STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345558	A. BUILDING ______ B. WING ______	C 11/12/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/08/21 through 11/12/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 3NLF11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 11/08/21 through 11/12/21. There were 27 complaint allegations investigated and 3 allegations were substantiated. Event ID# 3NLF11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		12/11/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/07/2021

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 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, and staff interviews the facility failed to maintain dignity by taking a call light away from a resident. This affected 1 of 6 (Resident #63) sampled residents reviewed for dignity. The resident expressed feelings of being upset and nursing staff didn't care about him. The findings included: Resident #63 was admitted to the facility on 2/5/21 with diagnoses which included muscle weakness, anxiety, depression, and history of falling. A review of Resident #63's quarterly Minimum Data Set (MDS) dated 10/11/21 indicated Resident #63 was cognitively intact and needed extensive assistance requiring two people assist for transfers.	F 550	What corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1)At this time resident #63 is unable to be interviewed due to expiring. 2)Education was provided to Nurse #4 on resident□s rights on 12/4/21 by the Director of Nursing(DON). 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)100% audit will be conducted by the Clinical Competency Coordinator (CCC) or designee by 12/11/21 with all residents	

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An interview conducted with Resident #63 on 11/9/21 at 10:00 AM revealed last week Resident #63's call light was not attached to his bed properly so he held it in his hand it so it would not fall in the floor. Resident #63 revealed he had pushed his call light button a couple of times by accident. Resident #63 stated Nurse #4 entered his room and Resident #63 asked Nurse #4 to attach his call light to his bed, but instead Nurse #4 took it away. Resident #63 revealed during the night he needed assistance with getting a drink he had to yell until someone came. Resident #63 revealed Nurse #4 tells residents frequently to not use their call light button. Resident #63 revealed he was upset and felt that nursing staff did not care about him.

An interview conducted with Resident #24, a cognitively intact resident, on 11/9/21 at 10:15 AM revealed he heard Nurse #4 tell Resident #63 to quit using his call light. Resident #24's room is next to Resident #63's room and further revealed he heard Resident #63 yelling for assistance throughout the night stating Nurse #4 took his call light away. Resident #24 stated Nurse #4 often tells Residents to not use their call lights and gets irritated when residents do. Resident #24 revealed Resident #63 was upset, and Resident #24 felt like nursing staff did not treat Resident #63 with care and respect.

An interview conducted with Nurse Aide (NA) #2 on 11/9/21 at 12:09 PM revealed Resident #63 and Resident #24 reported that Nurse #4 had taken away Resident #63's call light and Resident #63 was upset. NA #2 further revealed residents complain Nurse #4 gets aggravated when residents use their call light.

F 550

with a BIMS score of 13 or greater with issues on call lights being removed.

2)All concerns will be addressed on an individual basis by the DON and/or Administrator (NHA).

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not reoccur?

1)100% in-service of all staff will be conducted on resident□s rights and ensuring call light are within reach at all times with all staff by CCC and/or designees by December 11, 2021.

2)Any staff on PRN or on Leave of Absence will be in-serviced prior to their next scheduled shift.

3)Comprehensive resident interviews related to call lights being removed will be conducted on all residents by the Interdisciplinary Team (IDT)with a BIMs score of 13 or greater by 12/11/21 and every 30 days for 3 months.

4)Interdisciplinary Team (IDT) will ensure compliance rounds are conducted Monday □ Friday which includes proper call light placement weekly x 4 weeks and then monthly x 2months.

How will the corrective action be monitored to ensure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for

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F 550	Continued From page 3 An interview conducted with Nurse Aide #3 on 11/9/21 at 6:05 PM revealed she was assigned to Resident #63 the night Resident #63 disclosed his call light was taken. NA #3 denied Resident #63 yelling for assistance or the call light being took away. An interview conducted with Nurse #4 on 11/10/21 at 6:02 PM revealed Resident #63 was using his call light often for no reason. Nurse #4 further revealed he educated Resident #63 on using his call light and asked him not use it as much but stated he did not take it away. An interview conducted with the Director of Nursing on 11/10/21 at 12:50 PM revealed she was not aware that any residents call light had been taken away or told to not use it. The DON further revealed she expected for residents call lights not be taken away at any time.	F 550	monitoring to assure continued compliance? 1)Review of call light deficiencies as indicated by grievances and reports from resident council will be completed at morning meetings by the Social Worker 5 days a week (Monday-Friday) x 4 weeks, then weekly x 8 weeks. 2)5 random rooms, on compliance rounds sheets, will be reviewed for non-compliance in call lights being in reach, 5 days a week x 4 weeks and then weekly x 8 weeks by the DON and or designee 3)5 random residents with a BIMs score of 13 and greater will be interviewed about call light being taken away. Daily x 4 weeks and then weekly x 8 weeks by the DON and or designee 4)Audit forms will be presented to the Quality assurance performance improvement (QAPI) committee meeting by the DON/ADON and/or designee and reviewed for 3 months. Any issues or trends will be identified and addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. Date Certain 12/11/2021	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination.	F 561		12/11/21

