorie supplement 120 cc twice a day for weight stability. Resident with decreased appetite and oral intake. Will continue to monitor weight trend and oral intake. Care plan for weight loss.

The admission care plan dated 4/16/18 included the problem area, Resident is at risk for nutrition and hydration related to diagnosis of diabetes. One of the goals for this care plan was, Resident will maintain weight within 4% of current weight. Approaches to this problem area included:
-Resident with no specific food preferences
-Encourage hydration during and between meals
-Weigh resident per facility protocol and per physician order
-Record percentage of oral intake after each meal
The only change to the admission nutrition care plan was an additional approach dated 9/5/18 which noted the diet as no added salt, mechanical soft with chopped meat.

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F 657	Continued From page 20	F 657		

A handwritten note on the nutrition care plan dated 7/13/18 read, care plan reviewed and to continue through next review.

Review of weights in the medical record of Resident #6 noted the following:
4/9/18- 212
4/11/18-191
5/10/18-188
5/29/18-177
6/2/18- 180
7/6/18- 174
8/6/18- 174
9/4/18- 174

Review of multidisciplinary care conference meeting minutes noted the following:
4/26/18-Family in attendance. Nursing will work with resident for wound care/healing, pain management, management of diabetes and other underlying health conditions; therapy to work with resident to return to physical and cognitive baseline.
5/26/18-Family in attendance. No changes to care plan. Weight noted as 188 pounds with a goal to maintain weight and good nutrition.
9/13/18-Family in attendance. Weight noted as 174 with a goal of weight stability.

An initial admission nutrition assessment in the medical record of Resident #6 dated 4/11/18 noted the significant weight loss since admission. The only subsequent dietary progress note was a quarterly dietary assessment dated 7/13/18 which was not completed (in the electronic record it was listed as open, not complete) and noted the weight of Resident #6 as 174 pounds. There was no additional documentation included with the progress note.

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F 657	Continued From page 21 Review of physician progress notes since admission did not address the significant weight loss though the progress notes addressed issues with edema and adjustments to diuretics. On 10/17/18 at 9:45 AM the MDS coordinator that updated the nutrition care plan for Resident #6 on 7/13/18 stated it was an oversight that the additional 7% weight loss (from 191 to 174) had not been identified on the care plan when it was updated. The MDS coordinator stated though the Registered Dietitian (RD) was responsible for updating the nutrition care plans she was ultimately responsible for accuracy of care plans and stated it was not an accurate reflection of the resident's weight loss. The MDS coordinator stated the RD was on leave and not available to comment on the care plan or weight loss. Attempts made to contact the RD during the survey were unsuccessful. On 10/18/18 at 3:15 PM the physician of Resident #6 stated the RD usually kept him informed of any weight issues and that some of the weight loss experienced by Resident #6 might have been due to diuretics. The physician stated the care plan should have been an accurate reflection of the weight loss Resident #6 had since the admission care plan. On 10/18/18 at 5:33 PM the administrator stated he expected the care plan to be an accurate reflection of the resident at the time of the assessment. The administrator stated the weight loss of Resident #6 should have been identified when the care plan was updated 7/13/18.	F 657		

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F 658	Continued From page 22	F 658		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and interviews with staff and physician the facility failed to promptly implement a physician's order written in response to a pharmacy recommendation for 1 of 5 residents reviewed for medications (Resident #86) and failed to obtain oxygen orders for the rate of administration and monitoring oxygen saturation for 1 of 1 resident reviewed with oxygen (Resident #396). The findings included: 1. Resident #86 was admitted to the facility 06/12/18 with diagnoses which included atrial fibrillation, hypertension, right heart failure, hyperlipidemia, heart disease, old myocardial infarction and cardiomyopathy. The admission care plan for Resident #86 included the following problem areas: -Resident is at risk for congestive heart failure exacerbation. Approaches to this problem area included to administer resident's cardiac and diuretic medications as ordered. -Resident has a pacemaker in place and also has an implantable defibrillator. Approaches to this problem area included to monitor medications and give as ordered. -Increased risk for bleeding or excessive bruising	F 658	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1.The DHS immediately reviewed the pharmacy recommendations cited on 10/18/18 and talked with FNP and Medical Director further about any resident harm which was not noted. FNP checked resident #86 on 10/18/18. 2.The DHS immediately audited the O2 orders for resident #396 and then all oxygen orders in the building for correct implementation on 10/18/18 and with Medical Director added oxygen as needed to maintain O2 sats above 90% to Standing Orders. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1.All pharmacy recommendations will be reviewed by administrator and DHS, then medical records will give the pharmacy recommendations to the providers for review and completion. Medical records	11/15/18

