DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			` '	
		345492	B. WING			03/	23/2017
NAME OF P	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	214 COCHRAN AVENUE		
NC STATE	VETERANS HOME - FA	YEITEVILLE		F	AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
F 272 SS=D	483.20(b)(1) COMPR ASSESSMENTS	REHENSIVE	F	272			4/14/17
	(b) Comprehensive A	ssessments	ES     OMB NO. C       ERVCLA     (x2) MULTIPLE CONSTRUCTION     (x3) DATE SU       A. BUILDING				
	must make a compre resident's needs, stre preferences, using th instrument (RAI) spec assessment must inc (i) Identification and (ii) Customary routir (iii) Cognitive patterr (iv) Communication. (v) Vision. (v) Vision. (vi) Mood and behav (vii) Psychological we (viii) Psychological we (viii) Psychological we (viii) Psychological we (viii) Physical fun problems. (ix) Continence. (x) Disease diagnos (xi) Dental and nutrit (xii) Skin Conditions. (xiii) Activity purs (xiv) Medications (xv) Special treatment (xvi) Discharge p (xvii) Documentat regarding the additior on the care areas of the Minimum Data (xviii) Documentat	lude at least the following: d demographic information ne. ns. vior patterns. ell-being. ictioning and structural is and health conditions. ional status. uit. tis and procedures. lanning. tion of summary information nal assessment performed triggered by the completion					
	the resident, as well a	n and communication with as communication with					
	licensed and						
I ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE

Electronically Signed

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.

04/10/2017

		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 04/24/2017 FORM APPROVED IB NO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		TRUCTION	(X3	B) DATE SURVEY COMPLETED
		345492	B. WING				03/23/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET	ADDRESS, CITY, STATE, ZIP CODE		
	VETERANS HOME - FA	VETTEVILLE		214 COO	CHRAN AVENUE		
NC STATE	VETERANS HOME - PA			FAYET	TEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 272 Continued From page 1 non-licensed direct care staff member on all shifts. The assessment process must include direct observation and communication with the resider as well as communication with licensed and non-licensed direct care staff members on all		ed direct care staff members cess must include direct munication with the resident, ation with licensed and	F 2	72			
	shifts. This REQUIREMENT by: Based on record revi facility failed to compl summaries which incl risk factors and factor developing individual for 2 of 32 residents v assessments (Reside findings included: 1. Resident #25 was 8/11/15 and had diag Accident (Stroke) and	is not met as evidenced iew and staff interviews, the lete Care Area Assessment luded underlying causes, rs to be considered in ized care plan interventions with comprehensive ent #25 and 158). The re-admitted to the facility on noses of Cerebrovascular		corri of s and con pro con defi pre it is and sub	is time line investigation and p rection constitutes a written all substantial compliance with Fe d Medicaid requirements. Prep d/or execution of this correction stitute admission or agreemen vider of the truth of items alleg inclusions set forth for the allege iciencies. The plan of correction pared and/or executed solely to required by the provision of the d federal law in order to remove ostantial noncompliance. It also nonstrates our good faith and o	egation deral aration n do not nt by the led or ed on is because ne state e	
20 Ha 7h 8/4 re: Th Dr	2016 revealed Reside Haldol, an antipsycho The Annual Minimum 8/4/16 under section resident received an a The Care Area Asses Drug Use dated 8/4/1	ent #25 had an order for otic medication. Data Set (MDS) dated		Con and Ste Ass resi moo Mat	tinue to improve the quality of services to our residents.	care nd for ill be	
	antipsychotic medicat on an antipsychotic m On 3/23/17 at 2:15 Pl	tion or that the resident was		Ste To o		ALL	