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F 561	Continued From page 4 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 by: Based on observation, record review, and resident and staff interviews the facility failed to allow a resident assessed as a safe smoker to smoke independently and at will for 1 of 2 residents (Resident # 61) reviewed for smoking. Findings included: Resident #61 was admitted to the facility on 10/21/2020.	F 561	What corrective action will be accomplished for the resident found to have been affected by the deficient practice? 1.Resident #61 was reassessed and determined to be a supervised smoker due to routine prescribed sedatives and the use of Oxygen (02).	

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F 561	Continued From page 5 A grievance/complaint form dated 12/8/2020 revealed Resident #61 was sitting in her coat and toboggan waiting for someone to take her out to smoke. The resident stated the staff always had an excuse and could not take her out. Housekeeping was the only ones that would take her out to smoke. The resolution of the grievance stated the facility would be setting up a smoking schedule and that Nurse Aides and Housekeeping would take the residents outside to smoke at the scheduled times. Resident was informed that the smoking schedule with the assigned staff would be posted by the end of 12/18/2020. A review of the annual Minimum Data Set (MDS) dated 10/1/21 revealed Resident #61's cognition was intact. Resident #61 was independent with all bathing, mobility and transfers. Resident #61 was coded as a current tobacco user. Resident #61's care plan dated 8/7/21 revealed she has requested to smoke. The goal was that the resident would smoke safely in a designated area with current interventions. The interventions included explaining the facility smoking policy to the resident, providing supervision when smoking, keeping all smoking tobacco and lighters at the nursing station, and showing the resident where the designated smoking areas were located. A review of the smoking assessment dated 11/9/21 revealed Resident #61 was alert with adequate cognitive function, good hand dexterity, good vision, and did not endanger others or self while smoking. It further revealed Resident #61 was to smoke only in the designated area and	F 561	2.Resident #61 was in-serviced on where the new smoking schedule for supervised smokers is located and the limit of 15 minutes for each designated smoking time. This will be done by Social Services (SSD) by 12/10/21. 3.Resident #61 was in-serviced that personnel from the nursing, housekeeping and laundry department are available during the designated smoking times 7 days a week by Social Services Director (SSD) and Administrator (NHA) on 12/11/21. 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 current designated smokers were identified and reassessed as to being a supervised or an unsupervised smoker by ADON or designee by 12/2/21. 2.All smokers will be in-serviced on where the new smoking schedule for supervised smokers is located and the limit of 15 minutes for each designated smoking time. This was done by Social Services (SSD) on 12/10/21 for resident #61 and for all other smokers on 12/11/21 by NHA. 3.All new admissions will receive a smoking assessment to determine whether or not they are supervised or unsupervised by Admitting Nurse or Charge Nurse within 24 hours of admission.	

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F 561	Continued From page 6 able to extinguish a cigarette safely and completely using the ashtray provided. A review of the posted smoking schedule located on the wall outside all designated smoking areas on 11/9/21 revealed the smoking times were 9:00 AM - housekeeping, 10:30 AM - housekeeping, 2:30 PM - Nursing Assistant (NA), 4:30 PM - housekeeping, 7:00 PM - housekeeping, 9:00 PM - NA, 11:00 PM NA. Nursing assistants and housekeeping were to take them out to smoke. There were no time limits for smoke breaks. On 11/9 /21 at 2:55 PM an observation was made of a NA bringing Resident #61 back in from smoking. An interview with Resident #61 on 11/9/21 at 2:55 PM revealed she was a smoker and must be assisted and supervised when she went out to smoke. Resident #61 further reported on 3 days of last week (she could not recall the exact days) she missed the smoke breaks on day shift because staff told her they were busy. She revealed that some days she would get a smoke break, but it would not be at the scheduled smoking times. Resident #61 stated that sometimes a nursing assistant would take her out and sometimes a housekeeper would take her outside to smoke. An interview with NA # 9 on 11/9/21 at 3:05 PM revealed the smoking schedule was posted on the wall at every smoking exit on each hall. NA #9 reported she was trained on watching residents while they smoked and making sure the residents put out their cigarettes appropriately. NA #9 stated when they were short - staffed they could not take the residents out to smoke.	F 561	4.Any residents deemed to be an unsupervised smokers by using the Pruitthealth□s smoking assessment form will be in-serviced that smoking cannot occur inside of the center, the whereabouts of the outside smoking areas, the safety rules as it applies to proper disposal of cigarettes, use of fire extinguisher, the use of a smoking blanket and the safety of other supervised smokers etc. This will be done by NHA or designee upon assessment indicating an unsupervised smoker. 5.All unsupervised smokers - resident #61 was in-serviced on 12/10/21 by SSD. All other unsupervised smokers were in-serviced on 12/11/21 by NHA. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not reoccur? 1)All Housekeeping and Nursing staff will be in-serviced on self determination, the difference between supervised and unsupervised residents, the new smoking schedule for supervised smokers, areas for smoking and the time limit for each designated time. In addition, they will be in-serviced that schedules cannot be missed due to staffing issues. This in-service will be done by CCC or designee by 12/11/21. 2)All designated smokers will be in-serviced by CCC or designee on 12/11/21 on where the new smoking	

