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 ______	C 07/12/2023

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 000	INITIAL COMMENTS A follow-up survey and complaint investigation was conducted on 7/5/23 through 7/6/23. The credible allegation of jeopardy removal was validated on 7/11/23 and additional information was obtained on 7/12/23. Therefore the exit date was changed to 7/12/23. The following intakes were investigated: NC00204204 and NC00204327. Both intakes resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.25 at tag F684 at a scope and severity (J) CFR 483.35 at tag F725 at a scope and severity (L) CFR 483.35 at tag F867 at a scope and severity (L) The tag F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 06/26/23 and was removed on 07/08/23. A partial extended survey was conducted. The 2567 was posted one day late on 7/27/23 due to management review.	F 000		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes	F 583		8/10/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/04/2023

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.

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accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews the facility failed to safeguard protected health information (PHI) for 6 of 6 resident (Residents #3, #4, #5, #6, #7, and #8) observed for privacy and confidentiality, by leaving confidential PHI exposed on an unattended medication cart, in an area accessible to the public.

Findings included:

F 583

This plan of Correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do 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

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F 583 Continued From page 2

A continuous observation was made on 07/05/23 from 3:42 PM through 3:44 PM of an unattended medication cart on the Bravo unit. Nurse #4 left the medication cart with the PHI of Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, and Resident #8 exposed while he was providing care for Resident #2 in the resident's room. The computer screen showed the name, picture, and code status of Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, and Resident #8. Nurse #4 returned to the medication cart at 3:44 PM.

During an interview with Nurse #4 on 07/05/23 at 3:45 PM he confirmed he left the computer screen with the PHI of Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, and Resident #8 unattended while he provided care to Resident #2. Nurse #4 stated he went in Resident #2's room to administer medication and he noticed the resident had been incontinent of urine, so he provided incontinence care while he was in the room. He stated he should have locked the computer screen or minimized it before going into Resident #2's room and acknowledged it was his oversight.

An interview with Director of Health Services (DHS) #1 on 07/12/23 at 4:17 PM revealed resident PHI should never be exposed and unattended. She stated all nursing staff should either cover or minimize the computer screen if they had to step away from the medication cart.

F 583

it is required by law to remove the deficiency. It also demonstrates our good faith and desire to continue to improve the quality of care and services for our residents.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident□s #3, #4, #5, #6, #7, and #8 electronic health records was closed after nurse #4 completed med pass on July 5, 2023. Quality Improvement (QI) coordinator nurse provided education to Nurse #4 on July 18, 2023, on closing and/or minimizing computer screens when not in use to ensure resident□s personal health information (PHI) is secured.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice.

The Registered Nurse supervisor completed a 100% audit on August 2, 2023, looking at all three med carts focusing on the computer screen to ensure PHI is secure.

All three medication cart tablets were locked, and no PHI records were visible.
Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not

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F 583	Continued From page 3	F 583	recur. The Director of Health Services (DHS) and/or nurse managers will in-service all licensed nurses by closing and/or minimizing computer screens when not in use to ensure resident□s PHI is secure. The in-service training started on July 18, 2023. Any licensed nurse not receiving education by 8/10/23 due to FMLA, or scheduled time off will be educated by DHS and/or nurse managers prior to their next scheduled shift. Education will be added to the new hire orientation for licensed nurses conducted by the Clinical Competency Coordinator and/or registered nurse. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DHS and/or nurse managers will conduct audits of med carts computer screen at random times of the day, daily for 2 weeks, then 3 times weekly x 4 weeks, then weekly for 4 weeks and then monthly x 2 months. The Director of Health Services will track and trend the results via the audit tool weekly and report the findings to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months or until substantial compliance is achieved. Date of Compliance: August 10, 2023	
F 684 SS=J	Quality of Care	F 684		8/10/23

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F 684	Continued From page 4 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner and Medical Director (MD) interviews the facility failed to send a resident with an elevated troponin (a heart enzyme that can indicate heart damage) to the hospital on 06/26/23, as ordered by the Physician. A troponin level was ordered by the Physician 06/26/23, with results reported back to the facility on 06/26/23, which noted a troponin level of 6.730 nanograms per milliliter (the reference range is 0.000-0.034 ng/ml). On 06/26/23 at 7:16 PM, the Physician gave orders to send the resident to the hospital, but Emergency Medical Services (EMS) were not notified of the need for resident transport to the hospital until 11:43 PM. The Physician was not notified of the delay in sending the resident to the hospital on 06/26/23. The resident was hospitalized from 06/27/23 through 06/29/23 and was diagnosed with a myocardial infarction (heart attack). This deficient practice occurred for 1 of 1 resident reviewed for hospitalization (Resident #1). Immediate Jeopardy (IJ) began on 06/26/23 when Resident #1 was not transported to the hospital for an elevated troponin as directed by the	F 684	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. "Resident #1 experienced chest pain and shortness of breath during the night of 6/25/23 through the morning of 6/26/23. The resident was assessed by the Nurse Practitioner who ordered an EKG, labs, and a chest x-ray to be done. On 06/26/23 at 7:16 PM the Director of Health Services (DHS) received a Physician order to send Resident #1 to the emergency room STAT for evaluation for an elevated troponin (a cardiac enzyme that can indicate heart damage). The DHS notified Nurse #1 that Resident #1 needed to be sent to the hospital. The DHS then left the facility. Nurse # 1, who was filling in at the facility from a sister facility printed the paperwork to be completed to send the resident to the hospital but could not find where it printed therefore, she waited for the nurse that came in at 11:00 PM for him to complete the transfer paperwork and	

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Physician until hours after the order was obtained to send him to the hospital and was diagnosed with a myocardial infarction. Immediate jeopardy was removed on 07/08/23 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity "D" (no actual harm that is not immediate jeopardy) to complete education and to ensure monitoring systems are put into place that are effective.

Findings included:

Resident #1 was admitted to the facility 12/09/20 with diagnoses including heart failure, coronary artery disease (CAD-narrowing of the arteries of the heart), and paroxysmal atrial fibrillation (sudden onset of irregular heartbeat).

The quarterly Minimum Data Set dated 04/07/23 indicated Resident #1 was moderately cognitively impaired.

Review of Resident #1's Physician orders revealed an order dated 08/19/21 for nitroglycerin sublingual (under the tongue) 0.3 milligrams (mg) as needed for chest pain and notify the Physician if no relief after 3 doses of medication.

Resident #1's June 2023 Medication Administration Record revealed he received a dose of nitroglycerin 0.3 milligrams sublingual at 5:20 AM and 5:27 AM on 06/26/23.

A nurse's note dated 06/26/23 at 5:49 AM written by Director of Health Services #1 revealed Resident #1 notified a nurse aide (NA) that he had been experiencing mid-sternal chest pain (pain in the middle of the chest) for about 30

F 684

send Resident #1 to the hospital. Nurse #1 was told by the DHS that the order was stat to send the resident to the ER, and the DHS offered to assist Nurse #1 and she declined.

" Resident #1 was sent to the ER 06/27/23 at 12:56 AM. Resident discharge diagnosis was non-st elevated myocardial infraction.

"A review of medical records was conducted centered on the entries of 6/26/2023 to identify if additional residents were affected or if other instances occurred requiring STAT orders or requiring transfer to a higher care level. No other residents or instances were identified. There were no other residents noted with stat orders in the month of June as well.

"The Director of Health Services (DHS), and Clinical Competency Coordinator (CCC) began education on July 7, 2023, for Licensed nurses on transfer to the hospital to include but not limited to the following:

o Immediately upon receipt of the order from the physician to transfer to the hospital.

o Copies from the medical record to include the following.

¿ Continuity of Care Document (CCD) which include.

" Medications

" Contact information.

" Vital signs

" Plans of care

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minutes. The note stated Resident #1's vital signs were checked and were as follows: pulse 81 (normal range is 60-90 beats per minute), oxygen saturation 93% (meaning the percent of oxygen in the blood and the normal range is 90-100%) on room air, and his blood pressure was 146/87 millimeters of mercury (normal blood pressure is 120/80 millimeters of mercury). Resident #1 received 2 doses of nitroglycerin (medication for chest pain) which relieved his chest pain. After the second dose of nitroglycerin Resident #1's oxygen saturation decreased to 88% on room air and he was place on oxygen at 2 liters per minute by nasal cannula (a tube in the nose). Resident #1's blood pressure after the second dose of nitroglycerin was 156/81 millimeters of mercury.