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 _____	10/18/2018

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

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F 658	Continued From page 23 related to anticoagulant therapy due to diagnosis of atrial fibrillation An admission history and physical progress note dated 06/12/18 by the physician of Resident #86 noted the resident was admitted from another facility and medications taken by Resident #86 included Metoprolol. However, review of admission medication orders noted Metoprolol was not part of the drug regimen for Resident #86. Review of physician orders from the facility Resident #86 had resided (prior to 06/12/18 admission) noted he had been taking 12.5 milligrams of Metoprolol twice a day. A pharmacy review dated 6/29/18 read, Resident #86 "was noted to be on Metoprolol from his discharge summary as well as his history and physical. It is listed in the first progress notes, but there was never an order for it. Does he need to continue on Metoprolol for his atrial fibrillation?" A response from the physician to the pharmacy note was dated 7/31/18 and read, Metoprolol 12.5 milligrams twice a day for atrial fibrillation. Review of physician orders and the July and August 2018 Medication Administration Records (MARs) noted the 7/31/18 response from the physician of Resident #86 was not transcribed to an order until 8/29/18 and the first dose of Metoprolol was not given until 8/30/18. On 10/18/18 at 2:55 PM the nurse practitioner for Resident #86 reviewed the medical record of Resident #86 and noted the admission medication orders were completed by another nurse practitioner and the Metoprolol was not included in the orders for Resident #86. The Nurse Practitioner stated she was not aware of	F 658	will then note completion and file completions in the appropriate charts. 2.A complete audit of all oxygen orders for all residents was completed 10/18/18 with 100% compliance 3.One on one education was completed for all nurses on 10/18/18 for transcription of discharge orders to medication reconciliations for completion What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? 1.Medical records will monitor pharmacy recommendations and in what part of the process they are in. They will be double checked for correct completion by the DHS and supervisor 2.All new admissions will be triple checked for accurate completion of transcription from discharge summary to medication reconciliations to MARS 3.When the MD/FNP responds to the pharmacy recommendations and writes orders, the supervisors and DHS will ensure that the orders are processed efficiently and in a timely manner. The audit process for this was expanded from the pharmacy recommendation audit to encompass the response to orders on 11/11/18 and will be reviewed weekly or as pharmacy recommendations arrive until 1/1/19. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality	

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	345558	A. BUILDING _____ B. WING _____	10/18/2018

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F 658	Continued From page 24	F 658		

the delay in starting the Metoprolol for Resident #86 (after the physician's 7/31/18 response to the pharmacy recommendation) and deferred discussion of the matter to the physician since the physician responded to the pharmacy recommendation on 7/31/18.

On 10/18/18 at 3:00 PM the Director of Nursing (DON) explained after pharmacy recommendations were addressed by the physician or nurse practitioner it was her understanding they went to medical records to be filed. The DON stated she was not aware of the delay in writing the order (in response to the 6/29/18 pharmacy recommendation) for Metoprolol for Resident #86 and did not have a medication variance report on the delay. The DON stated she expected orders to be written in a timely manner. In a follow-up interview with the DON on 10/18/18 at 4:20 PM she stated there was not a system in place to ensure orders written on pharmacy recommendations were addressed.

On 10/18/18 at 3:10 PM the Physician of Resident #86 stated he wasn't aware there was a delay in the 7/31/18 order being written for the start of Metoprolol for Resident #86. The physician stated he didn't think the delay in starting Metoprolol had caused any harm to Resident #86 because the resident was being managed on other cardiac medications. The physician stated he expected a quicker response to orders being transcribed from his response to pharmacy recommendations.