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An interview with Nurse #7 on 11/10/21 at 9:43 AM revealed that the residents that smoke could go during the times posted on the smoking schedule accompanied by either housekeeping or nursing assistants.

An interview with the Director of Nursing on 11/10/21 at 8:22 AM stated it was her expectation that residents who smoked were offered and taken out to smoke at the designated break times. She further stated it was the resident's right to smoke.

An interview with the Administrator on 11/10/21 at 3:10 PM revealed residents who smoked had the right to smoke, and the facility should adhere to the resident choices regarding smoking. He stated that the residents usually get 15 minutes to smoke which gives them the opportunity to smoke at least two (2) cigarettes within that 15 minutes. He stated that all residents are to be supervised by a staff member while smoking, and that he was unaware that residents were not being taken out at the scheduled times.

F 561

areas and smoking schedules are located. In addition, they will be in-serviced on the time limits of 15 minutes for each smoking scheduled time.

3)The smokers will be interviewed each week for 4 weeks and each month for 90 days. This will be conducted by the SSD and or designee to ensure the process for smokers stays in place and to determine if adjustments need to be made to ensure resident□s self determination.

How will the corrective action be monitored to ensure 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)Smoking times will be randomly observed 5 times a week X 4 weeks and 1 time a week X 8 weeks by Medical Records Coordinator (MRC).

2)Smoking Assessments will be monitored by MDS staff and after each new admission and every week for 4 weeks and monthly for 90 days.

3)The smokers will be interviewed each week for 4 weeks and each month for 90 days. This will be conducted by the SSD and or designee to ensure a sustained process for smokers and to determine if adjustments need to be made to ensure resident□s self determination.

4)Any smoking issues will be brought up

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F 561	Continued From page 8	F 561	and assessed during monthly QAPI meeting x three months. Date Certain for POC- 12/11/21	
F 563 SS=F	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by:	F 563		12/11/21

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F 563	Continued From page 9 Based on record review, resident interview, staff interviews, and family interviews the facility imposed restricted visitations by requiring visits to be scheduled, limited visitation times and did not allow for privacy during outdoor visits for 2 of 5 residents (Resident #32 and Resident #61) reviewed for visitation. This practice had the potential to affect all residents. Findings included: 1. Resident #32 was admitted to the facility on 4/2/19. Review of Resident #32 quarterly Minimum Data Set (MDS) dated 9/8/21 revealed Resident #32 was moderately cognitive impaired but was able to make his needs known. An interview conducted with Resident #32 on 11/9/21 at 10:15 AM revealed Resident #32 had an outdoor visit with an out of state family member two weeks ago and was only allowed 30 minutes to visit. Resident #32 further revealed staff would not allow him to visit longer and took him back to his room. Resident #32 stated outdoor visitation was always scheduled and was not allowed for more than 30 minutes. An interview conducted with Resident #32's legal representative (LR) on 11/10/21 at 8:45 AM revealed on 11/5/21 Resident #32 had visitation with family members visiting from out of state. The LR further revealed outdoor visitation was scheduled and only allowed for 30 minutes. The LR stated the resident and family requested more time, but staff denied extra visitation and took Resident #32 back to the resident's room. The LR revealed Resident #32 was upset and frustrated	F 563	What corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1.Resident #32 and #61 were affected by the deficient practice. Resident #32 is deceased. Resident #61 was given a copy of the CMS QSO-20-39-NH and a copy of the new Pruitt Policy updated memo (dated 11/16/21) from Pruitthealth which summarizes in layman□s terms the new visitation guidelines. This was done by the Social Services Director on 12/6/21. In addition, the Responsible Party for Resident# 61 was mailed copies of the Policy updated memo from Pruitt on 12/6/21 and mailed the official CMS QSO-20-39-NH on 12/10/21 by the SSD. 2.Prior to the 2567 the new CMS guidelines QSO-20-39-NH dated 11/12/21 were immediately instituted throughout the Center and all restricted visitations was discontinued. (DC□d) by the Administrator on 11/12/21. 3.All Staff were inserviced on new Pruitthealth Policy guidelines based on the CMS □ QSO-20-39-NH Visitation by 12/6/21 by their respective Interdisciplinary Team Leader. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current and future residents could be affected by the deficient practice.	

