DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. BUILDING ______ B. WING ______	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS HOME - SALISBURY	**1601 BRENNER AVE, BUILDNG #10 SALISBURY, NC 28145**

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 06/24/2019 through 06/27/2019. The facility was found in compliance with the requirement CFR483.73, Emergency Preparedness. Event ID XLB11.	E 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced	F 561		7/19/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/22/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 561	Continued From page 1 by: Based on observations, resident and staff interviews and record reviews, the facility failed to honor the beverage preference for 1 of 1 resident (Resident #12) reviewed for choices. The findings included: Resident #12 was admitted to the facility on 09/26/2017 with diagnoses that included but not limited to Type 2 Diabetes Mellitus without complications. Review of the Minimum Data Set (MDS) which was a Significant Change dated 03/28/2019 revealed Resident #12 had moderate impaired cognition. The MDS further revealed he required supervision with set up help only for eating his meals. An observation was conducted of the lunch meal service on 06/24/19 at 12:51 PM for Resident #12. The meal tray card read under special instructions, Lactaid Milk and the word "out" was written underneath it. Resident was observed with Fat Free Milk on his tray and no Lactaid Milk was observed to be served to resident. An observation was conducted on the lunch meal service on 06/25/19 at 12:47 PM for Resident #12. The meal tray card read under special instructions, Lactaid Milk. Resident was observed with Fat Free Milk on his tray and no Lactaid Milk was observed to be served to resident. An interview was conducted with Resident #12 on 06/25/19 at 12:45 PM. During this interview, he stated his choice was to have Lactaid Milk at	F 561	This Plan of correction constitutes a written allegation of compliance. Preparation and submission of the plan of correction does not constitute an admission or agreement by the provider of the truths of the conclusions alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. The facility failed to meet CFR 483.10(f)(1)-(8) self-determination by failing to provide the beverage preference of Resident #12. The corrective action for Resident #12 was accomplished by the administrator and the dietary manager obtaining Lactaid Milk from Sysco foods on 6/26/2019. Process that lead to deficiency. The Dietary Manager failed to order Lactaid Milk. The Dietary Manager failed to consult with the Registered Dietician to determine if Fat free milk was a suitable substitute for Lactaid Milk. The process for implementation of the acceptable Plan of Correction for the specific deficiency are as follows. 100% Audit of Resident Preferences completed and verified on 7/19/18. The dietary manager will order 4 cases of Lactaid milk per order. The dietary manager will check weekly orders to verify receipt of all ordered items.	

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F 561	Continued From page 2 every meal related to his preference. Resident #12 further stated that he was getting Fat Free milk at every meal and he had to "turn it away" because he could not drink it. He expressed that when he drank regular milk it caused him to have loose bowel movements. Furthermore, Resident #12 stated that he loved to drink milk but preferred Lactaid Milk. During an interview with NA #1 on 06/25/19 at 12:47 PM, she revealed that Resident #12 preferred Lactaid Milk and that Lactaid Milk was not available to be served to the resident and fat free milk was given as alternative. During an interview with NA #2 on 06/26/19 at 08:01 AM, she revealed that Residents #12's choice was to drink Lactaid Milk and that the facility was out of it, so he was given fat free milk in its place. Interview with Registered Dietician (RD) on 06/26/19 at 04:24 PM revealed fat free milk was not an appropriate substitution for Lactaid Milk. RD said he was aware of Resident #12's preference for Lactaid Milk. During an interview with Dietary Manager (DM) on 06/27/19 at 01:20 PM, DM stated that they ran out of Lactaid Milk over the weekend and he forgot to order it. An interview was conducted with the Director or Nursing (DON) and the Administrator on 06/27/19 at 04:25 PM. During this interview the DON stated it was disappointing that the Lactaid Milk was not available to be served to Resident #12 in accordance with his preferences.	F 561	The dietary manager will monitor tray line 4 days a week to ensure that trays are accurate. All dietary staff completed 100% education on 6/28/2019 to read and initial every tray, ensuring accuracy to each Veterans likes and dislikes, and special requests and to inform the Dietary Manager when running low on said items. The title of the person responsible for implementing the acceptable Plan of Correction. The Administrator/Dietary Manager/designee. is responsible for implementing the acceptable Plan of Correction	

