NC STATE VETERANS HOME-BLACK MOUNTAIN SUMMARY STATEMENT OF DEFICIENCY PHEERX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH EDERISERY MAY OF CASCIDENTIFY MAY TO EDERTIFY MONITOR MONITOR) In PHEERX TAG Isouth of the precision		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
NC STATE VETERANS HOME-BLACK MOUNTAIN 22 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711 (M,I) TAC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAC D PRETX (EACH CORRECTIVE ADD FOR LSO DENTERING INFORMATION) PREXX TAC PREVIDENT FLAN OF CORRECTION SHOULD BE CROBEREREDED TO THE APPROPRIATE DEFICIENCY Order Provident STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ADD SHOULD			345558	B. WING		10/10/2019	
NC STATE VETERANS HOME-ELACK MOUNTAIN BLACK MOUNTAIN, NC 2871 (Y4) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIATION OF DEFICIENCIES (EACH DEPICIATION MUST BE PRECIDENT BULL (EACH DEPICIATION MUST BE PRECIDENT WILL (EACH DEPICIATION MUST BE PRECIDENT (EACH DEPICIATION MUST BE PRECIDENT WILL AND ALL AND A	NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BLACK MOUNTAIN, NC 29711 Description Display and the provided set of the state of the	NC STATE	VETERANS HOME-BLA	CK MOUNTAIN				
Precry, TAG CEACH DEFICIENCY MUST BE PRECIDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PMERIX TAG PMERIX TAG CEACH CORRECTIVE ACTION SHOULD BE DEFICIENCY COMPLETE DEFICIENCY E 000 Initial Comments E 000 E 000 Initial Comments E 000 An unannounced recertification survey was conducted on 1007/19 through 10/10/19. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID# 216211. F 641 10/31/19 F 641 Second CFR(s): 483.20(g) F 641 10/31/19 Second CFR(s): 483.20(g) S482.20(g) Accuracy of Assessments. The assessment must accurately cell thre resident's status. F 641 This 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 and/or execution of the state and drequire diabetes and end stage renal disease (the gradual loss of kidney function). This plan of correction is prepared and/or execution is prepared and/or execution is prepared and/or execution is prepared and/or execution is prepared and/or the state and federal law. It also domonstrates our good faith and desire to continue to improve the quality of care and services to our residents. Review of the admission MDS dated 12/20178 review of the admission MDS dated 12/20178 review of the quarty MDS dated 03/18/19 revaled Resident #94 was not coded as being 1. The Case Mix Director (CMD) immediately corrective the definited MDS assessments for Resident #94 and	-			E	BLACK MOUNTAIN, NC 28711		
An unannounced recertification survey was conducted on 10/07/19 through 10/10/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 216211. F 641 F 641 CCR(s): 483.20(g) F 641 SS=D CFR(s): 483.20(g) F 641 Stassesment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code three consecutive Minimum Data Set (MDS) assessments in the area of dialysis treatment for 1 of 2 residents reviewed for dialysis treatment for 1 of 2 residents reviewed for dialysis treatment for 1 of 2 residents reviewed for dialysis treatment for 1 of 2 residents gradual loss of kidney function. This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction is prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. Review of the admission MDS dated 12/20/18 invesale Meeident #94 was not coded as being on dialysis under Section 0 - Special Treatments and Programs. What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1. The Case Mix Director (CMD) immediately corrected the identified MDS assessments for Resident #94 and	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	E COMPLETIO	
conducted on 10/07/19 through 10/10/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 216211.F 641F 641Accuracy of Assessments CFR(s): 483.20(g)F 64110/31/19§ 483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code three consecutive Minimum Data Set (MDS) assessments in the area of dialysis retaintent of 12 residents reviewed for dialysis (Resident #94).This 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 by the provider of the truth of items alleged or conclusions set forth for the alleged diciencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and Programs.Review of the admission MDS dated 12/20/18 in dicated he received dialysis 3 times a week due to end stage renal disease.Review of the admission MDS dated 12/21/18 revealed Resident #94 was not coded as being on dialysis under Section 0 - Special Treatments and Programs.Review of the quarterly MDS dated 03/18/19 revealed Resident #94 was not coded as beingReview of the quarterly MDS dated 03/18/19 revealed Resident #94 was not coded as being	E 000	Initial Comments		E 000			
The assessment must accurately reflect the resident's status.This REQUIREMENT is not met as evidenced by:Based on record review and staff interviews the facility failed to accurately code three consecutive Minimum Data Set (MDS) assessments in the area of dialysis treatment for 1 of 2 residents reviewed for dialysis (Resident #94).This 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 by the provider of the truth of items alleged or conclusions set forth for the alleged diabetes and end stage renal disease (the gradual loss of kidney function).This 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 by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents.Review of the admission MDS dated 12/27/18 revealed Resident #94 was not coded as being on dialysis under Section O - Special Treatments and Programs.What Corrective action will be accomplished for the resident found to have been affected by the deficient practice?Review of the quarterly MDS dated 03/18/19 revealed Resident #94 was not coded as being1. The Case Mix Director (CMD) immediately corrected the identified MDS assessments for Resident #94 and		conducted on 10/07/1 facility was found in c requirement CFR 483 Preparedness. Event Accuracy of Assessm	9 through 10/10/19. The ompliance with the 3.73, Emergency ID# 2l6Z11.	F 641		10/31/19	
		The assessment must resident's status. This REQUIREMENT by: Based on record revi facility failed to accur Minimum Data Set (Marea of dialysis treatmereviewed for dialysis treatmereviewed for dialysis of Findings included: Resident #94 was ad 12/20/18 with multiple diabetes and end state gradual loss of kidney Review of Resident # dated 12/20/18 indicatimes a week due to of Review of the admiss revealed Resident #9 on dialysis under Sec and Programs. Review of the quarter	t accurately reflect the is not met as evidenced iew and staff interviews the ately code three consecutive IDS) assessments in the nent for 1 of 2 residents (Resident #94). mitted to the facility on e diagnoses that included ge renal disease (the y function). 94's baseline care plan ted he received dialysis 3 end stage renal disease. ion MDS dated 12/27/18 4 was not coded as being tion O - Special Treatments 1y MDS dated 03/18/19		 written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely becauti tis required by the provision of the state and federal law. It also demonstrates of good faith and desire to continue to improve the quality of care and service our residents. What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1. The Case Mix Director (CMD) immediately corrected the identified MI 	ise te ur s to	
	DODATODY				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.

STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	<u>. 0938-039</u> Survey
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPL	
		345558	B. WING		10/1	0/2019
NAME OF P	ROVIDER 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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 641	Continued From page	e 1	F 64	1		
	on dialysis under Sec and Programs.	ction O - Special Treatments		resubmitted them on October 8,	2019	
	revealed Resident #9 on dialysis under Sec and Programs. During an interview of Mix Coordinator (CM #94 received dialysis the MDS assessmen and 06/17/19 and con been coded under Se how it was missed ar each MDS assessme submitted to accurate received dialysis. During an interview of Director of Health Se was made aware CM dialysis on Resident s	ely reflect Resident #94 on 10/09/19 at 5:03 PM, the prvices (DHS) indicated she IC #1 had overlooked coding #94's MDS assessments. would expect for the MDS		 performed a 100% audit on 10/8 residents on hemodialysis in the and their Minimum Data Set (MI assessments were completed o 8, 2019 and no other errors wer identified. 3.CMD immediately developed a Performance Improvement Plan October 8, 2019 to ensure accu MDS assessments in document hemodialysis. How will you identify other resid having the potential to be affect same deficient practice and wha corrective action will be taken? 1.MDS-CMD and CMC develop- implemented an audit tool on 10 address both new admissions a residents to identify their hemodi status. MDS CMD and CMC will audit form to validate MDS accu coding section O-00100J. 2.MDS and Inter-Disciplinary Te will review orders for new developed will review orders for new developed 	e facility DS) n October e a (PIP) on racy in ing ents ed by the at ed and 0/8/19 to nd current lialysis I use this uracy in am (IDT)	
				that could affect MDS coding ac 3.MDS and IDT will review the 8 documentation weekly as a sec measure to ensure current MDS assessments have captured the dialysis information on the MDS assessment.	scuracy. 802 ondary s correct	

