PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345492	B. WING			C
NAME OF DE	ROVIDER OR SUPPLIER	343432		STREET ADDRESS, CITY, STATE, ZIP CO)DE	01/10/2019
IVAIVIL OI II	TO VIDER OR OUT FEET			214 COCHRAN AVENUE)DL	
NC STATE	VETERANS HOME - FA	YETTEVILLE		FAYETTEVILLE, NC 28301		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD I		E COMPLETION
E 000	Initial Comments		E 0	000		
		3.73, Emergency				
F 000	INITIAL COMMENTS		F 0	000		
		e cited as a result of the on conducted on 01/10/19.				
F 641 SS=D	Accuracy of Assessn CFR(s): 483.20(g)	nents	F 6	41		2/6/19
	resident's status. This REQUIREMEN' by: Based on record rev	st accurately reflect the T is not met as evidenced riew and staff interview, the rately code the Minimum		This time line investigation correction constitutes a writ of substantial compliance w	ten allegation	
		of 36 sampled residents ments were reviewed for esident # 138).		and Medicaid requirements and/or execution of this corn not constitute admission or the provider of the truth of it	ection does agreement	s by
	The findings included	d:		or conclusions set forth the deficiencies. The plan of co	alleged	
	12/19/18 with diagnoral asthma, hyperlipident coronary artery disease. Review of the Medic for December 2018 in	admitted to the facility on uses of dementia, depression, nia, hypertension and ase. ation Administration Record revealed there was no ations prescribed or given.		prepared and/or executed s it is required by the provisio and federal law in order to r substantial noncompliance. demonstrates our good faith continue to improve the qua and services to our resident	olely becaun of the stand emove It also and desire allity of care	te e to
	•	cian Orders dated for the		F 641 483.20		
ABORATORY I	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	?⊢	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

02/03/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345492	B. WING _				C 10/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	10/2013
				21	14 COCHRAN AVENUE		
NC STATE	EVETERANS HOME - FA	AYETTEVILLE		F	AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY OF			(X5) COMPLETION DATE			
F 641	Continued From pag	ge 1	F 6	641			
	month of December	2018 revealed there was no					
	anticoagulant medic	ations prescribed.			Step 1.		
		mum Data Set (MDS) dated			The assessment with deficiency found		
		sident #138 as receiving			Resident #138 was modified by the Ca		
	previous 7 days.	ation 3 days out of the			Mix Director (RN) on 1/09/2019 to com with RAI Manual/Medicaid/Federal	piy	
	providuo r dayo.				Guidelines.		
	Interview with MDS	Nurse #1 on 01/09/19 at					
	10:15 AM revealed				Step 2.		
	anticoagulant medic			To complete a 100% audit of admission	_		
	period for the MDS of the coding on her fo			To complete a 100% audit of admission assessments will be conducted by the	1		
		should have been coded as			Case Mix Director (RN)for all active		
	antibiotic medication				residents from 12/1/2018 to 2/07/2019	to	
					ensure accuracy in section N.		
		dministrator on 01/09/19 at			Cton 2		
	documentation be co	er expectation is that all MDS oded correctly.			Step 3.		
		•			a. Education was done on 1/17/2019 b	y	
					the Clinical Reimbursement Coordinate	or	
					for the Case Mix Director (CMD) on		
					completing the MDS accurately, with emphasis section N, with quarterly		
					assessments, per the RAI Manual/Fed	eral	
					Guidelines.		
					b. An assessment audit tool for section	N,	
					will be implemented by the Case Mix	d	
					Director (CMD) and will be implemente as follows:5 times per week for 4 week		
					then 2 times per week for 4 weeks, the		
					audit done monthly for three months.		
					Step 4.		
					Monitoring will be done by the Cose Mi	ív.	
					Monitoring will be done by the Case Mi Director (CMD), Director of Nursing (RI		
					and Administrator to ensure accuracy in		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						,	c
		345492	B. WING _			01/	10/2019
	ROVIDER OR SUPPLIER	/ETTEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page			641	section N. Continued monitoring will the occur 5 times per week for 4 weeks, the 2 times per week for 4 weeks, then aud done monthly for three months. Results of the monitoring with tracking and trending will be reported by the Ca Mix Director monthly to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvement and changes.	en lit	2/6/19
SS=D	§483.20(k) Preadmiss individuals with a mer with intellectual disable §483.20(k)(1) A nursing or after January 1, 19 (i) Mental disorder as (i) of this section, unlea uthority has determined by a person State mental health a (A) That, because of a condition of the individual reservices, whether the specialized services; (ii) Intellectual disability (a) (ii) of this section intellectual disability of authority has determined individual reservices.	sion Screening for ntal disorder and individuals lility. Ing facility must not admit, on 89, any new residents with: defined in paragraph (k)(3) ess the State mental health ned, based on an and mental evaluation n or entity other than the uthority, prior to admission, the physical and mental dual, the individual requires provided by a nursing facility; quires such level of individual requires or ty, as defined in paragraph					