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F 656	Continued From page 3	F 656		
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 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	F 656		7/19/19

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F 656	Continued From page 4 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 observation, record review and staff interview, the facility failed to implement care plans for 4 of 17 sampled residents (Resident #57, Resident #44, Resident #11 and Resident #64) reviewed for care plans. The Findings Included: 1. Record review revealed Resident #57 was admitted on 5/30/17 with diagnosis that included diabetes, hypertensive heart disease with heart failure, and chronic diastolic (congestive) heart failure Review of the most recent Minimum Data Set (MDS) dated 5/21/19 showed Resident #57 needed extensive assistance with bed mobility, transfers and toileting and was independent with eating. Review of the care plan updated 5/21/19 for Resident #57 revealed a potential for alteration in nutrition and significant weight loss with poor intake with meals. Approaches included, serve diet as ordered and provide magic cup (a protein and calorie packed ice cream) at all meals. On 6/27/19 at 8:15 an observation of Resident #57's breakfast meal tray revealed resident did not receive magic cup on his tray. An observation of Resident #57's meal card revealed that resident was to receive a magic cup as a	F 656	The title of the person responsible for implementing the acceptable Plan of Correction. The Administrator/Dietary Manager/designee. is responsible for implementing the acceptable Plan of Correction. The facility failed to develop/implement comprehensive care plan CFR483.21(b)1 by failing to provide magic cups for resident #57. The corrective action for resident #57 was accomplished by the administrator and dietary manager obtaining Magic Cups from Sysco Foods 6/28/2019. The process for implementation the acceptable Plan of Correction for the specific deficiency was accomplished by the Administrator/Director of Health Services/Dietary manager on 7/19/19 was as follows. 100% audit of veteran□s supplements was completed on 6/28/2019. On 7/19/2019 a monitoring tool was created and utilized by the Administrator /designee to collect data weekly on all veterans with supplements and discussed with the Interdisciplinary Team. On 6/28/2019 a supplement monitoring tool was created and utilized by the dietary manager/designee to ensure said supplement is on tray. The results from	

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F 656	Continued From page 5 supplement. On 06/27/19 01:14 PM an observation of Resident #57's lunch meal tray showed resident did not receive magic cup on his tray. Magic Cup is typed on the meal card and "OUT" was written beside it. 2. A record review of Resident #44 revealed resident was admitted on 3/7/19 with diagnosis that included diagnosis that included hemiplegia following cerebral infarct affecting left side, hemiplegia following infarct affecting right side and atrial fabulation. Review of the most recent Minimum Data Set (MDS) dated 5/13/19 revealed resident was cognitively impaired. It showed resident needed total assistance with bed mobility, bathing, bowel and bladder. It also showed that resident was on a weight loss regimen with an altered and therapeutic diet. Review of care plans included potential for alteration in nutrition related to recent Cerebral Vascular Accident. Approaches to the care plan included dietary supplements as ordered. An observation of Resident #44's lunch meal tray on 6/27/19 at 1:15pm showed no magic cup on tray. Resident's lunch meal card revealed that resident was to receive a magic cup as a supplement. Magic Cup is typed on the meal card and "OUT" was written beside it. During an interview with the dietary manager at 1:20pm on 6/27/19, he stated the facility ran out of Magic Cups over the weekend and he had forgotten to order more. He further stated there	F 656	the monitoring tool will be forwarded to the Quality Assurance Performance Improvement meeting weekly and reported to the administrator and or designee weekly for 3 months then monthly ongoing. The title of the person responsible for implementing the acceptable Plan of Correction. The Administrator/Dietary Manager/designee. is responsible for implementing the acceptable Plan of Correction. The facility failed to develop/implement comprehensive care plan CFR483.21(b)1 by failing to provide magic cups for resident #44. The corrective action for resident #44 was accomplished by the administrator and dietary manager obtaining Magic Cups from Sysco Foods 6/28/2019. The process for implementation the acceptable Plan of Correction for the specific deficiency was accomplished by the Administrator/Director of Health Services/Dietary manager on 7/19/19 was as follows. 100% audit of veteran□s supplements was completed on 6/28/2019. On 7/19/2019 a monitoring tool was created and utilized by the Administrator /designee to collect data weekly on all veterans with supplements and discussed with the Interdisciplinary Team. On 6/28/2019 a supplement monitoring tool was created and utilized by the dietary manager/designee to ensure said supplement is on tray. The results from	