Several attempts were made to contact the nurse that wrote the 8/29/18 physician written order for Metoprolol for Resident #86 but there was no

assurance program will be put in place for monitoring to assure continued compliance.

1.The once Monthly Pharmacy recommendations will be audited monthly by medical records and DHS for correct completion
2.Weekly audits will occur by DHS for correct transcription of discharge orders to medication reconciliations and MARS until 1/1/19

Date of Compliance:
11/15/18

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	345558	A. BUILDING _____ B. WING _____	10/18/2018

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

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F 658	Continued From page 25	F 658		

response by the nurse.

On 10/18/18 at 4:00 PM the medical records director stated occasionally she received signed pharmacy recommendations to file in residents medical record. The medical records director stated she could not explain the delay in response to the pharmacy recommendation for Resident #86.

On 10/18/18 at 5:10 PM the unit coordinator over the unit Resident #86 resided stated she was not aware of the delay in the order for Metoprolol for Resident #86. The unit coordinator stated she typically did not receive the signed pharmacy recommendations and wasn't sure what happened. The unit coordinator reviewed nurses notes to determine if a notation was made by the nurse that wrote the 8/29/18 physician order for Metoprolol and noted there was nothing in the progress notes to explain what happened. The unit coordinator stated she would expect orders to be written promptly and wasn't aware if there was a system in place for a response to signed pharmacy recommendations.

On 10/18/18 at 5:30 PM the Administrator stated he expected staff to act on physician orders written on pharmacy reviews in a timely manner. The Administrator explained he had been in his position for only a few days and wasn't aware what system was in place to ensure orders were written in a timely manner in response to pharmacy recommendations. The Administrator noted the consultant pharmacist was out of the country and not available for interview.

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

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F 658	Continued From page 26	F 658		

2. Resident #396 was readmitted to the facility on 10/12/2018 with diagnoses that included: chronic obstructive pulmonary disease (COPD), acute respiratory failure, pulmonary embolism, active shingles, left-sided paralysis secondary to a stroke, and vascular dementia with behavioral disturbance.

A review of the baseline care plan, dated 10/12/2018, revealed Resident #396 had oxygen use related to COPD with a goal to maintain optimal breathing and oxygen level within constraints of terminal diagnosis through the next 30 days. The intervention of the oxygen care plan was to notify the physician of any changes.

A review of the physician orders, dated from 10/12/2018 through 10/17/2018, revealed there were no orders for oxygen use.

A review of Nursing Notes, dated 10/12/2018 at 4:18 PM, revealed Resident #396 was admitted to the facility via emergency medical services (EMS) on oxygen at 2 liters per minute (LPM).

Observations, made on 10/15/2018 at 03:48 PM, 10/16/2018 at 10:41 AM and 10/16/2018 at 04:45 PM, revealed Resident #396 was receiving oxygen via nasal cannula at 4.5 LPM.

An interview was conducted on 10/17/2018 at 08:50 AM with the Licensed Practical Nurse (LPN)-MDS Coordinator (MDSC). She stated that the oxygen orders should have been transcribed from the Hospital Discharge Summary Sheet to the Facility Physician Order sheet. She further stated that there used to be oxygen orders on the

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	345558	A. BUILDING _____ B. WING _____	10/18/2018

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F 658	Continued From page 27	F 658		

Facility Standing Orders. She indicated that there should have been an order for oxygen. She further indicated that the physician should have been notified to obtain a verbal order for oxygen, oxygen titration, and monitoring oxygen saturation.

An interview was conducted on 10/17/2018 at 12:48 PM with the facility physician. He indicated that his expectation was that the 10/12/2018 discharge summary oxygen order should have been transcribed on to the physician order sheet. He further indicated that Resident #396's liters per minute of oxygen should have started at 2 LPM up to a maximum of 5 LPM. He stated that the order for oxygen saturation should have been at 90% or greater titrated.