			(X3) DATE SURVEY COMPLETED		
		345492	B. WING		01/10/2019
	OVIDER OR SUPPLIER VETERANS HOME - FAYETTEVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires specialized services for intellectual disability. A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 645 F 645 S483.20(k)(2) Exceptions. For purposes of this		,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE COMPLETION
F 645	condition of the indivithe level of services and (B) If the individual reservices, whether the specialized services §483.20(k)(2) Excepsection- (i)The preadmission paragraph(k)(1) of the for determinations in to a nursing facility obeing admitted to the transferred for care in (ii) The State may chepreadmission screen paragraph (k)(1) of the to a nursing facility of (A) Who is admitted hospital after receiving hospital, (B) Who requires nurcondition for which the hospital, and (C) Whose attending before admission to is likely to require less facility services. §483.20(k)(3) Definitisection- (i) An individual is considered.	idual, the individual requires provided by a nursing facility; equires such level of a individual requires for intellectual disability. Itions. For purposes of this screening program under is section need not provide the case of the readmission of an individual who, after a nursing facility, was in a hospital. It is section to the admission of an individual-to the facility directly from a negacute inpatient care at the resing facility services for the individual received care in physician has certified, the facility that the individual is than 30 days of nursing inn. For purposes of this insidered to have a mental ual has a serious mental	F 64	5	
	_	onsidered to have an if the individual has an as defined in §483.102(b)(3)			