Facility ID: 970225

If continuation sheet Page 2 of 12

		ND HUMAN SERVICES MEDICAID SERVICES				APPROVEI 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	PLE CONSTRUCTION G	(X3) DATE S COMPL	
		345492	B. WING		03/2	3/2017
NAME OF P	ROVIDER OR SUPPLIER	-	•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				214 COCHRAN AVENUE		
NC STATE	EVETERANS HOME - FA			FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 272	Continued From pag	e 2	F 2	72		
	and the Care Area As Drug use for Resider stated she checked t did receive Haldol du the assessment com	ssessment for Psychoactive nt #25. The MDS Nurse the resident ' s chart and he uring the look back period for pleted on 8/4/16. The MDS not know why she missed		Active residents from 1/1/2017 t 4/9/2017 to ensure all Care Area Assessments have been comple are accurate. Step 3	а	
		as admitted to the facility on agnosis of Alzheimer ' s		1. Education began on 4/10/2 Clinical Reimbursement Coordin and/or designee for the Interdise Team on completing Care Area Assessments with comprehensi assessments, per the RAI Manu	nator ciplinary ive	
	Summary dated 9/22 triggered for Resider be completed for the	Area Assessment (CAA) 2/16 revealed Nutrition nt #158 and a CAA needed to resident. The CAA for the facility was blank and eted.		Guidelines. 2. All new Interdisciplinary team will be educated upon hire durin orientation on completing Care Assessments with comprehensi assessments, per the RAI Manu	team members during Care Area nensive	
	an interview she revi Resident #158 and the MDS Nurse stated the did the Nutrition CAA	AM MDS Nurse #1 stated in ewed the Nutrition CAA for he CAA was not done. The ne dietary manager usually As. The MDS Nurse stated assessment was completed an oversight.	Guidelines. 3. A Care Area Assessment au will be implemented by the Case Director (CMD), and will be com follows by the Interdisciplinary Te times per week for 4 weeks then, per week for 4 weeks, and then a done monthly for 3 months.		e Mix npleted as ſeam :5 n,2 times	
	stated in an interview supposed to do secti	PM the Dietary Manager v she knew she was ion K of the MDS but was not o do the CAA for nutrition		Step 4 Monitoring will be done by the O Director (RN) and/or Designee t all Care Area Assessments are and accurate with each Compre Assessment. Continued monitor then occur 5 times per week for then 2 times per week for 4 wee then monthly for 3 months. Res monitoring, with tracking and tree	to ensure completed ehensive oring will * 4 weeks, eks, and ults of the	

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PRINTED: 04/24/2017 FORM APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/24/20 M APPROVI D. 0938-03
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345492	B. WING			03	/23/2017
NAME OF P	ROVIDER OR SUPPLIER	1		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
NC STATE	VETERANS HOME - FA	YETTEVILLE			4 COCHRAN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 272	Continued From page	e 3	F	272	be reported by Case Mix Director s (F monthly to the Quality Assurance Performance Improvement committee recommendations and suggestions for improvements and changes.	for	
F 278 SS=D		SMENT DINATION/CERTIFIED	F2	278			4/14/17
		ssments. The assessment ct the resident's status.					
	(h) Coordination A registered nurse m each assessment wit participation of health						
	<ul><li>(i) Certification</li><li>(1) A registered nurse the assessment is co</li></ul>	e must sign and certify that mpleted.					
		ho completes a portion of the n and certify the accuracy of sessment.					
	(j) Penalty for Falsific (1) Under Medicare a who willfully and know	nd Medicaid, an individual					
	()	l and false statement in a is subject to a civil money nan \$1,000 for each					
	and false statement i	ndividual to certify a material n a resident assessment is ey penalty or not more than ssment.					