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for not having extra time.

An interview conducted with the Activity Director (AD) on 11/10/21 at 9:26 AM revealed outdoor visitation occurred on 11/5/21 due to the facility being in outbreak status. The AD stated there was covid positive in the facility. The AD revealed during outbreak status visitation was scheduled in 30-minute time increments. The AD further revealed she was not present for visitation on 11/5/21 but multiple staff assisted with visitation and were educated to follow guidelines put in place. The AD indicated families and residents were allowed more time if requested, but some staff might not had known this.

An interview conducted with the Administrator on 11/10/21 at 3:50 PM revealed on 11/5/21 the facility was declared in outbreak due to a resident being covid positive. The Administrator further revealed during an outbreak status visitation was scheduled outside for 30 minutes. The Administrator revealed residents and families were allowed more than 30 minutes and could not recall why Resident #32 was denied more visitation time with his family.

2. Resident #61 was admitted to the facility on 10/21/2020.

A review of the annual Minimum Data Set (MDS) dated 10/1/21 revealed Resident #61 was cognitively intact.

An interview conducted with Resident #61 on 11/10/21 at 2:10 PM revealed visits must be scheduled and wishes the facility would allow more time for visitation. She stated that a staff member takes her outside for the visit and stays

F 563 (Plan of Correction)

1.All new admits and their respective representative (RP) will be given current visitation Pruitt guidelines based on the new CMS-QSO-20-39-NH starting on 12/6/21 by the Admission□s Director and/or designee.

2.All new staff will be in-serviced and provided the current visitation Pruitthealth visitation guidelines based on the CMS-QSO-20-39-NH by 12/6/21 by their respective IDT leader.

3.Any complaints/grievance from residents and/or from their respective RP about visitation will be elevated to the Administrator and/or designee for resolution starting on 12/6/21.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not reoccur?

1.Visitation guidelines were given to each resident on 12/6/21 by the interdisciplinary team (IDT) via compliance round assignment.

2.Resident Council will be in-serviced/reminded again on the new guidelines related to Visitation on 12/14/21 by Administrator and/or designee.

3.Letters to the RPs have been mailed out to educate families on the new guidelines on 12/6/21 by receptionists.

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F 563	Continued From page 11 with the resident. She further stated that she was only allowed a thirty (30) minute visit with her family. Resident # 61 stated at the present time there was no inside visitation everything was outside. An interview was conducted with the Activities Director on 11/10/21 at 9:10 AM revealed family members could schedule an appointment either by calling the Corporate number or they could call her and schedule directly. She stated that the time frame for outside visitation was limited to 30-minute visits. If the family requested to stay longer than the thirty (30) minutes she tried to accommodate. Visits were being limited to thirty minutes due to the number of families with limited space, but she never denied family members extra time or compassionate care visits. When she was asked what the facility did in the event of bad weather, she responded the facility was currently in the process of discussing their options when bad weather occurred. An interview conducted with the Director of Nursing (DON) on 11/10/21 at 9:17 revealed when the facility was in code red status (which means the facility has a covid positive resident and/or staff member) all visitation was done outside. She stated that as of 11/10/21 the facility was out of code red status and were now allowing inside visitation. The DON further revealed visitation between residents and family should not be limited. An interview conducted with the Administrator on 11/10/21 at 3:45 PM revealed the facility came out of code red status on 11/10/21, therefore, the facility was now having inside visitation. The administrator further revealed there should not be	F 563	4.All RPs were notified (via Everbridge) of the new visitation guidelines starting on 11/15/21 via Mgt. Company. 5.All new staff have been in-serviced and provided the current guidelines for visitation starting on 12/6/21 by their respective department head and/or designee. 6.Any new updated policies and procedures from management company related to visitation will be reviewed and implemented as soon as possible and not beyond 48 hours by IDT team. 7.In the future, the IDT team will educate staff, residents and families within 24-48 hours of changes in visitation policies. How will the corrective action be monitored to ensure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to ensure continued compliance? 1.Corrective actions will be monitored by SSD and Administrator via Resident Council Minutes and/or resident and family grievance/s monthly x 3 months. 2.The IDT delivery of guidelines will be noted on resident census starting on 12/6/21 □ 12/10/21 and reviewed by Administrator or designee for completion. 3.All issues related to Visitation will be	