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBED:		X2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345492	B. WING _				C / 10/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	10/2019	
					14 COCHRAN AVENUE			
NC STATE	VETERANS HOME - FA	AYETTEVILLE			AYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 645	Continued From pag	je 4	F	645				
	or is a person with a	related condition as						
	described in 435.10							
		T is not met as evidenced						
	,	view and staff interviews the			This time line investigation and plan of	f		
	facility failed to apply	information for a resident			correction constitutes a written allegation	on		
	with a diagnosis of D				of substantial compliance with Federal			
	Traumatic Stress Dis	, ,			and Medicaid requirements. Preparation			
		ning and Resident Review			and/or execution of this correction doe			
		e-evaluation for 1 of 5			not constitute admission or agreement	-		
	sampled residents. (Resident #68).			the provider of the truth of items allege	d		
	T. C. P				or conclusions set forth the alleged			
	The findings include	d:			deficiencies. The plan of correction is			
	Decident #00 was a	riaria alla caducitta di ta tha facilita.			prepared and/or executed solely becau			
		riginally admitted to the facility			it is required by the provision of the sta	te		
	PTSD and Depression	gnoses which included:			and federal law in order to remove			
	P 1 3D and Depressi	OII.			substantial noncompliance. It also demonstrates our good faith and desire	o to		
	Decord review of De	sident #68's Admittance			continue to improve the quality of care			
		MDS) dated 7/25/18 had			and services to our residents.			
	resident coded as ha				and dervices to dur residents.			
		cation for 7 of the 7 days			F645			
	during the assessme				483.20			
	•	•						
	Record review of Re	sident #68's care plan which			Step 1.			
	was revised on 9/24	/18 indicated the resident was						
	care planned for use	of an antidepressant due to			PASARR screening and resident review	W		
	diagnoses of depres	sion.			for (PASARR) level 2 re-evaluation for			
					Resident #68 was submitted on 1/9/20	19.		
		aled that the resident had the						
	diagnoses of Depres admitted on 07/18/18	ssion and PTSD when he was 8.			Step 2.			
					To complete a 100% audit of PASARR			
	_	with the Social Worker (SW)			screenings and level 2 re-evaluations f	or		
		S P.M., the SW stated the			all new admissions from 2/3/2018 to			
		ed 7/18/18 with a diagnosis of			1/31/2019.			
	•	SD. The SW also stated it			Ston 2			
		when a resident has a illness the PASARR level II			Step 3.			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		345492	B. WING		С
NAME OF D	ROVIDER OR SUPPLIER	345492	B. WING _	ethert annuese city etate zin cone	01/10/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 214 COCHRAN AVENUE	
NC STATE	VETERANS HOME - FA	YETTEVILLE		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 645	Continued From page	e 5	F 64	15	
	01/10/19 01:18 PM re expectation when a r	valuation. vith the Administrator on evealed that it was her esident has a diagnosis of SARR level II be submitted		a. Education was done on 1/9/2019 by Administrator for the Social Worker's of PASARR screening and level 2 re-evaluations for all new admissions. b. A monitoring tool for Preadmission PASARR screenings will be implement by the Social Services Director on 2/1/2019 and will be implemented as follows: 5 times per week for 4 weeks, the audit done monthly for three months. Step 4. Monitoring will be done by the Social Services Director, Director of Nursing, Administrator to ensure the Preadmiss PASARR screenings and level 2 re-evaluations were done. Continued monitoring will then occur 5 times per week for 4 weeks, then 2 times per week for 4 weeks, then 2 times per we for 4 weeks, then audit done monthly three months. Results of the monitoring with tracking and trending will be reported by the Services Director monthly to the Quali Assurance Performance Improvements	and sion eek for gocial ety
F 812 SS=D	Food Procurement,S CFR(s): 483.60(i)(1)(tore/Prepare/Serve-Sanitary 2)	F 8′	committee for recommendations and suggestions for improvement and changes.	2/6/19
	§483.60(i) Food safe The facility must -				
	§483.60(i)(1) - Procu	re food from sources			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345492	B. WING		C 01/10/2019	
	ROVIDER OR SUPPLIER VETERANS HOME - FA'	/ETTEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 214 COCHRAN AVENUE	1 01/10/2019	
				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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 812	Continued From page 6 approved or considered satisfactory by federal,		F 81	2		
	state or local authoriti (i) This may include for from local producers, and local laws or regulation (ii) This provision does facilities from using progradens, subject to consider a safe growing and food (iii) This provision does from consuming foods from consuming foods from consuming foods satisfied foods and accordant standards for food see this REQUIREMENT by: Based on observation facility failed to discar failed to label and data nourishment room refundational food Policy indicated, in part, The findings included A review of the facility Personal Food Policy indicated, in part, Foods requiring refrigerators and the facility patient/residents' personal food Policy indicated and will be discappatiently personal food part of the facility patiently personal food patiently personal food personal food patiently personal food per	es. cod items obtained directly subject to applicable State plations. Is not prohibit or prevent roduce grown in facility compliance with applicable dehandling practices. It is not procured by the facility. It is not procured by the facility. It is not met as evidenced and and staff interviews, the dexpired food items and the food items in 2 of 3 arigerators observed. It is "Patient/Residents", revised 11/21/16, If igeration must be stored in the sonal refrigerators Food the sonal refrigerators Food the sonal refrigerators of the sonal refrigerators in the sonal maintained in the mand those stored in the mand those stored in the mand those stored in the sonal those stored in the mand the mand those stored in the mand the mand those stored in the ma		This time line investigation and plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement the provider of the truth of items alleged or conclusions set forth the alleged deficiencies. The plan of correction is prepared and/or executed solely becaute it is required by the provision of the stand federal law in order to remove substantial noncompliance. It also demonstrates our good faith and desire continue to improve the quality of care and services to our residents. F 812 483.60	on on s by d use tte	
	During an observation nourishment room ref	n of the "C" Wing rigerator, with the Dietary		Step 1.		