An interview was conducted on 10/17/2018 at 02:22 PM with Nurse Supervisor #2 (the nurse who transcribed the admission orders). She indicated that any orders should have been taken from the discharge summary form and transcribed to a Medication Regimen and Physician Order sheet. She further indicated that if there was no order for oxygen on the discharge summary, then an order should have been obtained from a physician. She stated that she thought Resident #396 came in to the facility with oxygen at 3 LPM from EMS. She revealed that it was an oversight and that she failed to address that there was no order in place for oxygen. She further revealed that it was her expectation that when someone returned from the hospital with oxygen orders that the orders should have been transcribed to the Physician Order sheet. She stated that an oxygen order had to be written to encompass the liters per minute and monitor oxygen saturation every shift to determine if any

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	345558	A. BUILDING _____ B. WING _____	10/18/2018

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

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F 658	Continued From page 28 residents with oxygen needed to be titrated. An interview was conducted on 10/18/2018 at 02:30 PM with the Director of Health Services (DHS). She stated that her expectation was that the oxygen order should have been transcribed from the discharge summary to the physician orders. An interview was conducted with the Interim Administrator on 10/18/2018 at 05:47 PM. He indicated that his expectation was that any orders should have been in place and the orders should have been transcribed from the discharge summary sheet to the physician orders.	F 658		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		11/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 29 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to discard an opened NovoLog insulin multi-dose vial that was not dated when opened which was available for use on 1 of 2 medication carts and failed to discard 2 of 3 multi-dose tuberculin purified protein derivative vials that were opened and available for use in 1 of 2 medication storage refrigerators. Findings included: 1. A review of the facility policy entitled Medication Storage in the Healthcare Centers with a revised date 09/15/17 indicated (in part) nurses were required to check all medications for expiration before administration. A multi-dose container of injectable was to be dated when opened. A review of the manufacturer's instructions indicated NovoLog insulin was to be discarded after 28 days once opened. Resident #26 was admitted to the facility on 11/20/17 with diagnoses of diabetes mellitus. A physician's order dated 10/10/18 indicated Resident #26 was to receive NovoLog insulin 4 units with breakfast and 6 units with lunch and dinner. On 10/16/18 at 08:42 AM Resident #26's NovoLog insulin multi-dose vial was observed on	F 761	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1.DHS immediately removed all undated vials. All nurses were counseled on shift and FNP immediately checked affected resident #26 for any adverse reaction and resident was monitored for 24 hours. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1.All carts were re-audited for any undated medications or expired medications on 10/16/18 by staff nurses and supervisors and DHS re-audited refrigerators in med rooms. Education to staff was provided on 10/16/18 by the DHS. Audit sheets are in the front of the MARS books for every shift check of carts by nurses on cart. DHS will check these on morning rounds and a weekly audit for 8 weeks will occur on all carts and med rooms, thereafter monthly until January 11, 2019. The DHS is responsible for monitoring and ensuring proper medication handling.	

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F 761	Continued From page 30 the Bravo medication cart ready for resident use and was opened and undated. On 10/16/18 at 08:44 AM an interview was conducted with Nurse #1 who stated she missed checking for an open date on the NovoLog multi-dose insulin vial before she administered 4 units of NovoLog insulin to Resident #26 at 07:30 AM. Nurse #1 stated the facility policy was that insulin was to be dated when opened and was good for 28 days once opened. Nurse #1 stated she was unsure how long Resident#26's NovoLog insulin multi-dose vial had been on the medication cart ready for resident use because it had not been dated when opened A review of the Medication Administration Record (MAR) revealed Resident #26 received NovoLog insulin 4 units on 10/16/18 at 7:30 AM at breakfast per physician's orders and as indicated by Nurse #1's documentation on the MAR. On 10/16/18 at 08:58 AM an interview was conducted with the Nurse Supervisor who stated Resident #26's NovoLog insulin multi-dose vial should have been dated when opened per facility policy. The Nurse Supervisor verified Resident #26's NovoLog insulin multi-dose vial was not dated when opened. The Nurse Supervisor stated once opened the NovoLog insulin multi-dose vial was good for 28 days but because it was not dated when opened the expiration date could not be determined. On 10/16/18 at 09:09 AM an interview was conducted with the Director of Nursing (DON) who verified Resident #26's NovoLog insulin multi-dose vial was opened and undated. The DON stated the NovoLog insulin should have	F 761	What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? 1.Starting 10/16/18 the daily audit sheets on the MARS were instituted and have had 100% compliance. Weekly audits began 10/23/18 and go weekly for 8 weeks until 1/11/19 with monitoring by the DHS and supervisors. The DHS is responsible for Plan of Correction compliance. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. 1.The daily medication audit sheets on each halls MARS will be monitored by the DHS. The weekly audits of the carts and medication rooms will be done by the supervisor and the DHS. The DHS is responsible for Plan of Correction compliance. 2.The monthly check will be done by the supervisor and DHS. The DHS is responsible for monitoring Plan of Correction compliance for proper medication handling and storage. 3.Reports of Plan of Correction compliance audits will be reported to the QAPI members at monthly meetings. Date of Compliance: 11/15/18	

