STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345558	A. BUILDING _____ B. WING _____	10/10/2019

NAME OF PROVIDER 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments 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# 2I6Z11.	E 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §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 treatment for 1 of 2 residents reviewed for dialysis (Resident #94). Findings included: Resident #94 was admitted to the facility on 12/20/18 with multiple diagnoses that included diabetes and end stage renal disease (the gradual loss of kidney function). Review of Resident #94's baseline care plan dated 12/20/18 indicated he received dialysis 3 times a week due to end stage renal disease. 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. Review of the quarterly MDS dated 03/18/19 revealed Resident #94 was not coded as being	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 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. 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	10/31/19

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

Electronically Signed | 10/30/2019

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F 641	Continued From page 1 on dialysis under Section O - Special Treatments and Programs. Review of the quarterly MDS dated 06/17/19 revealed Resident #94 was not coded as being on dialysis under Section O - Special Treatments and Programs. During an interview on 10/08/19 at 2:00 PM Case Mix Coordinator (CMC) #1 confirmed Resident #94 received dialysis treatment. She reviewed the MDS assessments dated 12/27/18, 03/18/19 and 06/17/19 and confirmed dialysis should have been coded under Section O. She was unsure how it was missed and stated a modification for each MDS assessment would need to be submitted to accurately reflect Resident #94 received dialysis. During an interview on 10/09/19 at 5:03 PM, the Director of Health Services (DHS) indicated she was made aware CMC #1 had overlooked coding dialysis on Resident #94's MDS assessments. The DHS stated she would expect for the MDS assessments to be accurately coded.	F 641	resubmitted them on October 8, 2019 2.The Case Mix Coordinator and the CMD performed a 100% audit on 10/8/19 of all residents on hemodialysis in the facility and their Minimum Data Set (MDS) assessments were completed on October 8, 2019 and no other errors were identified. 3.CMD immediately developed a Performance Improvement Plan (PIP) on October 8, 2019 to ensure accuracy in MDS assessments in documenting hemodialysis. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1.MDS-CMD and CMC developed and implemented an audit tool on 10/8/19 to address both new admissions and current residents to identify their hemodialysis status. MDS CMD and CMC will use this audit form to validate MDS accuracy in coding section O-00100J. 2.MDS and Inter-Disciplinary Team (IDT) will review orders for new developments that could affect MDS coding accuracy. 3.MDS and IDT will review the 802 documentation weekly as a secondary measure to ensure current MDS assessments have captured the correct dialysis information on the MDS assessment.	

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F 641	Continued From page 2	F 641		

4.MDS and IDT will review PIP for MDS coding accuracy in hemodialysis weekly for accuracy for 12 weeks.

What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?

1.MDS-CMD, CMC and IDT will review orders/order changes in Matrix (computerized Medical record) daily for changes to current hemodialysis resident status and addition of new hemodialysis residents and or orders.

2.The Admission-Quarterly audit tool on 10/8/19 developed by MDS-CMD and CMC will be referenced weekly when entering information into the MDS assessment section O-00100J to ensure accuracy in this section for 3 months.

How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.

1.MDS coding accuracy in hemodialysis will be reviewed weekly for 12 weeks from the date of compliance (10/31/19) in the Clinical Risk meeting by the clinical team, DHS and Administrator.

2.Results from the audit tool will be brought forward to the QAPI meeting

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F 641	Continued From page 3	F 641	monthly for review for 3 months. 3.Persons responsible for implementing the Plan of Correction are: Administrator, MDS-CMD and CMC and IDT members Date of Compliance: 10/31/19	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		10/31/19