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F 656	Continued From page 6 were no substitutions offered and he did not contact the dietitian about substitutions for the Magic Cup. An interview was conducted with the Administrator on 6/27/19 at 5:30pm and she stated that resident care plans are to be followed. 3. Resident #11 was admitted to the facility on 1/15/16 with a diagnosis that including Chronic Renal failure, Dementia with behavioral disturbance, Anxiety, Depression, Type 2 Diabetes mellitus without complication and Essential hypertension. The quarterly Minimum Data Set (MDS) assessment dated 3/27/2019 indicated Resident #11 was cognitively impaired and required the extensive assistance of 1 for eating. Resident #11's Care Plan dated 7/4/2018 revealed he was at risk for altered nutritional status. The interventions included dietary supplements as ordered, magic cup three times a day and Register Dietitian consult as needed. An observation on 06/27/19 at 08:10 AM revealed Resident # 11 during breakfast meal. Did not observe a magic cup on meal tray and meal tray ticket indicated resident was to have a magic cup on the breakfast meal tray. An observation on 06/27/19 at 1:15 PM revealed no magic cup on meal tray and noted that on meal ticket it stated out of magic cup written to the side. Record review of Significant weight loss/gain check list form dated 5/24/19 revealed recommendations included that of magic cup at	F 656	the monitoring tool will be forwarded to the Quality Assurance Performance Improvement meeting weekly and reported to the administrator and or designee weekly for 3 months then monthly ongoing. The title of the person responsible for implementing the acceptable Plan of Correction. The Administrator/Dietary Manager/designee. is responsible for implementing the acceptable Plan of Correction. The facility failed to develop/implement comprehensive care plan CFR483.21(b)1 by failing to provide magic cups for resident #11. The corrective action for resident #11 was accomplished by the administrator and dietary manager obtaining Magic Cups from Sysco Foods 6/28/2019. The process for implementation the acceptable Plan of Correction for the specific deficiency was accomplished by the Administrator/Director of Health Services/Dietary manager on 7/19/19 was as follows. 100% audit of veteran□s supplements was completed on 7/19/2019. On 7/19/2019 a monitoring tool was created and utilized by the Administrator /designee to collect data weekly on all veterans with supplements and discussed with the Interdisciplinary Team. On 6/28/2019 a supplement monitoring tool was created and utilized by the dietary manager/designee to ensure said supplement is on tray. The results from the monitoring tool will be forwarded to the	