Event ID: 2I6Z11

Facility ID: 090964

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 11/12/2019 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE	SURVEY
		345558	B. WING			10	/10/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
NC STATE	VETERANS HOME-BLA	CK MOUNTAIN		-	2 LAKE EDEN ROAD		
				В	LACK MOUNTAIN, NC 28711		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 641	Continued From page	2	F	641			
					4.MDS and IDT will review PIP for M coding accuracy in hemodialysis we for accuracy for 12 weeks.		
					What measures will be put in place of what systemic changes will be made ensure that the deficient practice will reoccur?	e to	
					1.MDS-CMD, CMC and IDT will revisorders/order changes in Matrix (computerized Medical record) daily changes to current hemodialysis res status and addition of new hemodial residents and or orders.	for ident	
					2. The Admission-Quarterly audit too 10/8/19 developed by MDS-CMD an CMC will be referenced weekly when entering information into the MDS assessment section O-00100J to en accuracy in this section for 3 months	d n sure	
					How will the corrective action be monitored to assure that the deficier practice will not reoccur, i.e., what qu assurance program will be put in pla monitoring to assure continued compliance.	uality	
					1.MDS coding accuracy in hemodial will be reviewed weekly for 12 weeks the date of compliance (10/31/19) in Clinical Risk meeting by the clinical to DHS and Administrator.	s from the	
	7(02-99) Previous Versions Obs	olete Event ID: 216			2.Results from the audit tool will be brought forward to the QAPI meeting	-	pet Page 3 of 13

Event ID: 2I6Z11

Facility ID: 090964

If continuation sheet Page 3 of 13

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/12/20 M APPROVI D. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345558	B. WING			10	/10/2019
NAME OF PI	ROVIDER OR SUPPLIER	·	•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE VETERANS HOME-BLACK MOUNTAIN				-	2 LAKE EDEN ROAD LACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 641	Continued From page	e 3	F	641	monthly for review for 3 months.		
					3.Persons responsible for implementin the Plan of Correction are: Administrat MDS-CMD and CMC and IDT member Date of Compliance:	or,	
F 761 SS=D		-	F	761	10/31/19		10/31/19
	Drugs and biologicals	y and cautionary					
	§483.45(h) Storage c	f Drugs and Biologicals					
	Federal laws, the fact biologicals in locked	ordance with State and ility must store all drugs and compartments under proper , and permit only authorized cess to the keys.					
	locked, permanently storage of controlled the Comprehensive I Control Act of 1976 a abuse, except when	cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to the facility uses single unit ution systems in which the					
	quantity stored is min be readily detected.	imal and a missing dose can					