A follow-up nurse's note dated 06/26/23 at 5:57 AM written by Director of Health Services #1 revealed Resident #1 was resting quietly and his oxygen saturation was 96% on oxygen at 2 liters per minute.

Review of the medical record revealed Resident #1's blood pressure was checked again on 6/26/23 at 9:00 AM and it was 123/68 millimeters of mercury.

An interview with Director of Health Services #1 on 07/06/23 at 1:05 PM revealed she cared for Resident #1 on 06/25/23 on the 11:00 PM to 6:00 AM shift. She stated Resident #1 had been having chest pain for about 30 minutes before he notified an NA of the chest pain. Director of Health Services #1 stated after being notified of Resident #1's chest pain she immediately checked his vital signs and administered the first dose of nitroglycerin. She stated Resident #1 still

F 684

¿ Face sheet
¿ Most Form (Medical orders for Scope of Treatment) including Code Status and if a Do Not Resuscitate (DNR), send the Golden Rod.
¿ Transfer form
¿ Bed hold information

Anyone not receiving the education due to FMLA, or scheduled time off will be educated prior to the next scheduled shift. Education will be added to the new hire orientation for Licensed nurse conducted by the CCC and/or registered nurse.

Staff coming from other facilities will be educated prior to the start of the shift by the nurse manager. Nurse managers were notified as of July 7, 2023, of this assigned duty. Education will be tracked for compliance by the DHS and the CCC.

" The DHS and CCC began education on July 6, 2023, with all Licensed nurses on the location of the DHS and Administrator phone number and when to notify the DHS of concerns. Notification of the DHS are as followed to included but not limited to the following:

o Changes in conditions of the residents
o Sending a resident to the hospital
o Unable to complete an assignment.
¿ Including but not limited to printing information to send a resident to the hospital.

Anyone not receiving the education due to

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reported chest pain after the first dose of nitroglycerin, so she administered a second dose of nitroglycerin. Director of Health Services #1 stated after the second dose of nitroglycerin Resident #1 reported his chest pain was relieved. She stated she placed Resident #1 on oxygen after he received the second dose of nitroglycerin because his oxygen saturation dropped a little and she checked on him again before she left the morning of 06/26/23 and he was resting comfortably.

Nurse Practitioner (NP) #1 note dated 06/26/23 indicated Resident #1 was seen for chest pain that occurred during the night of 06/25/23 and wheezing (a whistling sound made when breathing) that occurred the morning of 06/26/23. The note indicated Resident #1's chest pain could be due to fluid overload (too much fluid in the body), anemia, CAD, pneumonia, pulmonary vascular congestion (enlarged lung blood vessels) or a myocardial infarction. An electrocardiogram (tracing of the electrical activity of the heart), chest x-ray, brain natriuretic peptide (a blood test for heart failure), basic metabolic panel (a blood test that checks electrolytes), and a complete blood count (a blood test that can check for anemia and infection) were ordered.

Review of Resident #1's NP orders dated 06/26/23 at 11:20 AM revealed orders for an electrocardiogram, chest x-ray, brain natriuretic peptide, troponin, and complete blood count.

An interview with NP #1 on 07/06/23 at 3:35 PM revealed when she evaluated Resident #1 on 06/26/23 she ordered the electrocardiogram and lab tests to determine the source of the chest pain, and the troponin result did not return until

F 684

FMLA, or scheduled time off will receive education prior to the next scheduled shift. Education will be added to the new hire orientation for Licensed nurse conducted by the CCC. Education will be tracked for compliance by the DHS and the CCC.

" The DHS, and CCC began education on July 7, 2023, for licensed nurses on the meaning of a stat order which is as follows.

o Immediately upon receipt of the order from a physician, Nurse Practitioner (NP) and/or Physician□s Assistant (PA) to no longer than 1 hour from receipt of order.

Anyone not receiving the education due to FMLA, or scheduled time off will be educated prior to the next scheduled shift. Education will be added to the new hire orientation for Licensed nurse conducted by the CCC. Education will be tracked for compliance by the DHS and the CCC.

Date of alleged Immediate Jeopardy removal: July 8, 2023

The DHS and/or nurse managers will conduct audits of the facility activity report, daily Monday through Friday for 2 weeks, then 3 times weekly x 4 weeks, then weekly for 4 weeks and then monthly x 2 months.

The Director of Health Services will track and trend the results via the audit tool

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after her shift ended at 5:00 PM. She stated she was not aware of the delay in transferring Resident #1 to the hospital after his troponin level was elevated. The NP stated she reviewed Resident #1's electrocardiogram the morning of 06/26/23 and it was compatible with his previous electrocardiograms.

The lab report revealed Resident #1's blood was drawn on 06/26/23 at 12:06 PM and his troponin result was called and faxed to the facility on 06/26/23 at 6:03 PM and was 6.730 nanograms per milliliter.

A nurse's note dated 06/26/23 at 6:49 PM written by Nurse #1 revealed Resident #1's troponin was elevated and a message was left for the on-call provider. The note also stated Resident #1's blood pressure was 160/83 millimeters of mercury, his pulse was 77 beats per minute, and his oxygen saturation was 95% on room air.

A Physician's order dated 06/26/23 at 7:16 PM revealed Resident #1 was to be sent to the Emergency Room (ER) stat (meaning immediately) for evaluation.

An interview with Nurse #1 on 07/05/23 at 2:55 PM revealed she was employed at a sister facility that was not yet open and agreed to pick up some shifts at the facility. Nurse #1 stated she had picked up a few shifts at the facility before 06/26/23. She stated she was caring for Resident #1 on 06/26/23 on the 3:00 PM to 11:00 PM shift. Nurse #1 stated around 6:30 PM the evening of 06/26/23 the lab notified her that Resident #1's troponin was elevated, and she called the on-call provider to notify them but did not get an answer and left a message on the

weekly and report the findings to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months or until substantial compliance is achieved.

Date of compliance: August 10, 2023

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F 684	Continued From page 9 answering machine about the lab. Nurse #1 stated around 7:15 PM on 06/26/23 Director of Health Services #1 notified her there was an order to send Resident #1 to the hospital due to his elevated troponin. Nurse #1 stated she printed out Resident #1's transfer paperwork but could not locate the printer where the transfer paperwork printed out. She stated she was the only nurse in the facility at that time and did not know where else to look for Resident #1's transfer paperwork and waited for Nurse #4 to report for his shift at 11:00 PM on 06/26/23. She stated Nurse #4 helped her locate the transfer paperwork and send Resident #1 to the hospital for evaluation. Nurse #1 stated she did not notify the on-call provider there was a delay in sending Resident #1 to the hospital. She stated she monitored Resident #1 closely until he went to the hospital on 06/26/23 and he did not report chest pain or shortness of breath. An interview with Director of Health Services #1 on 07/06/23 at 5:14 PM revealed she notified Nurse #1 on 06/26/23 around 7:00 PM that Resident #1 had orders to be sent to the hospital for evaluation due to his troponin being elevated. She stated she asked Nurse #1 if she knew how to print off the transfer forms and call 911 for Resident #1's transfer to the hospital and Nurse #1 confirmed she did. Director of Health Services #1 stated after Nurse #1 told her she knew what needed to be done to send Resident #1 to the hospital, she left the facility because she was sick. She stated she did not know why it took so long for Resident #1 to arrive at the hospital, since he needed to be transported emergently. Director of Health Services #1 stated she received the order to send Resident #1 to the hospital on 06/26/23 from an on-call provider but	F 684		

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entered the transfer order in the computer under the Medical Director's name. She stated she could not recall the name of the on-call provider she spoke to on 06/26/23.

An interview with Nurse #4 on 07/05/23 at 4:26 PM revealed when he arrived for his shift at 11:00 PM on 06/26/23 Nurse #1 informed him Resident #1 needed to be sent to the hospital due to an elevated troponin level, but she did not know how to print the transfer paperwork. He stated he assessed Resident #1 shortly after being notified he needed to be transferred to the hospital and did not find him to be in any distress. Nurse #4 stated he helped Nurse #1 print out Resident #1's hospital transfer paperwork and Resident #1 left the facility with EMS around 11:30 PM on 06/26/23. Nurse #4 stated Resident #1 did not want to go to the hospital but agreed to go and said something like, "you gotta do what you gotta do".

