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 ______	R-C 07/12/2023

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

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F 000	INITIAL COMMENTS An onsite revisit was conducted on 7/12/2023. Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance.	F 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure medication cart keys for 2	F 761		

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

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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of 3 medication carts (Charlie Unit and Delta Unit medication carts) and failed to secure 1 of 3 medication carts observed to be unlocked and unattended by nursing staff (Bravo Unit medication cart).

Findings included:

1. (a) An interview with Nurse #2 on 07/06/23 at 9:02 AM revealed she worked the 6:00 AM to 6:00 PM shift on 06/26/23 on the Charlie Unit. She stated she agreed to stay and administer the 7:00 PM and 9:00 PM medications on the Charlie Unit due to a staffing shortage and left around 7:30 PM the night of 06/26/23. Nurse #2 stated the Director of Health Services (DHS) #1 told her to leave the Charlie Unit medication cart keys in the Director of Health Services' mailbox in the copier room when she completed the medication administration if she was not in her office. She stated she knocked on Director of Health Services #1's office door when she was ready to leave and did not get a response, so she placed the keys in Director of Health Services #1's mailbox in the copier room. Nurse #2 stated there was no lock on Director of Health Services #1's mailbox and the copier room door was not locked or closed. She stated she thought Director of Health Services #1 would pick up the medication cart keys shortly after she left. Nurse #2 stated she wrote out report on a report sheet and left it at the nurses' station for the oncoming shift.

An interview with Nurse #1 on 07/05/23 on 2:55 PM revealed she worked the 3:00 PM to 11:00 PM shift on 06/26/23. She stated around 8:30 PM the evening of 06/26/23 a nurse aide (NA) told her a resident on the Charlie Unit was

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requesting a prn (as needed) medication. Nurse #1 stated she could not administer the prn medication to the resident on the Charlie Unit because she was the only nurse in the facility, did not have the keys to the Charlie Unit medication cart, and did not know where to find the Charlie Unit medication cart keys.

An interview with Director Health Services #1 on 07/12/23 at 4:17 PM revealed the evening of 06/26/23 she told Nurse #3 to take the Charlie Unit medication cart keys to Nurse #1 on the Bravo Unit before she left for the evening. She stated she expected all nursing staff to hand off medication cart keys to another nursing staff member when leaving the facility rather than leaving them in an unsecured location.

(b) An interview with Nurse #3 on 07/05/23 at 12:41 PM revealed she worked the 6:00 AM to 6:00 PM on 06/26/23 on the Delta Unit. She stated she agreed to stay and administer the 7:00 PM and 9:00 PM medications on the Delta Unit due to a staffing shortage and left around 7:30 PM the night of 06/26/23. Nurse #3 stated Director of Health Services #1 gave her permission to leave the Delta Unit medication cart keys with Director of Health Services #1 or place the keys in Director of Health Services #1's mailbox in the copier room when she completed the medication administration. She stated she knocked on Director of Health Services #1's office door when she was ready to leave and did not get a response, so she placed the keys in Director of Health Services #1's mailbox in the copier room. Nurse #3 stated there was no lock on Director of Health Services #1's mailbox and the copier room door was not locked or closed. She stated she was not completely comfortable

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leaving the medication cart keys unattended and in an unlocked area, but she thought Director of Health Services #1 would pick up the medication cart keys shortly after she left. Nurse #3 stated she did not give report to a nurse before leaving the facility the evening of 06/26/23.

An interview with Director of Health Services #1 on 07/12/23 at 4:17 PM revealed the evening of 06/26/23 she told Nurse #3 to take the Delta medication cart keys to Nurse #1 on the Bravo Unit before she left for the evening. She stated she expected all nursing staff to hand off medication cart keys to another nursing staff member when leaving the facility rather than leaving them in an unsecured location.

2. A continuous observation of the Bravo Unit medication cart on 07/05/23 from 3:42 PM to 3:44 PM revealed the medication cart was parked outside room 212, the door to room 212 was shut, and the lock mechanism was observed in the unlocked position. During the observation one staff member walked by the unlocked medication cart. Nurse #4 exited room 212 and returned to the medication cart.

