STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345492	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS HOME - FAYETTEVILLE	214 COCHRAN AVENUE FAYETTEVILLE, NC 28301

(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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to accurately code the bed mobility status for 1 of 1 sampled resident (Resident #158) whose MDS was reviewed. Findings included: Resident #158 was admitted to the facility on	F 278	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness 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. 278 ASSESSMENT ACCURACY/COORDINATION/CERTIFIED **Corrective action for residents affected:** 1.Resident #158 no longer resides in the facility and expired on 1/6/2016. 2.All residents have the potential to be affected. * An audit will be conducted for MDS's that have been completed for all resident's effective 2/18/2016 until present to ensure accurate coding of section G of the MDS.	3/17/16 3/17/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Whitney Bell — TITLE: LNHA — (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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 1 9/10/2015 with diagnoses which included Hyponatremia, Anemia, Delirium and Dementia. The admission MDS (Minimum Data Set)dated 9/22/2015 indicated the resident was total dependent on staff with bed mobility. The quarterly MDS assessment dated 12/17/2015 indicated the resident required extensive assistance with bed mobility. On 2/17/2016 at 10:00 AM, the MDS nurse was interviewed. She acknowledged that the resident did not improve with bed mobility during her stay at the facility. She added the resident was admitted as total dependent on staff with bed mobility and continued to be total dependent on staff for bed mobility until her death on 1/6/2016 . She further added the quarterly MDS dated 12/17/2015 was inaccurately coded. On 2/17/2015 at 2:00 PM, the Director of Nursing(DON) was interviewed. She acknowledged the quarterly MDS dated 12/17/2015 was inaccurate. She added her expectation was for MDS nurse to accurately code the MDS information.	F 278	**3. System Changes:** * Case Mix Director education began on 3/10/2016 on accurate coding of section G of the MDS. * An audit of the MDS section G will be completed on 10% of scheduled MDS's for submission by the DHS or designee. * The Section G Accuracy Form will be reviewed by the Director of Nursing, Senior Care Partner,RN and/or designee daily x 4 weeks, then weekly x 4 weeks, then 1 time weekly x 4 weeks, and then monthly for 3 months, to ensure Section G of the MDS is coded accurately. **4. Monitoring the Performance:** The Director of Nursing and/or designee will correlate the data from the Section G Accuracy Form and report findings to the Quality Assurance and Performance Improvement Committee for recommendations and suggestions for improvements or changes.	3/17/16 3/17/16

A FACILITY OF THE
NORTH CAROLINA DIVISION
OF VETERANS AFFAIRS

DEPARTMENT
OF
ADMINISTRATION

FAX 910-822-0979

March 15, 2016

Mrs. Lena Clayton

Facility Survey Consultant

2711 Mail Service Center

Raleigh, NC 27699-2711

RE: PoC

Dear Mrs. Clayton,

I have enclosed a copy of our Plan of Correction for the annual survey conducted February 15, 2016 to February 18, 2016.

I would like to request a desk review for tag F-278.

Should you have any questions please feel free to contact me at (910) 822-7202.

Sincerely,

Whitney Bell

Whitney Bell,LNHA

Administrator