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STATEMENT	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DA	NO. 0938-039 <sup>2</sup> TE SURVEY MPLETED
AND FLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG		
		345492	B. WING		0	3/23/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
NC STATE	VETERANS HOME - FA			214 COCHRAN AVENUE		
NOUNTE				FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 278	Continued From page	e 4	F2	278		
	material and false sta This REQUIREMENT by: Based on record rev facility failed to accur Data Set (MDS) Asse section K of the MDS reviewed (Resident # findings included: 1. Resident #25 was 8/11/15 and had a dia Dementia and Mood Review of the physici August 2016 revealed antipsychotic medica	<ul> <li>Γ is not met as evidenced</li> <li>iew and staff interviews the ately code the Minimum</li> <li>essment in section N and</li> <li>for 3 of 32 residents</li> <li>£25, #143 and #151). The</li> <li>re-admitted to the facility on agnosis of Alzheimer 's Disorder.</li> <li>ian 's monthly orders for d an order for Haldol, an tion. Section N of the Annual d not show the resident</li> </ul>		This time line investigation correction constitutes a wri of substantial compliance v and Medicaid requirements and/or execution of this co constitute admission or age provider of the truth of item conclusions set forth for the deficiencies. The plan of co prepared and/or executed it is required by the provision and federal law in order to substantial noncompliance demonstrates our good fail continue to improve the qu and services to our resider	itten allegation with Federal s. Preparation rrection do not reement by the alleged or e alleged orrection is solely because on of the state remove e. It also th and desire to iality of care	
	that Resident #25 wa back period for the as 8/4/16. The MDS Nur MDS and did not kno antipsychotic medica 2. Resident #143 was 10/15/16 and had a c Dementia. Review of the Admiss (MDS) Assessment of K revealed a dash in	rse #1 stated in an interview as on Haldol during the look ssessment completed on rse stated she completed the w why she missed the tion. s admitted to the facility on diagnosis of Alzheimer ' s sion Minimum Data Set dated 10/28/16 under Section the space the resident ' s ered. When reviewing the		Step 1 Assessments with deficien resident #25 and resident a modified on 4/10/2017 to o /anual/Medicaid/Federal G Step 2 To complete 100% audit of Comprehensive assessme Active residents from 1/1/2 4/9/2017 to ensure all Sect Section K have been comp dashes, and are accurate.	#143 will be comply with RAI uidelines. f all ents for ALL 2017 to tion N and	

Facility ID: 970225

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · ·	NO. 0938-039 TE SURVEY MPLETED
			A. BUILDING			
		345492	B. WING		c	3/23/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE	EVETERANS HOME - FA	YETTEVILLE		214 COCHRAN AVENUE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 278	Continued From page	e 5	F 278	3		
	found in the record. The facility provided a nursing that revealed height was 67 inches On 3/23/17 at 1:56 Pl stated in an interview on her MDS assessm before the restorative the height on residen available when she d did not go back and c after restorative nursi 3. Resident #151 was 10/17/16 and had a c Dementia. Review of the Admiss (MDS) Assessment of K revealed a dash in height was to be enter Admission Nursing A s weight sheet reveal resident ' s height wa consultant dietician p accompanied the res	a document from restorative on 10/15/16 the resident ' s M the Dietary Manager that she tried to stay ahead nents and if she got the chart e nursing staff (who obtained ts), the height was not id the assessment and she complete the assessment ing documented the height. s admitted to the facility on liagnosis of Alzheimer ' s sion Minimum Data Set lated 10/24/16 under Section the space the resident ' s ered. Review of the ssessment and the resident ' ed the space to enter the s blank. The facility ' s		<ol> <li>Education began on 4/10/2 Clinical Reimbursement Coord and/or designee for the Case M and Interdisciplinary Team on or Section N and Section K with comprehensive assessments, p Manual/Federal Guidelines.</li> <li>An Assessment audit tool N and Section K of the MDS w implemented by the Case Mix I (CMD), and will be completed by the Interdisciplinary Team :5 week for 4 weeks then,2 times for 4 weeks, and then audit dor for 3 months.</li> <li>Step 4</li> <li>Monitoring will be done by the Director (RN) and/or Designee Section N and Section K of the completed and accurate Assess Continued monitoring will then times per week for 4 weeks, and ther for 3 months. Results of the mod with tracking and trending, will by Case Mix Director s (RN) n the Quality Assurance Perform Improvement committee for</li> </ol>	nator lix Director completing per the RAI for Section ill be Director as follows it imes per per week ne monthly Case Mix to ensure MDS are sment. occur 5 en 2 times nonthly ponitoring, be reported nonthly to	
	requirements and ref recommendation for an institutional setting On 3/23/17 at 12:20 I	the level of care needed in 9. PM MDS Nurse #1 stated in 1. In manager did section K of		recommendations and suggest improvements and changes.	ions for	