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	345558	A. BUILDING _____ B. WING _____	10/18/2018

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

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F 761	Continued From page 31	F 761		

been dated when opened per facility policy and was good for 28 days once opened. The DON stated her expectation was that Resident #26 would not have received NovoLog insulin from a multi-dose vial that had not been dated when opened. The DON stated because the NovoLog insulin multi-dose vial was not dated when opened then it could not be determined when the Novolog insulin would expire.

On 10/16/18 at 09:21 AM an interview was conducted with the Administrator who stated his expectation was that Resident #26 would not have received Novolog insulin from a multi-dose vial that was not dated when opened. The Administrator stated it was his expectation that Resident #26's NovoLog insulin multi-dose vial would have been dated when opened per facility policy.

2. A review of the manufacturer's recommendation for multi-dose tuberculin purified protein derivative indicated that once opened the product was to be discarded after 30 days.

A review of the facility policy entitled Medication Storage in the Healthcare Centers with a revised date 09/15/17 indicated (in part) nurses were required to check all medications for expiration before administration. A multi-dose container of injectable was to be dated when opened.

On 10/16/18 at 09:05 AM 2 of 3 multi-dose vials of tuberculin purified protein derivative were observed in the Bravo medication storage refrigerator opened and not dated and were available for resident use. The Director of Nursing (DON) verified 1 tuberculin purified protein derivative vial was 1 milliliter (ml) and had a lot

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	345558	A. BUILDING _____ B. WING _____	10/18/2018

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

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F 761	Continued From page 32 number of 307584 and an expiration date of 10/19 and was opened and not dated and verified a second 1 ml vial of tuberculin purified protein derivative with a lot number of 313378 and an expiration date of 11/19 was not dated when opened. Both vials of tuberculin purified protein derivative were removed from the Bravo medication storage refrigerator. On 10/16/18 at 09:12 AM an interview was conducted with the DON who stated it was her expectation that tuberculin purified protein derivative multi-dose vials would have been dated when opened per facility policy and should not have been in the Bravo medication storage refrigerator ready for resident use. On 10/16/18 at 09:21 AM an interview was conducted with the Administrator who stated it was his expectation that the tuberculin purified protein derivative multi-dose vials would have been dated when opened per facility policy and should not have been available in the Bravo medication storage refrigerator ready for resident use.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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	F 812		11/15/18

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	345558	A. BUILDING _____ B. WING _____	10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 33 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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to 1) ensure food was not stored beyond expiration or on the floor, 2) cover all hair when working in the kitchen and 3) maintain an ice scoop and fan in a sanitary condition. The findings included: 1. During the initial tour of the facility kitchen on 10/15/18 from 9:10 AM-9:35 AM the following concerns were identified: -In the walk in freezer 2 boxes of turkeys were stored on the floor, under a shelving unit. A box of hot dog buns (with 2 additional boxes on top) were stored on flooring, in the walk in freezer. -In the reach in refrigerator a bowl containing a sliced meat product was observed covered in plastic wrap and stored on shelving, ready for use. There was not a label on the bowl to indicate product or expiration date. A dietary aide was present at the time of the observation and stated she could not explain why the sliced meat was not labeled. -A male dietary aide was observed working in the walk in refrigerator as well as by the ice machine during the time of the initial kitchen tour. The male dietary aide had a full beard that was not covered with a beard guard.	F 812	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1.All food delivered will be stocked on shelves prior to the end of the working day. 2.All staff will be in-serviced on the requirement for hair and beard covers while in food service areas. Beard covers will be provided in addition to hair covers at the entrance to the kitchen. 3.Any product pulled from the freezer will be dated with a thaw date and or an open date to ensure spoiled food will be disposed. 4.Fans will not be allowed in the dishwashing area of the kitchen. 5.An ice scoop cleaning schedule is added to weekly cleaning list for dietary staff. 6.The nourishment refrigerators (B/C side and A/D side) will be checked daily by the dietary staff to ensure out of date food or non-labeled/dated food items will be disposed of.	