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F 563	Continued From page 12 a limit of how long and how many visits per week residents can receive. The Administrator stated that outside visitation was unrestricted, and family could visit as much as they wanted.	F 563	assessed during our monthly QAPI meeting by IDT x 3 months. 4.Any staff designated as PRN, Leave of Absence (LOA) etc. will not be able to work the floor until in-services on Visitation is complete. Date Certain for POC completion - 12/11/21	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		12/11/21

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F 583	Continued From page 13 of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to protect the private health information for 2 of 2 sampled residents (Resident #39 and # 40) by leaving confidential medical information unattended and exposed in an area accessible to the public. The findings included: 1. Resident #39 was admitted to the facility on 11/20/17. A continuous observation was made on 11/09/21 from 5:18 PM through 5:23 PM of an unattended medication cart next to the nurse station on B Hall. Nurse #2 left the medication cart with the Medication Administration Record (MAR) of Resident #39 visible on the medication cart's computer screen when he was approximately 10 feet away with his back facing the cart measuring blood pressure for Resident #34. The screen showed the name and the picture of Resident #39. The surveyor could easily access information related to the resident's current medications and other private health information. The unattended computer was accessible by anyone near the medication cart. During an interview with Nurse #2 on 11/09/21 at	F 583	What corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1)Resident #39 and #40 was affected by this deficient practice. The nurses were educated at the time of the occurrence to always minimize the electronical medical records (EMR) any time they step away from the computer. All charge nurses were educated on minimizing the EMR when stepping away from the computer on 11/10/2021 by the compliance care coordinator (CCC) and/or designee. 2)Medication administration audit will be performed by the DON/ADON and or designee on 12/3/21 with the 6a to 6p nurse to ensure EMR is minimized when nurse leaves the computer. 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 residents have the potential to be affected by the current deficient practice.	

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5:24 PM he explained while he was preparing insulin for Resident #39, Resident #34 asked him to measure his blood pressure. He was distracted and had forgotten to turn on the privacy protection screen before leaving the medication cart. He stated he had too many things going on at the same time and acknowledged that it was an oversight to leave the MAR screen unattended. He indicated that he had received the Health Insurance Portability and Accountability Act (HIPAA) training from the facility during orientation.

2. Resident #40 was admitted to the facility on 09/03/20.

A continuous observation was made on 11/10/21 from 8:21 AM through 8:25 AM of an unattended medication cart on D Hall. Nurse #1 left the medication cart with the MAR of Resident #40 visible on the medication cart's computer screen when she was approximately 20 feet away taking Resident #60's temperature. The screen showed the name and the picture of Resident #40. The surveyor could easily access information related to the resident's current medications and other private health information. The unattended computer was accessible by anyone near the medication cart.

During an interview with Nurse #1 on 11/10/21 at 8:28 AM she explained while she was preparing medication pass for Resident #40, Resident # 60 requested to have his temperature taken. She was distracted and had forgotten to turn on the privacy protection screen before leaving the medication cart. She stated even though she was about 20 feet away from the medication cart, she was facing the medication cart and still had visual

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To ensure that no other resident was affected by this deficient practice all staff with access to medical records (administrative department, nursing department, and activities department) will be provided an in-service regarding HIPPA which includes resident□s personal privacy/confidentiality of records and minimizing the computer with EMR visible when stepping away by the CCC/ADON/DON and/or Designee by 12/10/2021.

2)This in-service on confidentiality of medical records will be conducted by the CCC and/or designee to all applicable new hires with access to medical records (administrative department, nursing department, and activities department) at orientation. Any PRN/Leave of Absence staff will be in-serviced on Confidentiality prior to their first scheduled shift.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not reoccur?

1) In order to ensure that in-services were effective the DON/ADON and/or designee will perform med pass audits five x□s a week x four weeks, then one x a week x eight weeks to ensure confidentiality of medical information is secure.

How will the corrective action be monitored to ensure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for

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F 583	Continued From page 15 control of the cart. However, she acknowledged that it was inappropriate to leave the MAR screen unattended. She indicated that she had received the HIPAA training from the facility during orientation. In an interview conducted on 11/10/21 at 12:52 PM, the Director of Nursing (DON) stated she expected the nurses to turn on the privacy protection screen every time before leaving the medication cart to protect Resident's confidential, personal, and medical information. It was her expectation for all the staff to follow the HIPAA guidelines when working in the facility. Interview on 11/10/21 at 1:05 PM with the Administrator revealed all the staff had received training in HIPAA. He stated the nurse had to secure the computer each time before leaving it unattended. It was his expectation for all the staff to follow HIPAA guidelines all the times.	F 583	monitoring to ensure continued compliance? 1)Med pass privacy audit forms will be presented to the Quality assurance performance improvement (QAPI) committee meeting by the DON/ADON and/or designee and reviewed for 3 months. Any issues or trends will be identified and addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. Date Certain 12/11/2021	
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, record review and facility	F 679	What corrective action will be	12/11/21

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staff and resident interviews, the facility failed to provide an ongoing activities program that met residents' needs for 5 of 5 residents reviewed for activities (Resident's #43, 26, 24, 34, 63).