Review of the EMS Patient Care Record (PCR) dated 06/26/23 revealed EMS received a call for service at 11:43 PM, was dispatched to the facility at 11:57 PM, and arrived at the facility on 06/27/23 at 12:04 AM. The PCR indicated Resident #1 reported chest pain the morning of 06/26/23, was evaluated by NP #1, lab work was ordered, and his troponin resulted as elevated. The report revealed EMS staff asked why Resident #1 had not been transported to the hospital earlier and facility staff stated, "the labs just came back a few hours ago and they have had a mess". Resident #1 was transported to the hospital and arrived at 12:53 AM on 06/27/23.

A telephone interview with Nurse Practitioner #2 on 07/12/23 at 2:31 PM revealed she was on-call

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from 7:00 PM to 7:00 AM on 06/26/23. She explained all calls are logged and she did not have a record of a call from the facility the evening of 06/26/23 regarding a resident with an elevated troponin level and not remember receiving any calls about an elevated troponin.

The hospital history and physical dated 06/27/23 revealed Resident #1 was transferred to the hospital for a report of chest pain over the past 1 to 2 days and an elevated troponin. A heparin (blood thinner) drip (medication given in the vein) was initiated, telemetry (continuous heart monitoring) was ordered, troponin levels were to be trended (checking troponin levels over time), and a cardiology consult was ordered. The note stated Resident #1's condition appeared to be critical, he would be closely monitored, and his prognosis was guarded.

The hospital Discharge Summary dated 06/29/23 revealed Resident #1 arrived at the hospital on 06/27/23 at 12:56 AM for an elevated troponin and earlier reports of chest pain. Additional lab work and electrocardiogram were ordered, and Resident #1 was diagnosed with a myocardial infarction. Resident #1 was given aspirin and a heparin infusion and was admitted to the hospital on 06/27/23. Resident #1 was discharged to the facility 06/29/23.

An interview with the Medical Director on 07/06/23 at 9:40 AM revealed he rarely ordered anything stat, but he expected a resident with an elevated troponin to be sent to the hospital as soon as possible. He stated if there was a delay in sending the resident to the hospital he would expect himself or the on-call provider to be notified of the delay within a reasonable time

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frame. The Medical Director stated the delay between when the transfer order was given and when Resident #1 arrived at the hospital was a prolonged delay but did not affect the management of his care.

The Administrator #1 and Director of Health Services #1 were notified of immediate jeopardy on 07/06/23 at 8:00 PM.

The facility provided the following credible allegation of Immediate Jeopardy removal with a completion date of 07/08/23:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

* The facility failed to send Resident #1 to the hospital on 06/26/23 for an elevated troponin until hours after the transfer order was obtained.

* All residents had the potential to be affected by this deficient practice.

*A review of medical records was conducted for entries dated 06/26/23 to identify additional affected residents or any instances requiring stat orders or transfer to a higher level of care. No other residents or instances were identified.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

* Director of Health Services #1 and the Clinical Competency Coordinator began education on July 7, 2023, for licensed nurses on transfer to

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F 684	Continued From page 13 the hospital including: Immediately upon receipt of the order from physician to transfer to the hospital obtain copies from the medical record to including the Continuity of Care Document (CCD) which contains medications, contact information, vital signs, and care plan; face sheet; code status documentation; transfer form; and bed hold information. All licensed staff who were not present will receive training to include the above information prior to returning to work. Education will be added to the new hire orientation for licensed nurses and will be conducted by the Clinical Competency Coordinator. Staff coming from other facilities will be educated prior to the start of shift by nurse manager. Nurse managers were notified as of July 7, 2023, of this assigned duty. Education will be tracked for compliance by Director of Health Services #1 and the Clinical Competency Coordinator. * Director of Health Services #1 and the Clinical Competency Coordinator began education on July 6, 2023, with all licensed nurses on the location of Director of Health Services #1 and Administrator #1's phone numbers and when to notify the Director of Health Services of concerns. Notification of the Director of Health Services included: changes in conditions of the residents, sending a resident to the hospital, and being unable to complete an assignment, including printing information to send a resident to the hospital. All licensed staff who were not present will receive training to include the above information prior to returning to work. Education will be added to the new hire orientation for licensed nurses and will be conducted by the Clinical Competency Coordinator. Education will be tracked for compliance by the Director of Health Services and the Clinical Competency	F 684		

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F 684	Continued From page 14 Coordinator. * Director of Health Services #1 and the Clinical Competency Coordinator began education on July 7, 2023, for licensed nurses on the meaning of stat order which is as follows: immediately upon receipt of the order from physician and no longer than 1 hour from receipt of order. All licensed staff who were not present will receive training to include the above information prior to returning to work. Education will be added to the new hire orientation for licensed nurses and will be conducted by the Clinical Competency Coordinator. Education will be tracked for compliance by the Director of Health Services and the Clinical Competency Coordinator. Alleged IJ removal date is 07/08/23. The immediate jeopardy was removed on 07/08/23 with a validation completed on 07/11/23 through staff interview and in-service training records. Staff were able to verbalize the process for transferring residents to the hospital, including which documents to send with the resident and where the printer was located. Staff were able to verbalize the definition of a stat order and examples of circumstances in which the Director of Health Services would need to be contacted.	F 684		
F 725 SS=L	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial	F 725		8/10/23

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F 725	Continued From page 15 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to provide adequate staffing to provide care on 06/26/23. The evening of 06/26/23 Nurse #1 worked from 7:33 PM until 11:00 PM and was the only licensed nurse to provide resident care and services for 71 residents in the facility. Nurse #1 did not know where to locate transfer paperwork for Resident #1 and as a result he was not sent to the hospital until hours after the facility was notified of an elevated troponin level (a heart enzyme that can indicate heart damage). Nurse #1 was not aware she was the only nurse in the facility until approximately 8:30 PM when Nurse Aide #1 communicated this to her and informed her a resident on the Charlie unit had requested an as	F 725	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 6/26/23 there was one licensed Nurse, Nurse #1, in the facility for 71 residents from 7:33 PM until 11:00 PM and one Licensed Nurse, Nurse #2, from 11:00 PM until 6:00 AM. Resident #1 experienced chest pain and shortness of breath during the night of 6/25/23 through the morning of 6/26/23. The resident was assessed by the NP who ordered an EKG, labs, and a chest	

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needed medication. Nurse #1 did not have access to medication carts for 2 of 3 medication carts (Charlie unit and Delta unit) to administer medications when needed. In addition, Nurse #1 did not have access to the secured unit (Delta unit) to change Resident #9's dressing when needed due to being unable to locate the key to the unit and staff did not respond when she "beat" on the door. Nurse #4 arrived at the facility at 10:55 PM to relieve Nurse #1 and was the only nurse in the facility until 6:00 AM. There was the high likelihood of a serious adverse outcome for 71 of 71 residents.

Immediate Jeopardy (IJ) began 06/26/23 at 7:33 PM when Nurse #1 was the only nurse in the facility to care for 71 residents. Immediate jeopardy was removed on 07/08/23 when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at scope and severity level "D" (no actual harm that is immediate jeopardy) to complete education and to ensure monitoring systems are put into place that are effective.

Findings included:

Cross Refer to F684:

Based on record review and staff and Medical Director (MD) interviews the facility failed to send a resident with an elevated troponin (a heart enzyme that can indicate heart damage) to the hospital on 06/26/23, as ordered by the Physician. A troponin level was ordered by the Physician 06/26/23, with results reported back to the facility on 06/26/23, which noted a troponin level of 6.730 nanograms per milliliter (the

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x-ray to be done. On 06/26/23 at 7:16 PM the DHS (DHS) received a Physician order to send Resident #1 to the emergency room STAT for evaluation for an elevated troponin (a cardiac enzyme that can indicate heart damage). The DHS notified Nurse #1 that Resident #1 needed to be sent to the hospital. The DHS then left the facility. Nurse # 1, who was filling in at the facility from a sister facility, printed the paperwork to be completed to send the resident to the hospital but could not find where it printed therefore, she waited on the nurse that came in at 11:00 PM for him to complete the transfer paperwork and send Resident #1 to the hospital.

Resident #1 was sent to the ER 06/27/23 at 12:56 AM

All residing residents have the potential to be affected.

o Director of Health Services (DHS) and Senior Nurse Consultant (SNC) reviewed the facility activity report from MatrixCare (the Electric Health Record), on July 7, 2023, and there was one resident identified for a change in condition. The nurse responded to the change of condition with notification to the MD and orders were obtained and followed through. In review of the report the DHS and SNC reviewed progress notes, orders, and event from the date of 6/26/23.