If continuation sheet Page 4 of 13

		MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		345558	B. WING		10/10	0/2019
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIF	PCODE	
IC STATE VETERANS HOME-BLACK MOUNTAIN				62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	I	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 761	Continued From page	e 4	F 76	31		
	Based on observation interviews the facility antifungal cream and powder securely for	on, record review, and staff failed to store 1 tube of I 1 bottle of antifungal 1 of 7 sampled residents ion storage (Resident #73).		What Corrective action v accomplished for the resi have been affected by the practice?	idents found to e deficient	
	Findings included: Resident #73 was ad	lmitted to the facility on		1.Director of Health Servi immediately removed all medicated creams from F room. DHS immediately of	tubes of Resident #73⊡s	
	10/21/18 with diagno diabetes mellitus.	ses included atrial fibrillation,		Performance Improvene ensure that no medicated left in rooms) on 10/10/19	nt Plan (PIP □ to d creams were	
	10/07/19 at 10:40 AN	storage audit conducted on I, a tube of used antifungal f used antifungal powder the bed side table		2.All rooms in facility wer on 10/10/19 for medicate creams left in residents□	ed or otherwise	
	unattended in Reside			tube or cup and none we		
	administration record	orders and medication Is revealed Resident #73 had receive antifungals in the		3.Nurses were in-service with 100% compliance or		
	10:48 AM, Resident	conducted on 10/07/19 at #73 stated the 2 antifungals		How will you identify othe having the potential to be same deficient practice a corrective action will be ta	e affected by the and what	
	staff. However, he co the nursing staff. He	this morning by a nursing ould not recall the identity of further stated he did not ations were in his room and		1.All residents are identifing potential to be affected by deficient practice.	y the same	
				2.All non-medicated tube replaced facility-wide with use creams to be left in b on 10/9/19.	h single resident	
	facility required all the a locked compartment	morning. She added the e medications to be stored in nt. Only the authorized hitted to have the access to		3.Nurses were in-service compliant on 10/14/19) th resident use creams were that no medicated cream	hat the single e to be used, and	

Facility ID: 090964

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345558	B. WING		10/10/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
NC STATE	NC STATE VETERANS HOME-BLACK MOUNTAIN			62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 761	Continued From pag	le 5	F 761		
		acknowledged that the 2 ot be left unattended in		be in treatment carts) were to b residents□ rooms.	e left in
	During an interview conducted on 10/08/19 at 11:23 AM, the Director of Nursing (DON) stated she did not know why the 2 antifungals were left unattended in Resident #73's room. She stated the facility had a system in place to store all the medications in a secured and proper manner. She expected all the medications to be stored in a locked compartment. With only authorized personnel to have the access to the medications. It was her expectation for all the nursing staff to follow facility's policies and procedures to ensure no medications be left unattended in the facility all the times. An interview was conducted with the wound care nurse on 10/10/19 at 11:30 AM. She had checked			 4. Compliance rounds will be may for 4 weeks and then weekly for by supervisor/designee to ensu medicated creams are left in re- rooms. What measures will be put in pl what systemic changes will be n ensure that the deficient practic reoccur? 1. Starting 10/10/19 an audit too attachments 1-4) was developed checking rooms for any medication creams left in rooms, removal at subsequent reporting to DHS for noncompliance. Auditing by Sup- 	r 4 weeks re that no sidents □ ace or made to will not l (see d for ted ind the or any
	physician orders and	nistration records and I confirmed that Resident #73 rent orders related to the 2 his room.		 designee daily for 4 weeks, weeks. 2.Staff contributing to the deficie practice will be reprimanded. 3.All findings of noncompliance discussed with Inter-Disciplinar (IDT) team daily and proper act How will the corrective action be monitored to assure that the de practice will not reoccur, i.e., whassurance program will be put i monitoring to assure continued compliance. 	ent will be y Team ion taken. ne ficient nat quality

Facility ID: 090964

If continuation sheet Page 6 of 13

STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345558	B. WING		10/10/2019
NAME OF P	ROVIDER OR SUPPLIER		I	STREET ADDRESS, CITY, STATE, ZIP CODE	
NC STATE	VETERANS HOME-BL	ΔΩΚ ΜΟΠΝΤΔΙΝ		62 LAKE EDEN ROAD	
				BLACK MOUNTAIN, NC 28711	
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLET
F 761	Continued From pag	e 6	F 76	1	
				weeks by DHS/designee for co	ompliance
				2.All noncompliant findings wil disciplinary action of any partn review of the process complete deficient area.	er and a
				3.The DHS is responsible for e compliance of proper medication and storage.	
				4.Audit compliance will be report monthly Quality Assurance Per Improvement (QAPI) meetings months.	rformance
F 040			E 04	Date of Compliance: 10/31/19	10/21/1
F 812 SS=D	CFR(s): 483.60(i)(1)	tore/Prepare/Serve-Sanitary (2)	F 81	2	10/31/1
	§483.60(i) Food safe The facility must -	ty requirements.			
	approved or conside state or local authorit	re food from sources red satisfactory by federal, ties. food items obtained directly			
	and local laws or reg (ii) This provision do facilities from using p	es not prohibit or prevent produce grown in facility			
	safe growing and foc (iii) This provision do	compliance with applicable od-handling practices. sonot preclude residents ds not procured by the facility.			