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		, ,	1 ` ′			(X3) DATE SURVEY COMPLETED	
		345492	B. WING				0
NAME OF DE	201/IDED OD OLIDDLIED	343432	D. WING	0	TREET ARRESTO CITY OTATE ZIR CORE	01/	10/2019
	ROVIDER OR SUPPLIER VETERANS HOME - FA	AYETTEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	the refrigerator was a following items: 1. A plastic bag co sandwiches. The ite dated. 2. One clear re-usawith a clear liquid. T labeled or dated. 3. One clear contamanufacturer as Ice date of 12/12/18. The re-filled with a clear liabeled or dated. During an observation nourishment room refigerator was a following items: 1. One clear plastic preparation and a plapaper napkin. The item dated. 2. One Styrofoam pureed sweet potato labeled or dated. 3. One-half of a sawrap. This item had 4. One box of peace resident's name. The puring an interview of 1/10/19 at 3:15 p.m. dietary employees strefrigerator with foods.	ntaining two paper wrapped ems had not been labeled or able beverage container, filled this item had not been liner, labeled by the Tea, with a Best If Used By ne container had been liquid. The item had not been liquid at 3:15 p.m., observed to contain the c cup filled with a rice astic utensil, covered by a tem had not been labeled or container with two servings of les. The item had not been labeled or dated. In cobbler, labeled with a is item had not been dated. Italier of ricotta cheese. The	F	812	Nourishment room refrigerators for both Wing and C Wing were cleaned and all foods that were outdated, not labeled, a not dated were disposed of by the Dieta Manager on 1/10/2019. Step 2. A complete 100% audit of all nourishmer room refrigerators were cleaned and maintained on 1/11/2019 by the Dietary Manager. Step 3. a. Education was done by the Assistant Director of Nursing (ADHS) on 2/3/2019 for all staff on ensuring the proper disposal of expired food items, proper labeling, and dating of food items store in the nourishment room refrigerators. b. An audit tool for maintain the nourishment room refrigerators will be implemented on 2/3/2019 by the Dietar Manager (DM) and will be implemented as follows: 5 times per week for 4 week then 2 times per week for 4 week then 2 times per week for 4 weeks, the audit done monthly for three months. Step 4. Monitoring will be done by the Dietary Manager (DM), Director of Nursing, and Administrator to ensure the proper disposal of expired food items, proper labeling, and dating of food items in the nourishment room refrigerators. Continued monitoring will then occur 5.	l and ary ent y diss, n	

Facility ID: 970225

			l l			OATE SURVEY OMPLETED
		345492	B. WING	 		C 01/10/2019
	ROVIDER OR SUPPLIER VETERANS HOME - FA	YETTEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301	'	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 812	Continued From pag	e 8	F 81	2		
	housekeeping depart department were rest and removing expire room refrigerators. During an interview of 01/10/19 at 3:17 p.m. the nursing department housekeeping depart food in the nourishme Administrator stated were responsible for and freezers with iter Administrator stated food in for a resident staff were responsible food prior to it being freezer. The Administration stated food store the Administration of the staff were responsible food prior to it being freezer. The Administration of the staff were responsible food prior to it being freezer. The Administration food store the staff were responsible food prior to it being freezer. The Administration food store the staff were responsible food prior to it being freezer. The Administration food store the staff were responsible food prior to it being freezer.	with the Administrator on, the Administrator stated ent staff and the tment staff monitored the ent room refrigerators. The the dietary department staff stocking the refrigerators ms from the facility. The if a family member brought the nursing department e for dating and labeling the placed in the refrigerator or strator stated it was her red in the nourishment room ezers be labeled, dated and		times per week for 4 weeks, the per week for 4 weeks, then audi monthly for three months. Results of the monitoring with trand trending will be reported by Dietary Manager (DM) monthly to Quality Assurance and Performal Improvement committee for recommendations and suggestic improvement and changes.	t done acking the to the ance	
F 867 SS=D	§483.75(g)(2) The quassurance committee (ii) Develop and implaction to correct iden This REQUIREMEN' by: Based on medical re	n(ii) ssessment and assurance. uality assessment and	F 86	This time line investigation and correction constitutes a written a		2/6/19
	Assurance (QAA) Co implemented proced interventions the con	ommittee failed to maintain		of substantial compliance with F and Medicaid requirements. Pre and/or execution of this correction not constitute admission or agre	ederal eparation on does	