During an interview with Nurse #4 on 07/05/23 at 3:45 PM he confirmed he left the Bravo Unit medication cart unlocked and out of his line of sight while he was in room 212. He stated he should have locked the medication cart before he entered room 212 and he did not because it was an oversight.

An interview with Director of Health Services #1 on 07/12/23 at 4:17 PM revealed she expected medication carts to be locked any time they were not within a nurse's line of sight.

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{F 812} SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to date opened food and beverage items in 1 of 1 reach-in cooler, failed to ensure leftover food was securely stored for 1 of 1 walk-in cooler, failed to label, date, and cover food items in 1 of 1 walk-in freezer. The deficient practice had the potential to affect food served to residents. Findings included: 1. An observation of the reach-in cooler on 07/06/23 at 3:10 PM revealed an opened and undated gallon of barbecue sauce and an opened and undated 2-liter bottle of diet soda.	{F 812}		

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An interview with the Cook on 07/06/23 at 3:11 PM revealed the barbecue sauce should have been dated when it was opened. He stated he did not know where the bottle of soda came from but it should not be in the reach-in cooler.

An interview with the Dietary Manager (DM) on 07/12/23 at 8:49 AM revealed the barbecue sauce should have been dated at the time it was opened, and whoever opened an item was responsible for dating the item. He explained the bottle of soda was placed in the reach-in cooler by staff in the activities department and he had asked them repeatedly to label and date any items they placed in the cooler. He stated it was everyone's responsibility to check for labeled and dated items and the items in the reach-in cooler were overlooked.

An interview with Administrator #1 on 07/12/23 at 4:17 PM revealed he expected all food and beverage items to be labeled and dated appropriately.

2. An observation of the walk-in cooler on 07/06/23 at 3:15 PM revealed a metal pan of barbecue, a metal pan of green beans, and a metal pan of greens were sitting on a shelf. The metal pans were partially covered with clear plastic wrap and dated 07/05/23. The corner of the plastic wrap on each metal pan was pulled back, exposing the food to air. The barbecue appeared dried out in the area that was exposed to air. No condensation was noted to the clear plastic wrap.

An interview with the Kitchen Supervisor on 07/06/23 at 3:19 PM revealed the metal pans of food were placed in the cooler on 07/05/23 (she

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was unsure of the exact time) and the corner of the plastic wrap was pulled back to allow the food to cool and the corners of the plastic wrap should have been put back in place once the food had cooled.

An interview with the Dietary Manager (DM) on 07/12/23 at 8:49 AM revealed the food in the walk-in cooler should have been tightly covered when it was placed in the cooler and not left open to air. He stated the person who placed the food in the cooler was responsible for ensuring the food was properly covered and it was an oversight that the food was not stored correctly.

An interview with Administrator #1 on 07/12/23 at 4:17 PM revealed he expected all food to be stored correctly.

3. An observation of the walk-in freezer on 07/06/23 at 3:18 PM revealed a cart containing a metal pan of oatmeal, a metal pan containing scrambled eggs and 2 fried eggs, and a metal pan containing sausage patties, bacon, and chopped ham. All of the pans of food were open to air, unlabeled, and undated. The fried eggs appeared to have dry edges.

An interview with the Kitchen Supervisor on 07/06/23 at 3:19 PM revealed the foods in the metal pan were from breakfast on 07/06/23 were placed in the walk-in freezer around 9:30 AM on 07/06/23 to cool down. She stated the food should have been covered and dated. The Kitchen Supervisor stated the food should only have been left in the freezer for 4 hours.

An interview with the Dietary Manager (DM) on 07/12/23 at 8:49 AM revealed the pans of food in

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{F 812}	Continued From page 7 the walk-in freezer were leftovers from the breakfast meal on 07/06/23. He stated the food should have been labeled, covered, and dated when it was placed in the freezer by the person who placed the food in the freezer. The Dietary Manager stated the food should not have stayed in the freezer for longer than 4 hours. He stated the food in the freezer not being covered, labeled, dated, and being left in the freezer longer than 4 hours was an oversight. An interview with Administrator #1 on 07/12/23 at 4:17 PM revealed he expected food to be labeled, dated, and stored correctly.	{F 812}		