Facility ID: 090964

If continuation sheet Page 7 of 13

		MEDICAID SERVICES					D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345558	B. WING			10/	/10/2019
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
IC STATE VETERANS HOME-BLACK MOUNTAIN					2 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 812	Continued From page	e 7	F	812			
-	serve food in accorda standards for food se	ance with professional		012			
	Based on observatio facility failed to discar	ns and staff interviews, the rd nutritional supplements expiration dates stored in 1 ms (B/C hallway			What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?	D	
	The findings included	l:			1.The Bravo/Charlie nourishment room were checked on 10/8/19 to remove ar expired nutritional supplements and mi	ıy	
	1:37 PM, of the nouri facility's B and C half inside the nourishme included, three unope nutritional supplement March 1, 2019, and a	conducted on 10/08/2019 at shment room located on the way. Items observed stored nt room's refrigerator ened 6-ounce cartons of nts with an expiration date of an opened 20-ounce bottle of with an expired expiration			 2.All Dietary staff have been in-service 100% on 10/9/19 to reinforce the facilit policy on dating/labeling and nourishm room procedure. 3.Registered Dietician (RD) and Certifi Dietary Manager (CDM) immediately developed a Performance Improvemer 	y ent ed nt	
	10/08/2019 at 2:39 P Dietician/Dietary Mar	ervations were conducted on M, with the Registered nager (DM) concerning the s nourishment room. The			Plan (PIP), related to the deficient prac on 10/10/19, for checking and removin any expired nutritional supplements an milk from the nourishment rooms.	g	
	DM stated the server monitoring the stored cleaning of the nouris	rs were responsible for l items, stocking, and shment room.			How will you identify other residents having the potential to be affected by the same practice and what corrective active will be taken?		
	2:42 PM with nourish stated there were fou the nourishment room	ducted on 10/08/2019 at ment room Server #1, who ir servers that replenished ns starting with the morning ternoon shifts. Server #1			1. The Alpha/Delta nourishment room h been checked on 10/8/19 to remove ar expired nutritional supplements and mi	ny ilk.	
		s were responsible for ns, and re-stocking items ent's daily use.			2.All Dietary staff has been in-serviced 10/9/19 to reinforce the facility policy o dating/labeling and nourishment room procedure.		

Facility ID: 090964

	S FOR MEDICARE &				OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345558	B. WING		10/10/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
NC STATE	NC STATE VETERANS HOME-BLACK MOUNTAIN			62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 812	An interview was con 12:01 PM with the Kit KM explained she ma which included the fo servers. The KM stat the servers to monito dispose of expired ite area clean, and moni refrigerator and freez further stated the mon nourishment rooms for and refrigerator and f afternoon shift was re- the nourishment room An interview was con 1:29 PM with the Exe ED stated he was co- items found in the no inform the KM. The E- taking measures to co-	aducted on 10/09/2019 at tchen Manager (KM). The anaged the kitchen staff, our nourishment room ted the expectation was for or the nourishment rooms, ems, re-stock items, keep the itor and document the ter temperatures. The KM rning servers checked the or expired items, cleanliness freezer temperatures. The esponsible for re-stocking ns. aducted on 10/09/2019 at ecutive Director (ED). The oncerned about the expired urishment rooms and would ED stated they would be orrect the incidents, as well are of their responsibilities	F 81		ately prement nt practice emoving ents and s. ace or nade to e will not need to to sign off n expired c. utritional e daily for e no ducts. ent rooms looks as ngoing pok or or expired