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	СОМРЫ С О1/1	
		345492	B. WING			1	C 10/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	10/2013
		\\		21	14 COCHRAN AVENUE		
NC STATE	VETERANS HOME - FA	YETTEVILLE		F	AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 867	Continued From page	e 9	F	867			
F 807	was for the recited de Assessment Accuracy on the recertification continued failure of the consecutive federal is pattern of the facility's effective Quality Assessment Acreview and staff interaccurately code the Mareflecting antibiotics ause for 1 of 36 sample 138). During the 2-02-18 refacility had a F641 circode the Minimum Distatus, medications at An interview was con Administrator on 01/2 Administrator stated Quality Assessment awith committee mem departments. The Adexpectation was to reaccuracy in their Quality Assurance meeting at the continued of the c	eficiency in the area of by (F641). It was cited again survey of 1/10/19. The me facility from the two surveys of record shows a sinability to sustain an essment and Assurance. It: Couracy: Based on record view, the facility failed to Minimum Data Set (MDS) and anticoagulant medication led residents. (Resident # Excertification survey, the tation for failing to accurately ata Set for restraints, dental and for resistive care. Inducted with the H0/19 at 6:00 PM. The the facility has a functioning and Assurance Committee bers representing all dministrator indicated her exisit the assessment and and re-examine systems to if the issue to address it with		867	the provider of the truth of items allege or conclusions set forth the alleged deficiencies. The plan of correction is prepared and/or executed solely becauti is required by the provision of the state and federal law in order to remove substantial noncompliance. It also demonstrates our good faith and desire continue to improve the quality of care and services to our residents. Step 1. Assessments with deficiency found for Resident #138 was modified by the Cambridge Mix Director (RN) on 1/09/2019 to comwith RAI Manual/Medicaid/Federal Guidelines. Step 2. To complete a 100% audit of admission assessments will be conducted by the Case Mix Director (RN) for all active residents from 12/1/2018 to 2/07/2019 ensure accuracy in section N. Step 3. a. Education was done on 1/17/2019 by the Clinical Reimbursement Coordinate for the Case Mix Director (CMD) on completing the MDS accurately, with emphasis section N, with quarterly assessments, per the RAI Manual/Fede Guidelines.	use te te to se ply to	
					assessments, per the RAI Manual/Fed		

Facility ID: 970225

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345492	B. WING	R WING		С	
	ROVIDER OR SUPPLIER	1	B. WING	STI 214	REET ADDRESS, CITY, STATE, ZIP CODE 4 COCHRAN AVENUE 1YETTEVILLE, NC 28301	01/	10/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	e 10	F	867	Director (CMD) and will be implemente as follows:5 times per week for 4 weeks, the audit done monthly for six months. Step 4. Monitoring will be done by the Case Mi Director (CMD), Director of Nursing (RI Administrator, and Clinical Reimbursement Coordinator to ensure accuracy in section N. Continued monitoring will then occur 5 times per week for 4 weeks, then 2 times per weef or 4 weeks, then audit done monthly for three months. Results of the monitoring with tracking and trending will be reported by the Ca Mix Director monthly to the Quality Assurance Performance Improvement committee and Clinical Reimbursemen Coordinator for recommendations and suggestions for improvement and changes.	s, n x N), ek or se	