Address how the facility will identify other

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reference range is 0.000-0.034 ng/ml). On 06/26/23 at 7:16 PM, the Physician gave orders to send the resident to the hospital, but Emergency Medical Services (EMS) were not notified of the need for resident transport to the hospital until 11:43 PM. The Physician was not notified of the delay in sending the resident to the hospital on 06/26/23. The resident was hospitalized from 06/27/23 through 06/29/23 and was diagnosed with a myocardial infarction (heart attack). This deficient practice occurred for 1 of 1 resident reviewed for hospitalization (Resident #1).

A review of the facility matrix compiled from the resident Minimum Data Set (MDS) data provided on 7/06/23 revealed there were 5 diabetic residents that received insulin, 3 residents with feeding tubes, 18 residents who had a fall in the past 120 days, 3 residents who had a fall with major injury in the past 120 days, 1 resident who was on transmission-based precautions (isolation), 4 residents receiving hospice care, and 2 residents receiving palliative care (medical care for people living with a serious disease). Thirteen residents were full codes (meaning providing emergency care including CPR and transfer to the hospital if breathing and/or heartbeat stops). The facility also had 20 residents on the Memory Care unit.

An interview with the Scheduler on 07/05/23 at 12:11 PM revealed she completed the nursing schedule for a month at a time and she stated she completed June 2023's nursing schedule at the end of May 2023. The Scheduler explained when she had shifts that were not covered by licensed nurses, she posted a list of available shifts nurses could pick up and then if no one

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residents having the potential to be affected by the same deficient practice. Administrator and DHS reviewed the staffing schedules from July 7 through July 31, 2023, to ensure there are a minimum of two licenses nurses in the facility.

" Area Vice President and SNC reviewed the staffing expectation for staffing based on census and resident acuity with the Administrator and DHS on July 7, 2023, options were reviewed to include but not limited to:

- o Expanding the reach to sister facilities for open shift
- o Increase in incentive pay.
- o Review of open positions
- o Review of open shift from July 7 to July 31st

" The staffing coordinator was educated by the Administrator on the expectations of staffing and when to notify the Administrator and DHS when shifts are not able to be filled at a minimum of 2 weeks in advance. Education was completed on July 7, 2023. The expectation is for the staffing coordinator to work with the DHS and base staff needs on the census and the acuity of the residents.

" The staffing coordinator will bring the daily staffing sheet for the next 2 weeks in advance of the current week to the morning meeting. At any time where there are less than a minimum of two licensed staff Nurses per shift the facility will initiate

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signed up for the shifts she texted individual nurses to see if they could pick up the shift. She confirmed on 06/26/23 there was one licensed nurse who worked 3:00 PM to 11:00 PM which would leave that nurse as the only licensed nurse in the building when 2 nurses left at 6:00 PM. She explained Nurse #4 was scheduled to work 6:00 AM to 6:00 PM on 06/26/23 but volunteered to leave at 2:00 PM and return at 11:00 PM since there were no nurses scheduled for the 6:00 PM to 6:00 AM shift. The Scheduler stated when she left at 4:00 PM on 06/26/23 she notified Administrator #1 that she had not been able to find another nurse to come in at 11:00 PM. She stated she received a call from Director of Health Services #1 after she left at 4:00 PM confirming she was going to come in to work the evening of 06/26/23 but Director of Health Services #1 did not say how long she planned to work. The Scheduler stated she received calls from Director of Health Services #2 and the Regional Nurse Consultant notifying her that Nurse #1 was the only licensed nurse in the building the night of 06/26/23 but informed them Director of Health Services #1 was supposed to be working the evening shift and possibly the night shift. She stated the facility usually always staffed at least 2 nurses for each shift.

Review of the timecard punch for Nurse #2 on 06/26/23 revealed she clocked in at 6:01 AM and clocked out at 7:30 PM.

An interview with Nurse #2 on 07/06/23 at 9:02 AM revealed she was scheduled to work 6:00 AM to 6:00 PM on 06/26/23 on the Charlie unit. She stated she was asked to stay until 11:00 PM on 06/26/23 by Director of Health Services #1 but informed her she would not be able stay that late.

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the following staffing/recruiting steps to ensure that no less than 2 Licensed Staff Nurses cover each scheduled shift. The administrator and the DHS will meet to determine the needs. Steps will include but not be limited to:
- o Utilizing a sign-up sheet to fill open shifts.
- o Offering new increased incentive bonuses for extra hours
- o Utilizing staff from sister facilities expanded to other states with compact license.

" Facility has stopped admissions on 5/31/23 and only accepting readmissions until staffing stabilizes. The Facility Administrator and admission coordinator notified referral sources that the facility was on an admission hold.

" Facility consolidated the units on 5/31/2023 to aid in workflow for current staff and to ensure needs were met by the residents.

" Area Vice President and Regional Team (Senior Nurse Consultant, Partner Services, Regional Financial Counselor) will conduct a weekly call with the Administrator and the DHS to review the following:
- o Any assistance needed from the team.
- ¿ Coordinating assistance from sister facilities
- o Current open positions
- o Current use of overtime
- o Current open shifts

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F 725	Continued From page 19 Nurse #2 stated she agreed to stay until the 7:00 PM and 9:00 PM medications were administered on the Charlie unit because Director of Health Services #1 told her she could give the 7:00 PM and 9:00 PM medications early and then leave. She stated when she completed administration of 9:00 PM medications she wrote out a shift report for the oncoming nurse and counted narcotic medications for Charlie unit with Nurse #3. Nurse #2 stated when she was ready to leave the facility the evening of 06/26/23 around 7:30 PM she knocked on Director of Health Services #1's office door, did not receive an answer, and left the Charlie unit medication keys in the Director of Health Services' mailbox in the copier room. She stated that even though she did not see the Director of Health Services #1 when she left the evening of 06/26/23 she thought the Director of Health Services #1 was working until 11:00 PM that night. Review of the timecard punch for Nurse #3 on 06/26/23 revealed she clocked in at 5:47 AM and clocked out at 7:33 PM. An interview with Nurse #3 on 07/05/23 at 12:41 PM revealed she was scheduled to work the 6:00 AM to 6:00 PM shift on 06/26/23 on the Delta unit. She stated she was asked to stay until 11:00 PM by Director of Health Services #1 but told Director of Health Services #1 she could not stay that late. Nurse #3 stated she did agree to complete the 7:00 PM and 9:00 PM medication pass on the Delta unit before she left, and Director of Health Services #1 told her she could either give the medication cart keys to her or leave the keys in her mailbox. She explained she completed the medication pass on the Delta unit, assisted Nurse #2 with her medication pass on the Charlie unit,	F 725	o Current unused labor ¿ Unused FT and PT hours o Recruiting effects for the week o Numbers of new hires for the week " Area Vice President was notified of survey entering the facility on July 5, 2023, and have been in communication with the Administrator. Senior Nurse Consultant was in the center on July 5, 2023, assisting them with the survey process. Date of alleged Immediate Jeopardy removal: July 8, 2023 The DHS and/or nurse managers will conduct audits of the facility activity report, daily Monday Friday for 2 weeks, then 3 times weekly x 4 weeks, then weekly for 4 weeks and then monthly x 2 months. The Director of Health Services will track and trend the results via the audit tool weekly and report the findings to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months or until substantial compliance is achieved. Date of compliance: August 10, 2023	

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and counted the Delta unit narcotic medications with Nurse #2. Nurse #3 stated when she and Nurse #2 were ready to leave the facility around 7:30 PM the night of 06/26/23 they knocked on Director of Health Services #1's office door and did not receive an answer. She stated since she could not locate Director of Health Services #1, she placed her Delta unit medication keys in the Director of Health Services mailbox in the copier room. Nurse #3 stated she assumed Director of Health Services #1 was still in the facility when she left around 7:30 PM the evening of 06/26/23.

A telephone interview with Nurse Aide #2 on 07/06/23 at 7:22 PM revealed she worked 6:00 PM to 6:00 AM on 06/26/23 and was assigned to the Delta unit. She stated at some point between 7:30 PM and 8:00 PM she was assisting Resident #2 to bed and noticed he needed a dressing change to one of his forearms. Nurse Aide #2 stated she looked for a nurse on the Delta unit and could not locate one, so a coworker left the Delta unit and notified Nurse #1 that a resident needed a dressing change. She stated no nurse came to change Resident #2's dressing until Nurse #4 changed the dressing around 11:30 PM on 06/26/23.

Review of the timecard punch for Nurse #1 on 06/26/23 revealed she clocked in at 2:45 PM and clocked out at 12:00 AM.