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	345558	A. BUILDING _____ B. WING _____	10/18/2018

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F 812	Continued From page 34 -An undated bag of hoagie rolls was stored on the top of the bread rack. There was not a manufacturer date of expiration or any other label to indicate expiration. The hoagie rolls felt hard to touch and the underside of one of the hoagie rolls had mold growth. -A black stand fan, approximately 3' in height, was observed in the dish room. The setting on the fan was on "high" and air movement was directed toward the clean dish area. The fan was turned off and a significant amount of dust was observed on the majority of the surface area of the back grill and a noticeable amount of dust was on the outer perimeter of each fan blade. At approximately 9:30 AM the Food Service Director (FSD) came to the kitchen. The FSD stated bread was delivered twice a week and the "bread man" went through the bread racks and removed any bread products that were outdated. The FSD stated the hoagie rolls were kept frozen and removed for service when indicated on the menu. The FSD stated the hoagie rolls had been used for sandwiches the prior week and noted the hoagie rolls should have been discarded. The FSD stated food deliveries occurred on Tuesday and Thursday and the aide that put stock on shelving had worked Friday and Sunday. The FSD stated boxes should not be stored on flooring and could not explain why the turkeys and hot dog buns had not been stored on shelving in the walk in freezer. In a follow-up interview on 10/18/18 at 11:00 AM the FSD stated the black fan had been brought in for use in the kitchen when there had been issues with the air handler. The FSD stated she noticed the soiled condition of the fan on 10/15/18 and was going to have it removed from service in the	F 812	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1.Beard and hair covers will be checked daily M-F by the dietary manager and on weekends by the cook. 2.The cleaning schedule posted will the ice scoop as part of the weekly cleaning list for each kitchen area. 3.The stock room will be checked by the second shift cook on stock days to ensure all items are off the floor and stocked appropriately in accordance with food guidelines. Documented with cook cleaning list. 4.Nourishment rooms cleaning/stocking are initialed and dated on documentation forms daily. 5.All corrections of F 812 are completed on 11/9/18. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? 1.Beard and hair covers will be checked daily M-F by the dietary manager and on weekends by the cook. 2.The cleaning schedule posted will the ice scoop as part of the weekly cleaning list for each kitchen area. 3.The stock room will be checked by the second shift cook on stock days to ensure all items are off the floor and stocked appropriately in accordance with food guidelines. Documented with cook	

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F 812	Continued From page 35 kitchen. The FSD stated she expected a beard guard to be worn at all times when dietary staff with beards were in the kitchen. The FSD stated she expected opened food products to be labeled and dated when stored in refrigeration. 2. On 10/15/18 at 10:22 AM, 12:58 PM and 3:22 PM an observation was made of the kitchenette on A hall. An ice scoop holder stored beside the ice machine was observed on the counter and consisted of an upright, free standing clear plastic holder with a removable lipped insert. The ice scoop was stored inside the holder, in the removable lipped insert. There was a couple inches of water inside the lipped insert and, when held up to light, a significant amount of debris was noted in the water. On 10/15/18 at 3:32 PM a dietary aide was asked about the ice scoops and the dietary aide stated there was no set cleaning schedule for ice scoops; just when staff saw a need for cleaning. On 10/15/18 at 3:39 PM the Food Service Director (FSD) stated she expected ice scoops to be cleaned every night by the dietary aide that worked during the supper meal in the kitchenette. The FSD observed the ice scoop on the A hall kitchenette and noted the amount of debris floating in the water in the lipped insert the ice scoop was stored in. The water was emptied from the lipped insert and a slight slimy film was felt on the bottom interior of the lipped insert which the FSD indicated was not acceptable. 3. On 10/17/18 at 4:45 PM observations were made of the nourishment room that serviced the B and C hall. Inside a drawer of the reach in refrigerator in the nourishment room was a 4 pack of individual serving cups of jello. The manufacturer stamped label on each individual	F 812	cleaning list. 4.Nourishment rooms cleaning/stocking are initialed and dated on documentation forms daily. 5.100% of dietary staff have been in-serviced by the FSD on 11/9/18 concerning beard and hair cover, cleaning schedule of ice scoops, evening cooks in-serviced on ensuring boxes are not left on the freezer/cooler floors and to be documented on cleaning schedule, and on required cleaning/stocking of nourishment rooms with documentation of task completion. 6.All corrections of F 812 are completed on 11/9/18. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. 1.Daily audit schedules have been established on 11/9/18 and will be reviewed at daily IDT meeting by FSD and RD. 2.The Registered Dietician is responsible for reviewing audits 3.Audit compliance will be reported at the monthly QAPI meeting. Date of Compliance: 11/15/18	