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F 656	Continued From page 7 all meals. During an interview with the dietary manager at 1:20pm on 6/27/19, he stated the facility ran out of Magic Cups over the weekend and he had forgotten to order more. He further stated there were no substitutions offered and he did not contact the dietitian about substitutions for the Magic Cup. An interview was conducted with the Administrator and Director of Nursing on 6/27/19 at 5:30pm and they stated the Care plan interventions were always to be implemented. 4. Resident #64 was admitted to the facility on 9/2/17 with diagnoses that included middle cerebral artery cardiovascular accident (CVA), atrial fibrillation, Alzheimer's, dementia, coronary artery disease (CAD) w/o angina, hemiplegia due to CVA, essential hypertension, and peripheral vascular disease. Resident #64's most recent quarterly minimum data set (MDS) dated 5/28/2019 documented the resident was cognitively impaired. His MDS further revealed he received anticoagulation therapy 7 out of 7 days. Review of the care plan date 5/30/2019 revealed Resident #64 was at risk for bleeding or excessive bruising due to the use of anticoagulation therapy related to his diagnosis of atrial fibrillation. The interventions included monitor labs as ordered and notify physician (MD)	F 656	Quality Assurance Performance Improvement meeting weekly and reported to the administrator and or designee weekly for 3 months then monthly ongoing. The facility failed to develop/implement comprehensive care plan CFR483.21(b)1 by failing to provide magic cups for resident #64. The corrective action for resident #64 was accomplished by the administrator and dietary manager obtaining Magic Cups from Sysco Foods 6/28/2019. The process for implementation the acceptable Plan of Correction for the specific deficiency was accomplished by the Administrator/Director of Health Services/Dietary manager on 7/19/19 was as follows. 100% audit of veteran□s supplements was completed on 7/19/2019. On 7/19/2019 a monitoring tool was created and utilized by the Administrator /designee to collect data weekly on all veterans with supplements and discussed with the Interdisciplinary Team. On 6/28/2019 a supplement monitoring tool was created and utilized by the dietary manager/designee to ensure said supplement is on tray. The results from the monitoring tool will be forwarded to the Quality Assurance Performance Improvement meeting weekly and reported to the administrator and or designee weekly for 3 months then monthly ongoing.	

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F 656	Continued From page 8 of any abnormal labs. Review of Physician Order dated 6/10/2019 for Resident #64 revealed a clarification order that stated hematocrit and hemoglobin (H&H) every 2 weeks starting 6/11/2019. Indication was listed as long-term anticoagulation therapy. Further record review revealed the labs had not been drawn on 6/11/2019 or 6/25/2019. On 6/27/2019 at 3:37PM administration stated the MD was notified and labs were immediately (STAT) ordered.	F 656		
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 observation, record review, observations and staff interview the facility failed to provide a nutritional supplement ordered by the physician for 3 of 4 residents (Resident #57, Resident #44, Resident #11). The findings included: 1. Record review revealed Resident #57 was admitted on 5/30/17 with diagnosis that included diabetes, hypertensive heart disease with heart failure, and chronic diastolic (congestive) heart failure	F 658	The facility failed to develop/implement comprehensive care plan CFR483.21(b)1 by failing to provide magic cups for resident #57. The corrective action for resident #57 was accomplished by the administrator and dietary manager obtaining Magic Cups from Sysco Foods 6/28/2019. The process for implementation the acceptable Plan of Correction for the specific deficiency was accomplished by the Administrator/Director of Health Services/Dietary manager on 7/19/19 was as follows.	7/19/19

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F 658	Continued From page 9 Review of the most recent Minimum Data Set (MDS) dated 5/21/19 showed Resident #57 needed extensive assistance with bed mobility, transfers and toileting and was independent with eating. Review of the care plan updated 5/21/19 for Resident #57 revealed a potential for alteration in nutrition and significant weight loss with poor intake with meals. Approaches included, serve diet as ordered and provide magic cup (a protein and calorie packed ice cream) at all meals. Review of Physician Order dated 5/21/19 ordered add magic cup at meals for poor oral intake and significant weight loss. On 6/27/19 at 8:15 an observation of Resident #57's breakfast meal tray revealed resident did not receive magic cup on his tray. An observation of Resident #57's meal card revealed that resident was to receive a magic cup as a supplement. Continued observation of this meal revealed the magic cup was not present on the resident's tray. On 06/27/19 01:14 PM an observation of Resident #57's lunch meal tray showed resident did not receive magic cup on his tray. Magic Cup is typed on the meal card and "OUT" was written beside it. During an interview with the dietary manager at 1:20pm on 6/27/19, he stated the facility ran out of Magic Cups over the weekend and he had forgotten to order more. He further stated there were no substitutions offered and he did not contact the dietitian about substitutions for the Magic Cup.	F 658	100% audit of veteran□s supplements was completed on 6/28/2019. On 7/19/2019 a monitoring tool was created and utilized by the Administrator /designee to collect data weekly on all veterans with supplements and discussed with the Interdisciplinary Team. On 6/28/2019 a supplement monitoring tool was created and utilized by the dietary manager/designee to ensure said supplement is on tray. The results from the monitoring tool will be forwarded to the Quality Assurance Performance Improvement meeting weekly and reported to the administrator and or designee weekly for 3 months then monthly ongoing. The title of the person responsible for implementing the acceptable Plan of Correction. The Administrator/Dietary Manager/designee. is responsible for implementing the acceptable Plan of Correction. The facility failed to develop/implement comprehensive care plan CFR483.21(b)1 by failing to provide magic cups for resident #44. The corrective action for resident #44 was accomplished by the administrator and dietary manager obtaining Magic Cups from Sysco Foods 6/28/2019. The process for implementation the acceptable Plan of Correction for the specific deficiency was accomplished by the Administrator/Director of Health Services/Dietary manager on 7/19/19 was as follows. 100% audit of veteran□s supplements	