A telephone interview with Nurse #1 on 07/05/23 at 2:55 PM revealed she was not an employee of the facility but was employed at a sister facility that was not yet open and agreed to work 3:00 PM to 11:00 PM on the Bravo unit on 06/26/23. She stated she was the only licensed nurse scheduled in the facility on 06/26/23 from 6:00

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F 725	Continued From page 21 PM to 11:00 PM, but the Director of Health Services #1 told her Nurse #2 and Nurse #3 were going to stay until the 7:00 PM and 9:00 PM medications were given on the Charlie and Delta units. Nurse #1 further stated the Director of Health Services #1 told her another nurse was also coming in, but the Director of Health Services #1 did not say what time the other nurse was coming in. She stated around 8:30 PM on 06/26/23 a Nurse Aide #1 informed her that a resident on the Charlie unit was asking for a prn (as needed) medication and that she was the only nurse in the building. Nurse #1 stated she did not know when Nurse #2 and Nurse #3 left the facility because they did not give her report or give her the medication cart keys. She stated she was not able to give the resident the prn medication because she did not have the keys to the Charlie unit medication cart, and she did not know where to find the keys. Nurse #1 stated the resident on the Charlie unit had to wait to receive the prn medication until Nurse #4 came in at 11:00 PM. She stated at some point after she realized she was the only licensed nurse in the building on 06/26/23 a staff member notified her that a resident on the Delta unit (locked memory care unit) needed a dressing change. Nurse #1 stated she called the Delta unit repeatedly and could not get an answer, so she went down to the unit. She explained because she did not have keys to access the locked unit, she beat on the door for 30 minutes and no one answered the door. She stated since she could not access the locked unit, she returned to the Bravo unit and completed her medication pass. Nurse #1 stated Nurse #4 changed the dressing of the resident on the Delta unit after he arrived on 06/26/23. She stated she was the only nurse in the facility after Nurse #2 and Nurse #3 left until Nurse #4 reported for his	F 725		

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shift at 11:00 PM. Nurse #1 stated around 9:00 PM she notified the Director of Health Services #2 that she was the only licensed nurse in the facility. She stated she felt frustrated and overwhelmed when she discovered she was the only licensed nurse in the building.

Review of the timecard punch for Nurse #4 on 06/26/23 revealed he clocked in at 10:55 PM and clocked out at 8:13 AM.

An interview with Nurse #4 on 07/05/23 at 11:20 AM revealed when he reported for his shift at 11:00 PM on 06/26/23 the only other licensed nurse present in the building was Nurse #1. He stated was not sure how long Nurse #1 had been the only licensed nurse in the building on 06/26/23 but he gave a resident on the Charlie unit a prn medication, changed a dressing for a resident on the Delta unit, received report from her and she left the facility. He stated he located the keys to the Charlie and Delta units in the Director of Health Services' mailbox in the copier room. Nurse #4 stated when he arrived and found out he would be the only licensed nurse in the facility from 11:00 PM to 6:00 AM he called the Scheduler to see if she had been able to locate another nurse to work with him and she explained she was on a conference call with Director of Health Services #2, Administrator #2, and the Regional Nurse Consultant and they were trying to find another nurse to come in. He confirmed he was the only licensed nurse in the facility from 11:00 PM to 6:00 AM on 06/26/23. Nurse #4 stated he was concerned about being the only licensed nurse in the building on 06/26/23 because of all the things that could go wrong in the event of a crisis.

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An interview with Director of Health Services #2 on 07/05/23 at 2:36 PM revealed she was the Director of Health Services at a sister facility that had not yet opened, and she asked Nurse #1 to pick up at shift at the facility on 06/26/23. She stated between 8:30 and 9:00 PM on 06/26/23 Nurse #1 sent her a text that she was the only licensed nurse in the facility, and she called Nurse #1 right away. Director of Health Services #2 stated Nurse #1 told her she did not know that she was the only licensed nurse in the facility until a NA #1 told her the other 2 nurses had left the facility. She explained she immediately notified Administrator #2 (who is the Administrator at the facility where she is employed) that Nurse #1 was the only licensed nurse in the facility and Administrator #2 instructed her to call Director of Health Services #1 and the Regional Nurse Consultant. Director of Health Services #2 stated the Director of Health Services #1 informed her that she thought the Scheduler had found a nurse to come in at 7:00 PM on 06/26/23 and was not aware there was only one licensed nurse in the building. She stated she called the Scheduler after speaking with Director of Health Services #1 and was informed it was the Scheduler's understanding that no additional licensed nurse coverage from 6:00 PM until 11:00 PM had been located. Director of Health Services #2 stated she then called the Regional Nurse Consultant who stated she would contact the Scheduler to see if a nurse could come in earlier than 11:00 PM.

An interview with Administrator #2 on 07/06/23 at 10:39 AM revealed she received a call from DHS #2 around 10:00 PM the night of 06/26/23 informing her that Nurse #1 was the only licensed nurse in the facility. She stated she told Director

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of Health Services #2 to notify Director of Health Services #1 and the Regional Nurse Consultant. Administrator #2 stated she called Administrator #1 shortly after 10:00 PM to notify him there was only one licensed nurse in the facility and he informed her he was aware, and a nurse would be arriving at the facility in 10 minutes.

Review of the nursing schedule revealed Director of Health Services #1 worked 11:00 PM to 6:00 AM on 06/25/23.

An interview with Director of Health Services #1 on 07/05/23 at 1:29 PM revealed she asked Nurse #2 and Nurse #3 to stay until 11:00 PM on 06/26/23 because she wasn't sure why but either someone called in or there was not another licensed nurse scheduled for 6:00 PM to 11:00 PM or from 11:00 AM to 6:00 AM. She stated Nurse #2 and Nurse #3 told her they were not able to stay until 11:00 PM but did agree to stay until the 7:00 PM and 9:00 PM medications were administered on the Charlie and Delta units. Director of Health Services #1 stated she did not give permission for Nurse #2 and Nurse #3 to administer medications early on 06/26/23 and was not aware Nurse #1 would be the only licensed nurse in the building when Nurse #2 and Nurse #3 left. She stated she thought Nurse #4 agreed to come in early on 06/26/23 but was not able to give an exact time of when Nurse #4 was going to arrive. Director of Health Services #1 stated she was going to work part of the evening shift and possibly the night shift of 06/26/23 if licensed nurse coverage wasn't found but she became sick and informed Administrator #1 at some point during the day of 06/26/23 that she would not be able to work the evening or night of 06/26/23. She stated she reported to

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F 725	Continued From page 25 Administrator #1, and he should have addressed there only being one licensed nurse in the building the evening and night of 06/26/23. Director of Health Services #1 stated she did not have any missed calls from the facility or Director of Health Services #2 the night of 06/26/23. An interview with Administrator #1 on 07/05/23 at 1:47 PM revealed on 06/26/23 the Scheduler worked all day looking for licensed nurse(s) to work on the 6:00 PM to 6:00 AM shift on 06/26/23 since the nurses for Charlie and Delta units were scheduled to leave at 6:00 PM and there was only one licensed nurse scheduled for 3:00 PM to 11:00 PM and one licensed nurse for the 11:00 PM to 6:00 AM shift. He stated he was in communication with Director of Health Services #1 and the Scheduler the day of 06/26/23 to see if they could get nurses to split shifts and did not have a lot of success. He explained the Director of Health Services #1 was sick and would not be able to work the evening or night of 06/26/23. Administrator #1 stated he came by the facility on 06/26/23 around 8:00 PM and was aware there was only one licensed nurse in the facility at that time. He stated the Scheduler was going to continue to try to get a nurse to come in to work the evening and night of 06/26/23, but if no other nurse agreed to come in to work, "that's how it was." Administrator #1 stated he did not receive any calls from Administrator #2 or Director of Health Services #1 or Director of Health Services #2 around 11:00 PM the night of 06/26/23. He stated staffing meetings were conducted daily to determine what staffing needs were unmet, recruitment efforts were ongoing to hire additional nurses, and incentive pay was offered to nurses to pick up additional shifts.	F 725		

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An interview with the Regional Nurse Consultant on 07/06/23 at 11:04 AM revealed she received a call from Director of Health Services #2 at 10:14 PM on 06/26/23 notifying her that Nurse #1 was the only licensed nurse in the building. She stated she asked the Director of Health Services #2 if she had spoken with Director of Health Services #1 and Director of Health Services #2 informed her Director of Health Services #1 was sick and she spoke with the Scheduler. The Regional Nurse Consultant stated she called the Scheduler, and the Scheduler was under the assumption Director of Health Services #1 was in the building and was not aware that she got sick and left, resulting in there being only one licensed nurse in the building until 11:00 PM. She stated she could not recall if the Scheduler informed her during the call that there was only one licensed nurse scheduled for the 11:00 PM to 6:00 AM shift on 06/26/23 of if Administrator #1 was aware there was only one licensed nurse scheduled. The Regional Nurse Consultant stated Administrator #1 should have handled the staffing situation and she did not come in the night of 06/26/23 because she lived 3 hours away from the facility.