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F 761	Continued From page 4 Based on observation, record review, and staff interviews the facility failed to store 1 tube of antifungal cream and 1 bottle of antifungal powder securely for 1 of 7 sampled residents reviewed for medication storage (Resident #73). Findings included: Resident #73 was admitted to the facility on 10/21/18 with diagnoses included atrial fibrillation, diabetes mellitus. During a medication storage audit conducted on 10/07/19 at 10:40 AM, a tube of used antifungal cream and a bottle of used antifungal powder were found on top of the bed side table unattended in Resident #73's room. Review of physician orders and medication administration records revealed Resident #73 had not been ordered to receive antifungals in the past 6 months. During an interview conducted on 10/07/19 at 10:48 AM, Resident #73 stated the 2 antifungals were left in his room this morning by a nursing staff. However, he could not recall the identity of the nursing staff. He further stated he did not know why the medications were in his room and he did not use them. An interview was conducted with Nurse #1 on 10/07/19 at 10:54 AM. She did not recall seeing the 2 antifungals on the bed side table in Resident #73's room when she did the medication pass that morning. She added the facility required all the medications to be stored in a locked compartment. Only the authorized personnel were permitted to have the access to	F 761	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1.Director of Health Services (DHS) immediately removed all tubes of medicated creams from Resident #73□s room. DHS immediately developed a Performance Improvement Plan (PIP □ to ensure that no medicated creams were left in rooms) on 10/10/19 2.All rooms in facility were 100% audited on 10/10/19 for medicated or otherwise creams left in residents□ rooms, whether tube or cup and none were found. 3.Nurses were in-serviced on all shifts with 100% compliance on 10/14/19. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1.All residents are identified as having the potential to be affected by the same deficient practice. 2.All non-medicated tubes of creams were replaced facility-wide with single resident use creams to be left in bedside drawer on 10/9/19. 3.Nurses were in-serviced (100% compliant on 10/14/19) that the single resident use creams were to be used, and that no medicated creams (these should	

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F 761	Continued From page 5 the key. She further acknowledged that the 2 antifungals should not be left unattended in Resident #73's room. 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 the medication administration records and physician orders and confirmed that Resident #73 did not have any current orders related to the 2 antifungals found in his room.	F 761	be in treatment carts) were to be left in residents rooms. 4.Compliance rounds will be made daily for 4 weeks and then weekly for 4 weeks by supervisor/designee to ensure that no medicated creams are left in residents rooms. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? 1.Starting 10/10/19 an audit tool (see attachments 1-4) was developed for checking rooms for any medicated creams left in rooms, removal and the subsequent reporting to DHS for any noncompliance. Auditing by Supervisor or designee daily for 4 weeks, weekly for 4 weeks. 2.Staff contributing to the deficient practice will be reprimanded. 3.All findings of noncompliance will be discussed with Inter-Disciplinary Team (IDT) team daily and proper action taken. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. 1.The audit tool will be monitored daily for 4 weeks and weekly for the subsequent 4	

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F 761	Continued From page 6	F 761	weeks by DHS/designee for compliance 2.All noncompliant findings will result in disciplinary action of any partner and a review of the process completed for any deficient area. 3.The DHS is responsible for ensuring compliance of proper medication handling and storage. 4.Audit compliance will be reported at the monthly Quality Assurance Performance Improvement (QAPI) meetings for 3 months. Date of Compliance: 10/31/19	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		10/31/19

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F 812	Continued From page 7 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard nutritional supplements and milk with expired expiration dates stored in 1 of 2 nourishment rooms (B/C hallway nourishment room). The findings included: An observation was conducted on 10/08/2019 at 1:37 PM, of the nourishment room located on the facility's B and C hallway. Items observed stored inside the nourishment room's refrigerator included, three unopened 6-ounce cartons of nutritional supplements with an expiration date of March 1, 2019, and an opened 20-ounce bottle of flavored low-fat milk with an expired expiration dated 09/02/2019. An interview and observations were conducted on 10/08/2019 at 2:39 PM, with the Registered Dietician/Dietary Manager (DM) concerning the B/C hallway resident's nourishment room. The DM stated the servers were responsible for monitoring the stored items, stocking, and cleaning of the nourishment room. An interview was conducted on 10/08/2019 at 2:42 PM with nourishment room Server #1, who stated there were four servers that replenished the nourishment rooms starting with the morning shift and later with afternoon shifts. Server #1 stated that the servers were responsible for removing expired items, and re-stocking items needed for the resident's daily use.	F 812	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1.The Bravo/Charlie nourishment room were checked on 10/8/19 to remove any expired nutritional supplements and milk. 2.All Dietary staff have been in-serviced 100% on 10/9/19 to reinforce the facility policy on dating/labeling and nourishment room procedure. 3.Registered Dietician (RD) and Certified Dietary Manager (CDM) immediately developed a Performance Improvement Plan (PIP), related to the deficient practice on 10/10/19, for checking and removing any expired nutritional supplements and milk from the nourishment rooms. How will you identify other residents having the potential to be affected by the same practice and what corrective action will be taken? 1.The Alpha/Delta nourishment room have been checked on 10/8/19 to remove any expired nutritional supplements and milk. 2.All Dietary staff has been in-serviced on 10/9/19 to reinforce the facility policy on dating/labeling and nourishment room procedure.	