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM APPR OMB NO. 0938	OVED
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345492	B. WING		03/23/201	7
	ROVIDER OR SUPPLIER	/ETTEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		ETION
F 278 F 356 SS=C	stated in an interview on her MDS assessm before the restorative the height on resident available when she di did not go back and c after restorative nursin 483.35(g)(1)-(4) POS INFORMATION 483.35 (g) Nurse Staffing Info (1) Data requiremen the following informat (i) Facility name. (ii) The current date. (iii) The total number by the following catego unlicensed nursing sta resident care per shift (A) Registered nurses (B) Licensed practical	A the Dietary Manager that she tried to stay ahead ents and if she got the chart nursing staff (who obtained is), the height was not d the assessment and she omplete the assessment ing documented the height. TED NURSE STAFFING ormation ts. The facility must post ion on a daily basis: and the actual hours worked ories of licensed and aff directly responsible for :: s. I nurses or licensed defined under State law) des.	F 27	3	4/14/1	7
	(i) The facility must po	ost the nurse staffing data				

Facility ID: 970225

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			0.00			10.0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			TE SURVEY MPLETED
		345492	B. WING		0	3/23/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE	E VETERANS HOME - FA	YETTEVILLE		214 COCHRAN AVENUE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 356	Continued From page	e 7	F 35	6		
	specified in paragrap daily basis at the beg	h (g)(1) of this section on a jinning of each shift.				
	(ii) Data must be pos	ted as follows:				
	(A) Clear and readab	le format.				
	(B) In a prominent pla residents and visitors	ace readily accessible to s.				
	The facility must, upo make nurse staffing of	boosted nurse staffing data. on oral or written request, data available to the public ot to exceed the community				
	facility must maintain staffing data for a mir required by State law	ation requirements. The the posted daily nurse nimum of 18 months, or as ν, whichever is greater. Γ is not met as evidenced				
	Based on observation review of staff schedu	on, staff interviews, and ules, the facility failed to post a on the Daily Staffing days reviewed.		This time line investigation and p correction constitutes a written a of substantial compliance with Fe and Medicaid requirements. Prep and/or execution of this correctio	llegation ederal paration	
	dates of 10/16/2016 night shift, 10/22/201 - evening shift, 12/31 02/09/2017 - night sh	Staffing Posting for the - evening shift, 10/20/2016 - 6 - evening shift, 12/30/2016 /2016 - night shift, and hift, and 03/18/2017 - night umentation of census and		constitute admission or agreeme provider of the truth of items alleg conclusions set forth for the alleg deficiencies. The plan of correcti prepared and/or executed solely it is required by the provision of t and federal law in order to remov substantial noncompliance. It als	ged or led on is because he state re	
	Administrator was do the census and nursi	/2016 at 10:45 AM with the one regarding no posting of ng staff. Interview revealed sting should have been		demonstrates our good faith and continue to improve the quality o and services to our residents.	desire to	

Facility ID: 970225

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			0.00			D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	. ,	E SURVEY PLETED
		345492	B. WING		03	/23/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
NC STATE	VETERANS HOME - FA	YETTEVILLE		214 COCHRAN AVENUE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED <sup>~</sup> DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 356	Continued From page	e 8	F 35	56		
	completed for the ide			Step 1		
the s Staf Cop were	the staff was to accur Staffing Posting on e Copies of the nursing	g schedules and time sheets		Reviewed current staffin ensure all were complet regulation.		
	were provided by the nursing staff were on	e Administrator indicated		Step 2		
				All staffing needs were r There were no residents		
				Step 3		
			<ol> <li>Education began or Clinical Competency Co Registered Nurse □s on posting nursing staffing</li> <li>All new Registered Nurse □s on educated upon hire duri completing and posting data daily.</li> <li>A Nursing Staffing au- implemented by the Adm be completed as follows of Nursing (RN) :5 time weeks then,2 times per and then audit done mo Step 4</li> </ol>	ordinator for all completing and data daily. urses will be ng orientation on nursing staffing dit tool for will be ninistrator and will s by the Director s per week for 4 week for 4 weeks,		
				Monitoring will be done Nursing (RN) and/or De that nursing staffing data Continued monitoring w times per week for 4 we per week for 4 weeks, a for 3 months. Results of with tracking and trendir	signee to ensure a is posted daily. ill then occur 5 eks, then 2 times nd then monthly the monitoring,	