Facility ID: 090964

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/12/20 M APPROVE D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345558	B. WING			10	/10/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
NC STATE	NC STATE VETERANS HOME-BLACK MOUNTAIN				LAKE EDEN ROAD LACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 812 F 867 SS=D	QAPI/QAA Improvem CFR(s): 483.75(g)(2) §483.75(g) Quality as §483.75(g) Quality as §483.75(g)(2) The quassurance committee (ii) Develop and imple action to correct iden This REQUIREMENT by: Based on observation interview the facility's Assurance (QAA) con implemented procedu interventions that the put into place followir	nent Activities (ii) ssessment and assurance. uality assessment and e must: ement appropriate plans of tified quality deficiencies; Γ is not met as evidenced ons, record review and staff s Quality Assessment and mmittee failed to maintain		312	DEFICIENCY) assurance program will be put in place monitoring to assure continued compliance. 1.CMD/RD/or designee will monitor corrective action daily for twelve wee 2.Audit compliance will be reported a monthly QAPI meeting for 3 months. Date of Compliance: 10/31/19 What Corrective action will be accomplished for the residents found have been affected by the deficient practice? 1.The Bravo/Charlie nourishment roo were been checked on 10/8/19 to rem	ks. t to	10/31/19
	and complaint survey current recertification 10/10/19. The recited of the provision of foc nourishment rooms for	the 10/18/18 recertification which was recited on the and complaint survey of deficiency was in the area			 any expired nutritional supplements a milk. 2.All Dietary staff has been in-service 10/9/19 to reinforce the facility policy dating/labeling and nourishment room procedure. 	ed on on	

Facility ID: 090964

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				OMB NO. 0938-03
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
	345558	B. WING		10/10/2019
ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
NC STATE VETERANS HOME-BLACK MOUNTAIN				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	DULD BE COMPLETIO
Continued From page	e 10	F 867		
Continued From page 10 in the same area showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to:			3.Registered Dietician (RD) and (Dietary Manager (CMD) immedia developed a Performance Improv Plan (PIP), related to the deficien on 10/10/19, for checking and rer any expired nutritional supplement	tely /ement t practice noving nts and
serve-sanitary. Based interviews, the facility supplements and mill dates stored in 1 of 2	d on observations and staff r failed to discard nutritional k with expired expiration nourishment rooms (B/C		having the potential to be affected same deficient practice and what corrective action will be taken?1.All residents have the potential	d by the
10/18/18 the facility w to 1) ensure food was expiration (including in nourishment room) of hair when working in an ice scoop and fan During an interview c	vas cited for F-812 for failure s not stored beyond in the facility's B/C r on the floor, 2) cover all the kitchen and 3) maintain in a sanitary condition.		 2.Alpha/Delta nourishment rooms audited on 10/8/19 to ensure that were no expired supplements or in 3.Dietary staff will restock the nut supplements including milk twice ensure there are no expired supp 	there milk. ritional daily to lements
a system breakdown the nourishment room isolated incident. The QAA committee had facility had policies an ensure all nourishme expired foods. After the of correction was imp was ongoing until sub achieved. The Admin	related to food storage in ns and stated it was an Administrator stated the been functional and the nd procedures in place to nt rooms were free of he last Federal survey, plan blemented, and monitoring ostantial compliance was istrator added the repeated		Dietary Manager (CMD) immedia developed a Performance Improv Plan (PIP), related to the deficien on 10/10/19, for checking and rer any expired nutritional supplemer milk from the nourishment rooms What measures will be put in plac what systemic changes will be ma	tely rement t practice noving nts and ce or ade to
	PF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER VETERANS HOME-BLA SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page in the same area sho inability to sustain an Program. The findings included This tag is cross refe F-812: Food procurent serve-sanitary. Based interviews, the facility supplements and mill dates stored in 1 of 2 hallway nourishment During the recertifica 10/18/18 the facility v to 1) ensure food was expiration (including nourishment room) o hair when working in an ice scoop and fan During an interview of 12:37 PM the Admini a system breakdown the nourishment roor isolated incident. The QAA committee had facility had policies at ensure all nourishme expired foods. After t of correction was imp was ongoing until suf achieved. The Admini areas of concern wou	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345558 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 in the same area showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F-812: Food procurement, store, prepare, serve-sanitary. Based on observations and staff interviews, the facility failed to discard nutritional supplements and milk with expired expiration dates stored in 1 of 2 nourishment rooms (B/C hallway nourishment room). During the recertification and complaint survey of 10/18/18 the facility was cited for F-812 for failure to 1) ensure food was not stored beyond expiration (including in the facility's B/C nourishment room) or on the floor, 2) cover all hair when working in the kitchen and 3) maintain an ice scoop and fan in a sanitary condition. During an interview conducted on 10/10/19 at 12:37 PM the Administrator denied the facility had a system breakdown related to food storage in the nourishment rooms and stated it was an isolated incident. The Administrator stated the QAA committee had been functional and the facility had policies and procedures in place to ensure all nourishment rooms were free of expired foods. After the last Federal survey, plan of correction was implemented, and monitoring was ongoing until substantial compliance was achieved. The Administrator added the repeated areas of concern wou	OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A BUILDING. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 10 in the same area showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. ID PREFIX TAG The findings included: This tag is cross referenced to: F-812: Food procurement, store, prepare, serve-sanitary. Based on observations and staff interviews, the facility failed to discard nutritional supplements and milk with expired expiration dates stored in 1 of 2 nourishment rooms (B/C hallway nourishment room). During the recertification and complaint survey of 10/18/18 the facility was cited for F-812 for failure to 1) ensure food was not stored beyond expiration (including in the facility's B/C nourishment room) or on the floor, 2) cover all hair when working in the kitchen and 3) maintain an ice scoop and fan in a sanitary condition. During an interview conducted on 10/10/19 at 12:37 PM the Administrator denied the facility had a system breakdown related to food storage in the nourishment rooms and stated it was an isolated incident. The Administrator stated the QAA committee had been functional and the facility had policies and procedures in place to ensure all nourishment rooms were free of expired foods. After the last Federal survey, plan of correction was implemented, and monitoring was ongoing until substantial compliance was achieved. The Administrator added the repeated areas of concern would be reviewed b	pF DEFICIENCIES CORRECTION (X1) PROVIDER SUPPLIER/LIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 345558 B. WING SOUDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE (22 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711 SUMMARY STATEMENT OF DEFICIENCIES (REAL CORRECTIVE OR DEFICIENCIES (REAL CORRECTIVE ACTION SUPPLIER) (REAL CORRECTIVE ACTION S