The Findings Included:

1. Resident #43 was admitted to the facility on 02/09/18.

A review of Resident #43's most recent comprehensive Minimum Data Set Assessment dated 06/25/21 revealed Resident #43 to be cognitively intact for daily decision making with no instances of rejecting care. Resident #43 was coded as it being "very important" to do his favorite activities and to go outside to get fresh air when the weather was good.

During an interview with Resident #43 on 11/08/21 at 12:18 PM, he reported the facility used to have a really active and engaging activity department but currently it was inactive. Resident #43 stated he was never told about activities and that he just stayed in his room. He further stated there were times when activities were scheduled, and he showed up and the Activity Director did not show up to the scheduled activity. He did not know why scheduled activities were canceled.

An interview with Nurse Aide #1 on 1/09/21 at 12:09 PM revealed there had been several times in the past where she had encouraged and even transported residents to attend scheduled activities, only to get where they were supposed to occur to find no staff present to provide the scheduled activity and the scheduled activity would have to be canceled. She also reported there were multiple times when activities were

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accomplished for the residents found to have been affected by the deficient practice?

1.Resident #63 is deceased.

2.Resident #43, #34, #26 and #24 were interviewed by Activity Staff related to their experience with Activities and in-serviced on 12/6/21 on how Activities would be conducted in the future as in having Activities when scheduled and the process of cancelling and substituting activities due to circumstances beyond our control. In addition, these residents were given a current Activity calendar.

3.A review and updating of the Activity Interest Pattern on residents #43, #34, #26 and #24 were conducted by the Activity Director on 12/8/21.

4.Resident #43, #34,#26, #24 Activity Interest Patterns were personally conducted by the Activity Director on 12/8/21 and their Activity Interest of their choosing were ascertained. Their choices will be implemented as is possible.

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 other residents have the potential to be affected by the deficient practice.

2.All residents will be in-serviced that all

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F 679	Continued From page 17 canceled and residents and staff were not informed. She reported she had heard from residents, their frustration regarding activities not occurring. During an interview with Nurse Aide #2 on 11/09/21 at 6:10 PM, she reported she works every other weekend and stated when she worked on the weekends, she had never seen any staff member conducting or hosting activities for the residents. During an interview with the Activity Director on 11/10/21 at 9:26 AM, she verified there were times when scheduled activities had to be canceled. She reported she was expected to do other duties including passing trays and monitoring visitation. She reported if scheduled activities had to be canceled, she would post notes throughout the facility. During an interview with the Administrator on 11/10/21 at 3:52 PM, he stated outside of an extenuating circumstance, residents in the facility should not show up to a scheduled activity and it not happen. He reported he expected activities to occur as scheduled. 2. Resident #26 was admitted to the facility on 12/07/2018. A review of Resident #26's annual Minimum Data Set Assessment dated 06/10/21 revealed it was very important to do activities with groups of people, it was very important that he do his favorite activities, very important to go outside to get fresh air when the weather was good, and very important to participate in religious services or practices.	F 679	Activities will occur as indicated via calendar by 12/11/21 by Activity Director or designee. 3.Any canceled activities due to unforeseen circumstances will be communicated via intercom, via posting of cancellation/substitution notice placed on activity boards in halls and in the Administrator□s mailbox. 4.All residents will be reassessed individually by 12/11/21via the Activity Interest Pattern (person centered). Preferences will be noted up to and including residents preferring one on one activity. This will be done by Activity Director and/or designee. 5.Residents with cognitive Impairment will be assessed as to their activity preference using historical data from their lives as indicated by family, friends and others. This will be done by Activity Director and/or designee by 12/11/21. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not reoccur? 1.Activity Interest Patterns will be updated on all residents by 12/11/21 by AD and/or designee. 2.Any canceled activities due to unforeseen circumstances will be communicated via intercom, via posting of cancellation/substitution and a notice placed on activity boards in halls and in	

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A review of Resident #26's most recent quarterly Minimum Data Set Assessment dated 09/03/21 revealed him to be cognitively intact for daily decision making.

During an interview with Resident #26 on 11/10/21 at 9:48 AM he reported he felt there were no activities offered in the building. Resident #26 stated he sat in his room all day and watched television or listened to his compact disc player. Resident #26 reported the facility only offered BINGO as and activity and that he did not like to play BINGO. He stated he had gotten so bored that he counted leaves falling from the tree outside his window.