F 658

Continued From page 10

2. A record review of Resident #44 revealed resident was admitted on 3/7/19 with diagnosis that included diagnosis that included hemiplegia following cerebral infarct affecting left side, hemiplegia following infarct affecting right side and atrial fabulation.

Review of the most recent Minimum Data Set (MDS) dated 5/13/19 revealed resident was cognitively impaired. It showed resident needed total assistance with bed mobility, bathing, bowel and bladder. It also showed that resident was on a weight loss regimen with an altered and therapeutic diet.

Review of care plans included potential for alteration in nutrition related to recent Cerebral Vascular Accident. Approaches to the care plan included dietary supplements as ordered.

A review of Physician orders dated 6/3/19 revealed Resident #44 was to receive magic cup 2 times a day.

A review of a nutritional assessment for Resident #44 dated 5/13/19 showed that resident was to receive magic cup 2 times a day.

An observation of Resident #44's lunch meal tray on 6/27/19 at 1:15pm showed no magic cup on tray. Resident's lunch meal card revealed that resident was to receive a magic cup as a supplement. Magic Cup is typed on the meal card and "OUT" was written beside it.

During an interview with the dietary manager at 1:20pm on 6/27/19, he stated the facility ran out of Magic Cups over the weekend and he had

F 658

was completed on 6/28/2019.
On 7/19/2019 a monitoring tool was created and utilized by the Administrator /designee to collect data weekly on all veterans with supplements and discussed with the Interdisciplinary Team.
On 6/28/2019 a supplement monitoring tool was created and utilized by the dietary manager/designee to ensure said supplement is on tray. The results from the monitoring tool will be forwarded to the Quality Assurance Performance Improvement meeting weekly and reported to the administrator and or designee weekly for 3 months then monthly ongoing.
The title of the person responsible for implementing the acceptable Plan of Correction. The Administrator/Dietary Manager/designee. is responsible for implementing the acceptable Plan of Correction.

The facility failed to develop/implement comprehensive care plan CFR483.21(b)1 by failing to provide magic cups for resident #11.
The corrective action for resident #11 was accomplished by the administrator and dietary manager obtaining Magic Cups from Sysco Foods 6/28/2019.
The process for implementation the acceptable Plan of Correction for the specific deficiency was accomplished by the Administrator/Director of Health Services/Dietary manager on 7/19/19 was as follows.
100% audit of veteran□s supplements

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	345531	A. BUILDING ______ B. WING ______	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS HOME - SALISBURY	1601 BRENNER AVE, BUILDNG #10 SALISBURY, NC 28145