Administrator #1, Director of Health Services #1, and the Regional Nurse Consultant were notified of Immediate Jeopardy on 07/06/23 at 8:00 PM.

The facility provided the following credible allegation of immediate jeopardy removal with a completion date of 07/08/23:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

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* The facility failed to ensure there was adequate licensed nursing staff available to care for each of the 71 residents as needed.

* All residents had the potential to be affected by this deficient practice.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

* Administrator #1 and Director of Health Services #1 reviewed the staffing schedules from July 7 through July 31, 2023, to ensure there are a minimum of 2 licenses nurses in the facility.

* Area Vice President and Senior Nurse Consultant reviewed the staffing expectation for staffing based on census and resident acuity with Administrator #1 and Director of Health Services #1 on July 7, 2023, options were reviewed to include but not limited to:

o Expanding the reach to sister facilities for open shifts
o Increase in incentive pay
o Review of open positions
o Review of open shift from July 7 to July 31st

* The Staffing Coordinator was educated by Administrator #1 on the expectations of staffing and when to notify the Administrator and Director of Health Services when shifts are not able to be filled at a minimum of 2 weeks in advance. Education was completed on July 7, 2023. The expectation is for the staffing coordinator to work with the Director of Health Services and base staff need on the census and the acuity of the

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resident.

* The Staffing Coordinator will bring the daily staffing sheet for the next 2 weeks in advance of the current week to the morning meeting. At any time where there are less than a minimum of 2 licensed staff nurses per shift the facility will initiate the following staffing/recruiting steps to ensure that each scheduled shift is covered by no less than 2 licensed staff nurses. The Administrator and the Director of Health Services will meet to determine the needs. Steps will include but not be limited to:

o Utilizing a sign-up sheet to fill open shifts
o Offering new increased incentive bonuses for extra hours
o Utilizing staff from sister facilities expanded to other states with compact license

* Facility has stopped admissions on 5/31/23 and only accepting readmissions until staffing stabilizes. The Administrator and Admission Coordinator notified referral sources that the facility was on admission hold.

* Facility consolidated the units on 5/31/2023 to aid in workflow for current staff and to ensure needs were met by the residents.

* Area Vice President and Regional Team (Senior Nurse Consultant, Partner Services, Regional Financial Counselor) will conduct a weekly call with the Administrator and the Director of Health Services to review the following:

o Any assistance needed from the team
o Coordinating assistance from sister facilities
o Current open positions

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F 725	Continued From page 29 o Current use of overtime o Current open shifts o Current unused labor o Unused FT and PT hours o Recruiting effects for the week o Numbers of new hires for the week * Area Vice President was notified of survey entering the facility on July 5, 2023, and has been in communication with Administrator #1. Senior Nurse Consultant was in the center on July 5, 2023, assisting them with the survey process. Alleged IJ removal date is 07/08/23. The immediate jeopardy was removed on 07/08/23 with a validation completed on 07/11/23 through staff interview and in-service training records. Staff were able to verbalize nurse staffing should include a minimum of 2 licensed nurses per shift and who to notify if 2 licensed nurses were not available.	F 725		
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	F 761		8/10/23

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F 761	Continued From page 30 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: Based on observations and staff interviews the facility failed to secure medication cart keys for 2 of 3 medication carts (Charlie Unit and Delta Unit medication carts) and failed to secure 1 of 3 medication carts observed to be unlocked and unattended by nursing staff (Bravo Unit medication cart). Findings included: 1. (a) An interview with Nurse #2 on 07/06/23 at 9:02 AM revealed she worked the 6:00 AM to 6:00 PM shift on 06/26/23 on the Charlie Unit. She stated she agreed to stay and administer the 7:00 PM and 9:00 PM medications on the Charlie Unit due to a staffing shortage and left around 7:30 PM the night of 06/26/23. Nurse #2 stated the Director of Health Services (DHS) #1 told her to leave the Charlie Unit medication cart keys in the Director of Health Services' mailbox in the copier room when she completed the medication administration if she was not in her office. She stated she knocked on Director of Health Services #1's office door when she was ready to leave and did not get a response, so she placed	F 761	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Nurse #4 removed the keys for Delta and Bravo on June 26, 2023, from the Director of Health Services in the mail room. Nurse #4 locked the med cart on July 5, 2023, once realized the med cart was left unlocked. On August 1, 2023, Nurse #2, Nurse #3, and Nurse #4 received education by Quality Improvement (QI) nurse on nurses must give face to face reports when reporting off for the shift and med cart keys are to be always secured with the assigned unit nurse. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice.	

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F 761	Continued From page 31 the keys in Director of Health Services #1's mailbox in the copier room. Nurse #2 stated there was no lock on Director of Health Services #1's mailbox and the copier room door was not locked or closed. She stated she thought Director of Health Services #1 would pick up the medication cart keys shortly after she left. Nurse #2 stated she wrote out report on a report sheet and left it at the nurses' station for the oncoming shift. An interview with Nurse #1 on 07/05/23 on 2:55 PM revealed she worked the 3:00 PM to 11:00 PM shift on 06/26/23. She stated around 8:30 PM the evening of 06/26/23 a nurse aide (NA) told her a resident on the Charlie Unit was requesting a prn (as needed) medication. Nurse #1 stated she could not administer the prn medication to the resident on the Charlie Unit because she was the only nurse in the facility, did not have the keys to the Charlie Unit medication cart, and did not know where to find the Charlie Unit medication cart keys. An interview with Director Health Services #1 on 07/12/23 at 4:17 PM revealed the evening of 06/26/23 she told Nurse #3 to take the Charlie Unit medication cart keys to Nurse #1 on the Bravo Unit before she left for the evening. She stated she expected all nursing staff to hand off medication cart keys to another nursing staff member when leaving the facility rather than leaving them in an unsecured location. (b) An interview with Nurse #3 on 07/05/23 at 12:41 PM revealed she worked the 6:00 AM to 6:00 PM on 06/26/23 on the Delta Unit. She stated she agreed to stay and administer the 7:00 PM and 9:00 PM medications on the Delta Unit	F 761	The Registered Nurse supervisor completed a 100% audit on August 2, 2023, looking at all three med carts focusing on med carts locked and med cart keys secure with assigned unit nurse. All three med carts were noted to be locked and med cart keys were secured with assigned unit nurse. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The DHS and/or nurse managers will in-service all licensed nurses on giving face to face reports when reporting off for the shift, med cart keys are to always secure with assigned unit nurse and med cart maintain locked when not present at cart or not being used. This education was started on July 18, 2023. Any licensed nurse not receiving education by 8/10/23 due to FMLA, or scheduled time off will be educated prior to the next scheduled shift by the DHS and/or nurse manager. Education will be added to the new hire orientation for Licensed nurse conducted by the Clinical Competency Coordinator (CCC) and/or registered nurse. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DHS and/or nurse managers will conduct audits of med carts looking to	

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due to a staffing shortage and left around 7:30 PM the night of 06/26/23. Nurse #3 stated Director of Health Services #1 gave her permission to leave the Delta Unit medication cart keys with Director of Health Services #1 or place the keys in Director of Health Services #1's mailbox in the copier room when she completed the medication administration. She stated she knocked on Director of Health Services #1's office door when she was ready to leave and did not get a response, so she placed the keys in Director of Health Services #1's mailbox in the copier room. Nurse #3 stated there was no lock on Director of Health Services #1's mailbox and the copier room door was not locked or closed. She stated she was not completely comfortable leaving the medication cart keys unattended and in an unlocked area, but she thought Director of Health Services #1 would pick up the medication cart keys shortly after she left. Nurse #3 stated she did not give report to a nurse before leaving the facility the evening of 06/26/23.

An interview with Director of Health Services #1 on 07/12/23 at 4:17 PM revealed the evening of 06/26/23 she told Nurse #3 to take the Delta medication cart keys to Nurse #1 on the Bravo Unit before she left for the evening. She stated she expected all nursing staff to hand off medication cart keys to another nursing staff member when leaving the facility rather than leaving them in an unsecured location.