An interview with Nurse Aide #1 on 1/09/21 at 12:09 PM revealed there had been several times in the past where she had encouraged and even transported residents to attend scheduled activities, only to get where they were supposed to occur to find no staff present to provide the scheduled activity and the scheduled activity would have to be canceled. She also reported there were multiple times when activities were canceled and residents and staff were not informed. She reported she had heard from residents, their frustration regarding activities not occurring.

During an interview with Nurse Aide #2 on 11/09/21 at 6:10 PM, she reported she works every other weekend and stated when she worked on the weekends, she had never seen any staff member conducting or hosting activities for the residents.

During an interview with the Activity Director on

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the Administrator□s mailbox. In addition, canceled activities will be documented by Activity Department on spreadsheet every day. This will be an ongoing process 24/7 .

3.Activities will be provided 7 days a week by the Activity Dept.

4.Activity Calendar was revised to correspond with Activity staff□s schedule on 11/30/21 by Administrator (NHA) and AD.

5.Activities will be reviewed for content and applicability for current cliental by NHA monthly.

6.Activity personnel daily hours were revised by AD to better meet the needs of residents on 11/30/21.

7.Activity personnel/licensed CNAs will not be pulled to floor to the point of compromising activities from being done as directed by the NHA on 11/30/21.

8.Any new hires up to and including PRN and LOA staff will in-serviced on this POC prior to working in the department. This will be conducted by the AD.

How will the corrective action be monitored 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?

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F 679	Continued From page 19 11/10/21 at 9:26 AM, she verified there were times when scheduled activities had to be canceled. She reported she was expected to do other duties including passing trays and monitoring visitation. She reported if scheduled activities had to be canceled, she would post notes throughout the facility. During an interview with the Administrator on 11/10/21 at 3:52 PM, he stated outside of an extenuating circumstance, residents in the facility should not show up to a scheduled activity and it not happen. He reported he expected activities to occur as scheduled. 3. Resident #24 was admitted to the facility on 12/9/20. Resident #24's admission MDS dated 12/17/20 was coded it was very important for resident to complete activities of his liking and going outside. Review of Resident #24's quarterly Minimum Data Set (MDS) dated 8/31/21 revealed Resident #24 was cognitively intact for daily decision making and required extensive assistance with most activities of daily living (ADL) skills. An interview conducted with Resident #24 on 11/9/21 at 10:00 AM during resident council revealed the facility had failed to follow the activity schedule often. Resident #24 further revealed residents often showed up for an activity and no staff would be present to conduct the activity. Resident #24 indicated the facility did not offer any other group activities that the alert and oriented residents enjoyed.	F 679	1.Activity Compliance will be monitored through Electronic Medical Records weekly by AD weekly for 12 weeks. 2.AD will review Cancellation Spreadsheet 5 x a week x 4 weeks and then weekly x 8 weeks indicating reasons for cancellation. 3.New Activity process and related issues will be reviewed by the NHA in Monthly Resident Council meetings and adjustments made if necessary. 4.Any issues related to Activities will be reviewed and discussed monthly x 3 months in the monthly (QAPI) meeting. Date Certain for POC 12/11/21	

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An interview conducted with Nurse Aide (NA) # 2 on 11/9/21 at 12:09 PM revealed there had been multiple times NA #2 would assist residents to activities and staff who facilitated activities would not be present for scheduled activities. NA #2 indicated residents would be upset and nursing staff had no idea that activities would be canceled.

An interview conducted with NA #4 on 11/9/21 at 6:10 PM revealed when she worked weekend shifts the only activity offered to residents was Sunday church. The NA indicated no staff were present on the weekend to direct activities for the residents and NA #4 was never educated on following the activity schedule during shifts. The NA #4 further revealed multiple residents had complained of activities being missed.

An interview conducted with the Activity Director (AD) on 11/10/21 at 9:26 AM revealed activities had been missed due to the AD having to be pulled onto the floor to assist nursing staff. The AD further revealed she would notify the residents of canceled activities by posting notes throughout the facility. The AD stated weekend and night shift activities are led by nursing staff but could not recall who educated staff on leading activities during weekend and evening shifts.

An interview conducted with the Administrator on 11/10/21 at 3:52 PM revealed there had been times the AD was pulled to the floor to assist with care but was expected to have back up staff to assist with activities. The Administrator further revealed he expected no resident should show up to a scheduled activity and it not occur. The Administrator also indicated it was expected for all staff to be aware of scheduled evening and

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weekend activities.

4. Resident # 34 was admitted to the facility on 3/3/21.

Resident #34's admission MDS dated 3/22/21 was coded it was very important for resident to complete activities of his liking and going outside.