Event ID: MSR511

Facility ID: 970225

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/24/20 <sup>,</sup> M APPROVE D. 0938-039
TATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345492	B. WING			03	/23/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE	VETERANS HOME - FA	YETTEVILLE			4 COCHRAN AVENUE AYETTEVILLE, NC 28301		
		ATEMENT OF DEFICIENCIES	10		PROVIDER'S PLAN OF CORRECTION		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 356	Continued From page	<u>- 9</u>	F	356			
				550	by Director of Nursing (RN) monthly to Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes.		
F 371 SS=E	483.60(i)(1)-(3) FOOI STORE/PREPARE/S		F	371			4/14/17
		rom sources approved or ry by federal, state or local					
		ood items obtained directly subject to applicable State ulations.					
	facilities from using p	es not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices.					
		es not preclude residents s not procured by the facility.					
		, distribute and serve food in essional standards for food					
	foods brought to residuation visitors to ensure safe handling, and consure	egarding use and storage of dents by family and other e and sanitary storage, nption. is not met as evidenced					
	Based on observation facility failed to discard	n and staff interviews, the rd abraded dome plate lids sible food contamination for oserved. The findings			This time line investigation and plan of correction constitutes a written allegat of substantial compliance with Federa and Medicaid requirements. Preparati	ion I	

Event ID: MSR511

Facility ID: 970225

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CENTERS FOR MEDICARE & ME	DICAID SERVICES				FORM	: 04/24/2017 APPROVED . 0938-0391
	) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE S COMPL	
	345492	B. WING			03/2	23/2017
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE VETERANS HOME - FAYET	TEVILLE			4 COCHRAN AVENUE		
			FA	AYETTEVILLE, NC 28301		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
to cover plates of food to until served to the reside	n observation of the racks with dome lids used b keep the food warm ints. The interior surface s was abraded with some surface of the dome lids. The Dietary Manager al months she had been per case) of dome lids allowed. The Administrator stated program and as part of eplace the dome lids to	F	371	<ul> <li>and/or execution of this correction do a constitute admission or agreement by provider of the truth of items alleged o conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely becauit is required by the provision of the state and federal law in order to remove substantial noncompliance. It also demonstrates our good faith and desir continue to improve the quality of care and services to our residents.</li> <li>Step 1</li> <li>36 dome plate lids were ordered on 3/23/2017.</li> <li>Step 2</li> <li>A 100% audit of dome plate lids was d to ensure satisfactory condition by fed state, and local authorities.</li> <li>Step 3</li> <li>1. Education began on 3/23/2017 by Dietary Manager for all Dietary Aides of discarding materials that could potentic cause food contamination.</li> <li>2. All new Dietary partners will be educated upon hire during orientation discarding materials that could potentic cause food contamination.</li> <li>3. A dietary materials audit tool for will implemented by the Registered Dietitia (RD) and Dietary Manager and will be completed as follows by the Cooks :5 times per week for 4 weeks then, 2 times per week fo</li></ul>	the r use ate e to one eral, on ally on ally be an	

Facility ID: 970225

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APP OMB NO. 093	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVI COMPLETED	
		345492	B. WING		03/23/20	17
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
				214 COCHRAN AVENUE		
NC SIAIE	VETERANS HOME - FA			FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COM E APPROPRIATE	(X5) IPLETION DATE
F 371 Continued F	Continued From page 11		F 3	71 per week for 4 weeks, and th done monthly for 3 months.	nen audit	
				Step 4		
				Monitoring will be done by the Dietitian (RD) and Dietary M ensure that we are not using materials that could potential contamination. Continued m then occur 5 times per week then 2 times per week for 4 w then monthly for 3 months. F monitoring, with tracking and be reported by Dietary Mana to the Quality Assurance Per Improvement committee for recommendations and sugge improvements and changes.	anager to dietary Ily cause food nonitoring will for 4 weeks, weeks, and Results of the d trending, will oger monthly formance	

Facility ID: 970225

If continuation sheet Page 12 of 12