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F 812	Continued From page 8 An interview was conducted on 10/09/2019 at 12:01 PM with the Kitchen Manager (KM). The KM explained she managed the kitchen staff, which included the four nourishment room servers. The KM stated the expectation was for the servers to monitor the nourishment rooms, dispose of expired items, re-stock items, keep the area clean, and monitor and document the refrigerator and freezer temperatures. The KM further stated the morning servers checked the nourishment rooms for expired items, cleanliness and refrigerator and freezer temperatures. The afternoon shift was responsible for re-stocking the nourishment rooms. An interview was conducted on 10/09/2019 at 1:29 PM with the Executive Director (ED). The ED stated he was concerned about the expired items found in the nourishment rooms and would inform the KM. The ED stated they would be taking measures to correct the incidents, as well as, make all staff aware of their responsibilities and accountabilities when accessing the nourishment rooms.	F 812	3.Registered Dietician (RD) and Certified Dietary Manager (CDM) immediately developed a Performance Improvement Plan (PIP), related to the deficient practice on 10/10/19, for checking and removing any expired nutritional supplements and milk from the nourishment rooms. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? 1.Dietary staff have been assigned to nourishment rooms twice a day to sign off for twelve weeks, to ensure that nourishment rooms are free from expired nutritional supplements and milk. 2.Dietary staff will restock the nutritional supplements including milk twice daily for twelve weeks to ensure there are no expired supplements or milk products. 3.The CDM/RD/or designee will additionally check the nourishment rooms twice a day and initial the log books as well for twelve weeks. 4.Dietary staff log book will be ongoing and dietary manager/dietician/cook or designee will check twice daily for expired nutritional supplements and milk for 12 weeks. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality	

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F 812	Continued From page 9	F 812	assurance program will be put in place for monitoring to assure continued compliance. 1.CMD/RD/or designee will monitor corrective action daily for twelve weeks. 2.Audit compliance will be reported at monthly QAPI meeting for 3 months. Date of Compliance: 10/31/19	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the facility's 10/18/18 recertification and complaint survey. The failure related to one recited deficiency that was originally cited during the 10/18/18 recertification and complaint survey which was recited on the current recertification and complaint survey of 10/10/19. The recited deficiency was in the area of the provision of food storage in the nourishment rooms for residents. The continued failure of the facility during two surveys of record	F 867	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? 1.The Bravo/Charlie nourishment room were been checked on 10/8/19 to remove any expired nutritional supplements and milk. 2.All Dietary staff has been in-serviced on 10/9/19 to reinforce the facility policy on dating/labeling and nourishment room procedure.	10/31/19

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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: 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 by the QAA committee for root cause analysis and a performance improvement plan would be developed to correct the deficiencies. If problems	F 867	3.Registered Dietician (RD) and Certified Dietary Manager (CMD) immediately developed a Performance Improvement Plan (PIP), related to the deficient practice on 10/10/19, for checking and removing any expired nutritional supplements and milk from the nourishment rooms. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1.All residents have the potential to be affected by deficient practice. 2.Alpha/Delta nourishment rooms were audited on 10/8/19 to ensure that there were no expired supplements or milk. 3.Dietary staff will restock the nutritional supplements including milk twice daily to ensure there are no expired supplements or milk products for twelve weeks. 4.Registered Dietician (RD) and Certified Dietary Manager (CMD) immediately developed a Performance Improvement Plan (PIP), related to the deficient practice on 10/10/19, for checking and removing any expired nutritional supplements and milk from the nourishment rooms. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? 1.Inter-Disciplinary Team (IDT team) has	

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F 867	Continued From page 11 still existed, the monitoring would continue daily for at least 3 months until the desired change was effective, and the goals were achieved and sustained.	F 867	constructed a root cause analysis on 10/28/19 to assess food storage issue and monitoring methods will be developed for strict compliance. 2.Audit compliance by QAPI and/or administrator and reported to QAPI for 3 months. 3.Dietary staff have been assigned to monitor the nourishment rooms twice a day to verify (via log book), that nourishment rooms are rooms are free from expired nutritional supplements and 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 twice a day and initial the log books as well. 6.Dietary staff log book will be ongoing and dietary manager/dietician/cook or designee will check twice daily for expired nutritional supplements and milk for 4 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 quality assurance program will be put in place for monitoring to assure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345558	A. BUILDING _____ B. WING _____	10/10/2019

NAME OF PROVIDER 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 12	F 867	1.CMD, RD and or designee will monitor corrective action daily for twelve weeks. 2.Audit compliance will be reported at monthly QAPI meeting for 3 months. Date of Compliance: 10/31/19	