Review of Resident #34's quarterly Minimum Data Set (MDS) dated 9/8/21 revealed Resident #34 was cognitively intact for daily decision making and required limited assistance with most activities of daily living (ADL) skills. Resident #34's admission MDS dated 3/22/21 was coded it was very important for resident to complete activities of his liking and going outside.

An interview conducted with Resident #34 on 11/9/21 at 10:00 AM during resident council meeting revealed the facility had failed to follow the activity schedule often. Resident #34 further revealed residents often showed up for an activity and no staff would be present to conduct the activity. Resident #34 stated he would enjoy group activities outside and not just staring at a screen. Resident #34 had requested several times for new activities, but no one would listen.

An interview conducted with Nurse Aide (NA) # 2 on 11/9/21 at 12:09 PM revealed there had been multiple times NA #2 would assist residents to activities and staff would not be present to carry out the scheduled activity. The NA #2 indicated residents would be upset and the nursing staff had no idea that activities would be canceled.

An interview conducted with NA #4 on 11/9/21 at 6:10 PM revealed when she worked weekend

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345558	A. BUILDING ______ B. WING ______	C 11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS HOME-BLACK MOUNTAIN	62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 22	F 679		

shifts the only activity offered to residents was Sunday church. The NA indicated no staff was present on the weekend to direct activities for the residents and NA #4 was never educated on following the activity schedule during shifts. The NA #4 further revealed multiple residents had complained of activities being missed.

An interview conducted with the Activity Director (AD) on 11/10/21 at 9:26 AM revealed activities had been missed due to the AD having to be pulled onto the floor to assist nursing staff. The AD further revealed she would notify the residents of canceled activities by posting notes throughout the facility. The AD stated weekend and night shift activities are led by nursing staff but did not know if nursing staff was educated on leading activities during their shifts. The AD revealed residents could request different and new activities. The AD further revealed she was working on new activities for the alert and oriented residents.

An interview conducted with the Administrator on 11/10/21 at 3:52 PM revealed there had been times the AD was pulled to the floor to assist with care but was expected to have back up staff to assist with activities. The Administrator further revealed he expected no residents should show up to a scheduled activity and it does not occur. The Administrator stated any resident can request new activities and would expect them to be considered.

5. Resident #63 was admitted to the facility on 2/5/21.

Resident #63's admission MDS dated 2/10/21 was coded it was very important for resident to

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	345558	A. BUILDING ______ B. WING ______	C 11/12/2021

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

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F 679	Continued From page 23	F 679		

complete activities of his liking and going outside.

Review of Resident #63's quarterly Minimum Data Set (MDS) dated 10/11/21 revealed Resident #63 was cognitively intact for daily decision making and required extensive assistance with most activities of daily living (ADL) skills.

An interview conducted with Resident #63 on 11/9/21 at 10:00 AM during resident council meeting revealed the facility had failed to follow the activity schedule often. Resident #63 further stated residents often showed up for an activity and no staff would be present to conduct the activity. Resident #63 stated he enjoyed group activities and going outside. Resident #63 indicated during the weekend there was nothing to do since no one led activities.

An interview conducted with Nurse Aide (NA) # 2 on 11/9/21 at 12:09 PM revealed there had been multiple times NA #2 would assist residents to activities and staff would not be present to carry out the scheduled activity. The NA #2 indicated residents would be upset and the nursing staff had no idea that activities would be canceled.

An interview conducted with NA #4 on 11/9/21 at 6:10 PM revealed when she worked weekend shifts the only activity offered to residents was Sunday church. The NA indicated no staff was present on the weekend to direct activities for the residents and NA #4 was never educated on following the activity schedule during shifts. The NA #4 further revealed multiple residents had complained of activities being missed.

An interview conducted with the Activity Director

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	345558	A. BUILDING ______ B. WING ______	C 11/12/2021

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F 679	Continued From page 24 (AD) on 11/10/21 at 9:26 AM revealed activities had been missed due to the AD having to be pulled onto the floor to assist nursing staff. The AD further revealed she would notify the residents of canceled activities by posting notes throughout the facility. The AD stated weekend and night shift activities are led by nursing staff but did not know if nursing staff was educated on leading activities during their shifts. The AD revealed residents could request different and new activities. The AD further revealed she was working on new activities for the alert and oriented residents. An interview conducted with the Administrator on 11/10/21 at 3:52 PM revealed there had been times the AD was pulled to the floor to assist with care but was expected to have back up staff to assist with activities. The Administrator further revealed he expected no residents should show up to a scheduled activity and it does not occur. The Administrator stated any resident can request new activities and would expect them to be considered.	F 679		