2. A continuous observation of the Bravo Unit medication cart on 07/05/23 from 3:42 PM to 3:44 PM revealed the medication cart was parked outside room 212, the door to room 212 was shut, and the lock mechanism was observed in the unlocked position. During the observation

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ensure the med carts are locked and checking to see with assigned unit nurse that the med cart keys are secured with them. The audits will be completed at random times of the day, daily for 2 weeks then 3 times weekly for 4 weeks, then weekly times 4 weeks and then monthly times 2 months to ensure all medication carts are locked and keys secured by assigned nurse.

Results of these audits will be reported by the Director Health Services to the Quality Assurance Performance Improvement (QAPI) Committee for review and revision monthly x 3 months or until substantial compliance is achieved.

Date of Compliance: August 10, 2023

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 ______	C 07/12/2023

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NC STATE VETERANS HOME-BLACK MOUNTAIN	62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711

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F 761	Continued From page 33 one staff member walked by the unlocked medication cart. Nurse #4 exited room 212 and returned to the medication cart. During an interview with Nurse #4 on 07/05/23 at 3:45 PM he confirmed he left the Bravo Unit medication cart unlocked and out of his line of sight while he was in room 212. He stated he should have locked the medication cart before he entered room 212 and he did not because it was an oversight. An interview with Director of Health Services #1 on 07/12/23 at 4:17 PM revealed she expected medication carts to be locked any time they were not within a nurse's line of sight.	F 761		
F 812 SS=E	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 serve food in accordance with professional standards for food service safety.	F 812		8/10/23

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F 812	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to date opened food and beverage items in 1 of 1 reach-in cooler, failed to ensure leftover food was securely stored for 1 of 1 walk-in cooler, failed to label, date, and cover food items in 1 of 1 walk-in freezer. The deficient practice had the potential to affect food served to residents. Findings included: 1. An observation of the reach-in cooler on 07/06/23 at 3:10 PM revealed an opened and undated gallon of barbecue sauce and an opened and undated 2-liter bottle of diet soda. An interview with the Cook on 07/06/23 at 3:11 PM revealed the barbecue sauce should have been dated when it was opened. He stated he did not know where the bottle of soda came from but it should not be in the reach-in cooler. An interview with the Dietary Manager (DM) on 07/12/23 at 8:49 AM revealed the barbecue sauce should have been dated at the time it was opened, and whoever opened an item was responsible for dating the item. He explained the bottle of soda was placed in the reach-in cooler by staff in the activities department and he had asked them repeatedly to label and date any items they placed in the cooler. He stated it was everyone's responsibility to check for labeled and dated items and the items in the reach-in cooler were overlooked. An interview with Administrator #1 on 07/12/23 at 4:17 PM revealed he expected all food and	F 812	Corrective action for the residents found to be affected by the deficient practice. No specific residents were cited regarding this alleged deficient practice. The facility failed to date opened food and beverage items in 1 of 1 reach-in cooler, failed to ensure left over food was securely stored for 1 of 1 walk-in cooler, failed to label, date, and cover food items in 1 of 1 walk-in freezer. All identified items were discarded on July 6,2023 by Certified Dietary Manager. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of the reach-in cooler, walk-in cooler and walk-in freezer was completed to ensure there were no undated opened food items, unsecured leftover food items and/or no unlabeled and uncovered food items present. Any item found to be undated, unsecured, unlabeled, and unsecured was removed and disposed of immediately. Any items that In-servicing was conducted by the CDM on 7/13/23 with all food service staff related to food safety and storage of food products. The in-service included the timeframes and labeling of food, to include open date as related to all food in the refrigerator and freezers, disposal process of all unserved food items at the	

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F 812

Continued From page 35

beverage items to be labeled and dated appropriately.

2. An observation of the walk-in cooler on 07/06/23 at 3:15 PM revealed a metal pan of barbecue, a metal pan of green beans, and a metal pan of greens were sitting on a shelf. The metal pans were partially covered with clear plastic wrap and dated 07/05/23. The corner of the plastic wrap on each metal pan was pulled back, exposing the food to air. The barbecue appeared dried out in the area that was exposed to air. No condensation was noted to the clear plastic wrap.

An interview with the Kitchen Supervisor on 07/06/23 at 3:19 PM revealed the metal pans of food were placed in the cooler on 07/05/23 (she was unsure of the exact time) and the corner of the plastic wrap was pulled back to allow the food to cool and the corners of the plastic wrap should have been put back in place once the food had cooled.

An interview with the Dietary Manager (DM) on 07/12/23 at 8:49 AM revealed the food in the walk-in cooler should have been tightly covered when it was placed in the cooler and not left open to air. He stated the person who placed the food in the cooler was responsible for ensuring the food was properly covered and it was an oversight that the food was not stored correctly.

An interview with Administrator #1 on 07/12/23 at 4:17 PM revealed he expected all food to be stored correctly.

3. An observation of the walk-in freezer on 07/06/23 at 3:18 PM revealed a cart containing a

F 812

end of each meal and the complete covering and safe storage after food containers have been opened. In-service was conducted by the CDM on 8/2/23 with the activity staff on the safe handling and storage process for activity related food products.

Systemic changes made to ensure that the deficient practice will not recur.

The Dietary Services Manager was educated by the Administrator on August 13,2023 on ensuring all foods are in the reach-in cooler, walk-in cooler and walk-in freezer are dated upon opening, leftovers securely stored, food items labeled and covered. All dietary staff were educated by the Dietary Services Manager on August 2, 2023, on the facility expectations and policy titled Labeling, dating and storage to include proper procedures for labeling, dating and storage of food to ensure proper food safety. Any staff who do not receive the education by August 10, 2023, will receive the education prior to the start of their next scheduled shift by Dietary Service Manager. All new dietary hires will receive education during department orientation by Dietary Service Manager.

The Dietary Services Manager and/or designated dietary aide will perform an audit of all food storage to ensure all food is labeled, dated, and stored properly for food safety. This will be recorded via an audit tool and presented to the Administrator for weekly review to ensure compliance.

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F 812	Continued From page 36 metal pan of oatmeal, a metal pan containing scrambled eggs and 2 fried eggs, and a metal pan containing sausage patties, bacon, and chopped ham. All of the pans of food were open to air, unlabeled, and undated. The fried eggs appeared to have dry edges. An interview with the Kitchen Supervisor on 07/06/23 at 3:19 PM revealed the foods in the metal pan were from breakfast on 07/06/23 were placed in the walk-in freezer around 9:30 AM on 07/06/23 to cool down. She stated the food should have been covered and dated. The Kitchen Supervisor stated the food should only have been left in the freezer for 4 hours. An interview with the Dietary Manager (DM) on 07/12/23 at 8:49 AM revealed the pans of food in the walk-in freezer were leftovers from the breakfast meal on 07/06/23. He stated the food should have been labeled, covered, and dated when it was placed in the freezer by the person who placed the food in the freezer. The Dietary Manager stated the food should not have stayed in the freezer for longer than 4 hours. He stated the food in the freezer not being covered, labeled, dated, and being left in the freezer longer than 4 hours was an oversight. An interview with Administrator #1 on 07/12/23 at 4:17 PM revealed he expected food to be labeled, dated, and stored correctly.	F 812	Plans to monitor its performance to make sure that the solutions are sustained. The Dietary Services Manager will complete audits 5 times weekly x 2 weeks, 2 times weekly x 4 weeks then weekly x 2 months to ensure all items are dated upon opening, leftovers secured, and freezer items are labeled and covered. The audit findings will be reported by Certified Dietary Manager during the monthly Quality Assurance Performance Improvement (QAPI) Committee for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 8/10/2023	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		8/10/23

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(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or

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F 842	Continued From page 38 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain accurate Medication Administration Records (MAR) for 10 of 20 residents reviewed for accurate medical records (Resident #s 10, 11, 12, 13, 14, 15, 16, 17, 18 and 19). Findings included: Review of the timecard punch for Nurse #3 on 06/26/23 revealed she clocked in at 5:47 AM and clocked out at 7:33 PM. a. Review of the medical record revealed Resident #10's MAR for 06/26/23 revealed the	F 842	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 10, 11, 12, 13, 14,15, 16, 17, 18 and 19 electronic medical records cannot be altered. Nurse #3 was provided education on July 18, 2023, for medication administration general guidelines signing electronic medication administration records at the time the medication was administered. The Quality Improvement (QI) nurse provided this education.	