(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 658	Continued From page 11 forgotten to order more. He further stated there were no substitutions offered and he did not contact the dietitian about substitutions for the Magic Cup. An interview was conducted with the Administrator on 6/27/19 at 5:30pm and she stated the Magic Cup was to be ordered and kept in stock and it to be placed on meal trays as ordered by the physician. 3. Resident #11 was admitted to the facility on 1/15/16 with a diagnosis that including Chronic Renal failure, Dementia with behavioral disturbance, Anxiety, Depression, Type 2 Diabetes mellitus without complication and Essential hypertension. The quarterly Minimum Data Set (MDS) dated for 3/27/19 revealed the resident was cognitively impaired and required extensive assistance with activities of daily living. Resident #11's June 2019 Physician's orders revealed a current order, that was initiated on 08/1/17, for the resident to receive a supplement of magic cup one serving three times a day at breakfast, lunch, and dinner. Resident #11's Care Plan dated 7/4/2018 revealed he was at risk for altered nutritional status. The interventions included dietary supplements as ordered, magic cup three times a day and Register Dietitian consult as needed. An observation on 06/27/19 at 08:10 AM revealed Resident # 11 during breakfast meal. Did not observe a magic cup on meal tray and meal tray ticket indicated resident was to have a magic cup on the breakfast meal tray.	F 658	was completed on 7/19/2019. On 7/19/2019 a monitoring tool was created and utilized by the Administrator /designee to collect data weekly on all veterans with supplements and discussed with the Interdisciplinary Team. On 6/28/2019 a supplement monitoring tool was created and utilized by the dietary manager/designee to ensure said supplement is on tray. The results from the monitoring tool will be forwarded to the Quality Assurance Performance Improvement meeting weekly and reported to the administrator and or designee weekly for 3 months then monthly ongoing. The title of the person responsible for implementing the acceptable Plan of Correction. The Administrator/Dietary Manager/designee is responsible for implementing the acceptable Plan of Correction.	

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F 658	Continued From page 12 An observation on 06/27/19 at 1:15 PM revealed no magic cup on meal tray and noted that on meal ticket it stated out of magic cup written to the side. During an interview with the dietary manager at 1:20pm on 6/27/19, he stated the facility ran out of Magic Cups over the weekend and he had forgotten to order more. He further stated there were no substitutions offered and he did not contact the dietitian about substitutions for the Magic Cup. An interview was conducted with the Administrator on 6/27/19 at 5:30pm and she stated the Magic Cup was to be ordered and kept in stock and it to be placed on meal trays as ordered by the physician.	F 658		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review, physician assistant interview, and staff interview the facility failed to	F 773	The facility failed to meet CFR483.50(a)2)(i)(ii) for resident #64 by	7/19/19

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F 773

Continued From page 13

obtain H&H (hemoglobin and hematocrit) and repeat complete blood count (CBC) results as ordered by the physician for 2 of 6 sampled residents (Resident # 64 and resident # 293).

The findings included:
1. Resident #64 was admitted to the facility on 9/2/17 with diagnoses that included middle cerebral artery cardiovascular accident (CVA), atrial fibrillation, Alzheimer's, dementia, coronary artery disease (CAD) w/o angina, hemiplegia due to CVA, essential hypertension, and peripheral vascular disease.

Resident #64's most recent quarterly minimum data set (MDS) dated 5/28/2019 documented the resident was cognitively impaired. His MDS further revealed he received anticoagulation therapy 7 out of 7 days.

Review of the care plan date 5/30/2019 revealed Resident # 64's was at risk for bleeding or excessive bruising due to the use of anticoagulation therapy related to his diagnosis of atrial fibrillation. The interventions included administer medications as ordered, monitor labs as ordered, monitor for sign or symptoms of bleeding, and notify physician (MD) of any abnormal labs.

Review of medication administration records May 2019 and June 2019 revealed resident # 64 had received Eliquis (apixaban) at 5mg orally twice daily.

Review of Physician Order dated 6/10/2019 for Resident #64 revealed a clarification order that stated hematocrit and hemoglobin (H&H) every 2 weeks starting 6/11/2019. Indication was listed as

F 773

failing to obtain Hemoglobin and Hematocrit as ordered by physician.
The corrective action for resident #64 was accomplished by the Performance Improvement RN notifying the PA that the labs were not drawn as ordered and obtained an order to draw the missing labs on 6/27/2019 with the results of the labs given to the PA after obtaining.