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F 812	Continued From page 36 container of jello read, "best by September 13 2018". A resident's name and room number was written on the cardboard container housing the single servings of jello. A sign on the door of the refrigerator read, "Make sure when stocking refrigerators to check your dates and rotate items." On 10/18/18 at 11:00 AM the Food Service Director (FSD) stated she expected dietary aides to look at all items in the nourishment pantry refrigerators and remove any expired products. The FSD stated the resident that the jello belonged to no longer resided at the facility. On 10/18/18 at 5:35 PM the administrator stated he expected to maintain a level of sanitation in kitchen.	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee had previously put into place. This failure related to one recited deficiency (F761) which was originally cited following the August 2017 recertification survey and subsequently recited on the current recertification survey. The recited deficiency was in the area of label/store	F 867	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1.On 10/16/18 DHS immediately removed all undated vials. All licensed nurses were counseled on each shift and FNP immediately checked affected resident #26 for any adverse reaction and resident was monitored for 24 hours, no adverse	11/15/18

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F 867	Continued From page 37 drugs and biologicals. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: 483.45 (F761) Label/Store Drugs and Biologicals: Based on observations, record reviews and staff interviews, the facility failed to discard an opened NovoLog insulin multi-dose vial that was not dated when opened which was available for use on 1 of 2 medication carts and failed to discard 2 of 3 multi-dose tuberculin purified protein derivative vials that were opened and available for use in 1 of 2 medication storage refrigerators. During the annual recertification survey of 08/24/17 the facility was cited for failure to date 2 opened bottles of eye drops available for use on 1 of 4 medication carts. During an interview on 10/18/18 at 6:06 PM the Administrator explained he recently transferred to this facility and was not certain where the breakdown in the system occurred. He explained, going forward, he was committed to putting a system into place for the monitoring of medication carts and storage rooms to ensure compliance was maintained.	F 867	reactions noted. The Medical Director was also notified. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1.All carts were re-audited on 10/16/18 by staff nurses and supervisors and DHS re-audited refrigerators in med rooms. 2.Education to staff was provided on 10/16/18. Audit sheets located in the front of the MARS books for every shift check of carts. 3.DHS or designee will check daily on clinical rounds and a weekly audit for 8 weeks will occur on all carts and med rooms, thereafter monthly until January 11, 2019. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? 1.Starting 10/16/18 the daily audit sheets on the MARS were instituted the DHS for licensed nursing staff have had 100% compliance. 2.Weekly audits by the DHS began 10/23/18 and go weekly for 8 weeks until 1/11/19. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. 1.The daily medication audit sheets on	

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F 867	Continued From page 38	F 867	each halls MARS will be monitored by the DHS. The weekly audits of the carts and medication rooms will be done by the supervisor and the DHS. 2.The monthly check will be done by the supervisor and DHS. 3.Reports of findings will be reported to the QAPI members at monthly meetings 4.The DHS, Administrator and IDT members will be responsible that this deficiency is not repeated Date of Compliance: 11/15/18	