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
IND FLAN U	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COWFLETED	
		345558	B. WING		10/10/2019	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATI	NC STATE VETERANS HOME-BLACK MOUNTAIN			62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIER	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO	
F 867	still existed, the mo for at least 3 month	ge 11 nitoring would continue daily s until the desired change was oals were achieved and	F 867	 constructed a root cause analysis of 10/28/19 to assess food storage issuand monitoring methods will be develor for strict compliance. 2. Audit compliance by QAPI and/or administrator and reported to QAPI fmonths. 3. Dietary staff have been assigned to monitor the nourishment rooms twice day to verify (via log book), that nourishment rooms are rooms are from expired nutritional supplements milk. 4. Dietary staff will restock nutritional supplements and milk twice daily and ensure no products are expired. 5. The CDM/RD/or designee will additionally check the nourishment rooms well. 6. Dietary staff log book will be ongoin and dietary manager/dietician/cook of designee will check twice daily for exputitional supplements and milk for weeks. Thereafter, once daily for an additional 4 weeks. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quassurance program will be put in playmonitoring to assure continued 	t Jality	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345558			(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		B. WING		10/10/2019		
NAME OF PI	ROVIDER 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 (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLET CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)		
F 867	Continued From page 12		F 867	, 1.CMD, RD and or designee will r corrective action daily for twelve v		
				2.Audit compliance will be reported monthly QAPI meeting for 3 mont		
				Date of Compliance: 10/31/19		

Event ID: 2I6Z11

Facility ID: 090964

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