The process for implementation the acceptable Plan of Correction for the specific deficiency was accomplished by the Administrator/Director of Health Services on 7/19/19 was as follows.
A 100% audit of all lab orders obtained and verified from chart to lab system on 7/19/2019.
A new process of all lab orders will be verified and results of labs are checked daily by the Nursing Supervisor.
100% of nursing staff were educated on the new process to verify and ensure all labs ordered ore obtained.
On 7/19/2019 a lab monitoring tool was created and utilized by the to ensure ordered lab is obtained and results are on chart. The results from the monitoring tool will be forwarded to the Quality Assurance Performance Improvement meeting weekly and reported to the administrator and or designee weekly for 3 months then monthly ongoing.

The title of the person responsible for implementing the acceptable Plan of Correction. The Administrator/Director of Health Services/designee is responsible

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F 773	Continued From page 14 long-term anticoagulation therapy. Further record review revealed the labs had not been drawn on 6/11/2019 or 6/25/2019. During and interview with the Unit Manager on 6/27/2019 at 1:05PM, she stated she would check the electronic requisition for the 6/10/2019 and 6/25/2019 lab results. On 6/27/2019 at 3:37PM administration informed surveyor labs were not completed. She further stated the MD was notified and labs were immediately (STAT) ordered. 2. Resident #293 was admitted to the facility on 4/8/2019 with the diagnoses which included Major depressive disorder, Suicidal ideations, Pressure ulcer of sacral region and Cerebral infarction without residual deficits. The most recent Minimum Data Set (MDS) quarterly assessment dated 3/27/2019 revealed Resident #293 was cognitively impaired. An order received dated 4/10/2019 revealed Resident #293 was to have a repeat CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Panel) performed in one week. Review of Resident #293 lab results of a CBC with Differential and Platelet dated 4/10/2019 revealed a repeat CBC and a Comprehensive Metabolic Panel CMP was to be drawn in one week. Review of Resident #293's medical record	F 773	for implementing the acceptable Plan of Correction. The facility failed to meet CFR483.50(a)2)(i)(ii) for resident #293 by failing to obtain CBC as ordered by physician. The corrective action for resident #293 was accomplished by the Performance Improvement RN notifying the PA that the labs were not drawn as ordered and obtained an order to draw the missing labs on 6/27/2019 with the results of the labs given to the PA after obtaining. The process for implementation the acceptable Plan of Correction for the specific deficiency was accomplished by the Administrator/Director of Health Services on 7/19/19 was as follows. The process for implementation the acceptable Plan of Correction for the specific deficiency was accomplished by the Administrator/Director of Health Services on 7/19/19 was as follows. A 100% audit of all lab orders obtained and verified from chart to lab system on 7/19/2019. A new process of all lab orders will be verified, and results of labs are checked daily by the Nursing Supervisor. 100% of nursing staff were educated on the new process to verify and ensure all labs ordered ore obtained. 4.. On 7/19/2019 a lab monitoring tool was created and utilized by the to ensure ordered lab is obtained and results are on chart. The results from the monitoring tool will be forwarded to the Quality Assurance	

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F 773	Continued From page 15 revealed no results of the repeat lab requested by the Physician assistant dated 4/10/19. An interview with the Unit Manager conducted on 06/27/2019 at 12:43 PM revealed she was unable to locate the CBC that was ordered to be repeated on 4/17/2019 and was unaware of why the lab was missed. On 06/27/2019 at 02:48 PM an interview was conducted with Nurse #2 and revealed she did not recall this incident. She stated when she obtained an order for labs from the Physician she would transcribe the order and generate a requisition for labs in the computer. The Physician Assistant on 06/27/2019 at 03:19 PM revealed she had requested a repeat lab for Resident #293 due a high WBC level. During an interview with the Director of Nursing Services on 6/27/2019 at 5:30 PM he revealed the CBC lab should have been drawn per physician orders.	F 773	Performance Improvement meeting weekly and reported to the administrator and or designee weekly for 3 months then monthly ongoing. The title of the person responsible for implementing the acceptable Plan of Correction. The Administrator/Director of Health Services/designee is responsible for implementing the acceptable Plan of Correction.	