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F 842 Continued From page 39

medications listed due at 7, 8, and 9 pm were initialed as administered at 10:27 pm by Nurse # 3.

b. Resident #11's MAR for 06/26/23 revealed the medications listed due at 7, 8, and 9 pm were initialed as administered at 10:27 pm by Nurse # 3.

c. Resident #12's MAR for 06/26/23 revealed the medications listed due at 9 pm were initialed as administered at 10:27 pm by Nurse # 3.

d. Review of Resident #13's MAR for 06/26/23 revealed the medications listed due at 9 pm were initialed as administered at 10:27 pm by Nurse # 3.

e. Review of Resident #14's MAR for 06/26/23 revealed the medications listed due at 9 pm were initialed as administered at 10:27 pm by Nurse # 3.

f. Review of Resident #15's MAR for 06/26/23 revealed the medications listed due at 9 pm were initialed as administered at 10:27 pm by Nurse # 3.

g. Review of Resident #16's MAR for 06/26/23 revealed the medications listed due at 7 and 9 pm were initialed as administered at 10:27 pm by Nurse # 3.

h. Review of Resident #17's MAR for 06/26/23 revealed the medications listed due at 9 pm were initialed as administered at 10:27 pm by Nurse # 3.

i. Review of Resident #18's MAR for 06/26/23

F 842

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents have the potential to be affected by the alleged deficient practice.

On August 1, 2023, nurse consultant completed an audit of the electronic medication administration record (EMAR) from July 1 to July 31, 2023, focusing on late charting of medications administration, there were 62 residents on the EMAR noted with charted late documentations.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The Director of Health Services and/or nurse managers will provide in-service to all licensed nurses on medication administration general guidelines referring to signing EMAR at the time the medication is administered, this education was started on July 18, 2023. Any licensed nurse not receiving the education by August 10, 2023, due to FMLA, or scheduled time off will be educated prior to the next scheduled shift by the DHS and/or nurse manager. Education will be added to the new hire orientation for Licensed nurse conducted by the Clinical Competency Coordinator (CCC) and/or registered nurse.

Indicate how the facility plans to monitor

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revealed the medications listed due at 9 pm were initialed as administered at 10:27 pm by Nurse # 3.

j. Review of Resident #19's MAR for 06/26/23 revealed the medications listed due at 9 pm were initialed as administered at 10:27 pm by Nurse # 3.

In an interview with Nurse #3 on 07/05/23 at 12:41 PM she confirmed she cared for Resident #10, 11, 12, 13, 14, 15, 16, 17, 18 and 19 on 06/26/23 on the 6:00 AM to 6:00 PM shift. She stated she was asked to work until 11:00 PM on 06/26/23 by Director of Health Services #1 due to a staffing shortage but explained she could not work until 11:00 PM. Nurse #3 stated Director of Health Services #1 told her she could give 7:00 PM through 9:00 PM medications early, so she administered the Residents' scheduled medications through 9:00 PM before leaving on 06/26/23. She stated she left the facility around 7:30 PM the evening of 06/26/23.

A follow-up telephone interview with Nurse #3 on 07/06/23 at 11:02 AM revealed she forgot to initial the Residents' scheduled 7:00 PM through 9:00 PM medications at the time she administered them on 06/26/23. She stated when she realized around 10:30 PM on 06/26/23 that she had not initialed their medications as being administered, she logged onto her tablet from home and initialed the Residents medications as being given. Nurse #3 stated the Residents' MAR should reflect the time the Residents actually received medications and she should have initialed the medications as administered at the time they were given.

F 842

its performance to make sure that solutions are sustained.

The DHS and/or nurse manager will complete audits 5x/week for 2 weeks then 3x/week for 4 weeks then weekly for 2 months then monthly.

The Director of Health Services will track and trend the results via the audit tool weekly and report the findings to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months or until substantial compliance is achieved.

Date of Compliance: August 10, 2023

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F 842	Continued From page 41 During a joint interview with Administrator #1, Director of Health Services #1, and the Regional Nurse Consultant on 07/06/23 at 4:00 PM they confirmed staff were able to log on to the electronic medical record remotely. They explained the computer system used by the facility incorporated multiple layers of security and staff had to use an authentication code to log on remotely. A follow-up interview with Director of Health Services #1 on 07/12/23 at 4:17 PM revealed she expected nursing to staff to initial medications as administered at the time they were given.	F 842		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at	F 867		8/10/23

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§483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

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F 867	Continued From page 43 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its	F 867		

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activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions previously put in place following the recertification and complaint survey that occurred on 11/12/21 and 05/12/23 and the complaint investigation that occurred 03/25/22. This failure was for 4 deficiencies that were originally cited in the areas of Personal Privacy/Confidentiality of Records (F583), Sufficient Nursing Staff (F725), Food Procurement, Store/Prepare/Serve-Sanitary (F-812), and Label/Store Drugs and Biologicals (F-761) and were subsequently recited on the current follow-up and complaint investigation survey of 07/12/23. The continued failure of the facility during three surveys of record in the same area showed a pattern of the facility's inability to sustain an effective QAA program.

Findings included:

This tag is cross referenced to:

F725: Based on record reviews and staff interviews the facility failed to provide adequate staffing to provide care on 06/26/23. The evening

F 867

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 08/03/23, the Administrator had an Ad HOC Quality Assurance and Performance Improvement Committee (QAPI) meeting with the interdisciplinary team (IDT) to discuss the 4 repeat tags, F 583, F 725, F 812, and F 761. A root cause analysis identified that the facility has gone through increased turnover in leadership, extended vacancies in key managing/monitoring positions.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents have the potential to be affected.
On 8/02/23 the Administrator reviewed surveys for 11/12/21, 5/12/23, and 3/25/22, to identify ongoing trends. The areas identified as ongoing trends are to be addressed in the monthly QAPI

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 ______	C 07/12/2023

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 45

of 06/26/23 Nurse #1 worked and from 7:33 PM until 11:00 PM and was the only licensed nurse to provide resident care and services for 71 residents in the facility. Nurse #1 did not know where to locate transfer paperwork for Resident #1 and as a result he was not sent to the hospital until hours after the facility was notified of an elevated troponin level (a heart enzyme that can indicate heart damage). Nurse #1 was not aware she was the only nurse in the facility until approximately 8:30 PM when Nurse Aide #1 communicated this to her and informed her a resident on the Charlie unit had requested an as needed medication. Nurse #1 did not have access to medication carts for 2 of 3 medication carts (Charlie unit and Delta unit) to administer medications when needed. In addition, Nurse #1 did not have access to the secured unit (Delta unit) to change Resident #9's dressing when needed due to being unable to locate the key to the unit and staff did not respond when she "beat" on the door. Nurse #4 arrived at the facility at 10:55 PM to relieve Nurse #1 and was the only nurse in the facility until 6:00 AM. There was the high likelihood of a serious adverse outcome for 71 of 71 residents.

During the complaint investigation conducted 03/25/22 the facility failed to provide sufficient nursing staff to honor a resident's request to get out of bed to his wheelchair for 1 resident and failed to take a resident that required supervision with smoking out at designated times for 1 resident.

F812: Based on observations and staff interviews the facility failed to remove expired and spoiled food items available for use in 1 of 1 walk-in cooler and 1 of 1 reach-in cooler; remove expired

F 867

meetings.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 08/03/23 the Administrator educated the Interdisciplinary Team on the Quality Assurance and Performance Improvement policy and protocol for the facility with emphasis on continuing to monitor and evaluating prior areas cited during surveys.

The Administrator and Facility Management Team will complete the On-line educational course Implementing Quality Assurance Performance Improvement in the Nursing Facilities via the Relias training site by 8/10/23. Managers that have not completed the training by 8/10/2023 will be removed from the schedule until training is completed. This education has been added to the general orientation of all newly hired Facility Managers during general orientation.

The Quality Assurance and Performance Improvement committee will continually monitor implemented procedures and monitor the plan of correction (POC) put in place for Citations F 583, F725, F 812 and F 761 monthly until 3 consecutive months of compliance is maintained then quarterly thereafter. The Quality Assurance and Performance Improvement committee will meet monthly

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F 867

Continued From page 46

food from 1 of 1 dry storage room; and failed to ensure a pipe in 1 of 1 walk-in freezer was free from leaks. This practice had the potential to affect food served to residents.

During the recertification and complaint investigation conducted 05/12/23 the facility failed to remove expired and spoiled food items available for use in 1 of 1 walk-in cooler and 1 of 1 reach-in cooler; remove expired food from 1 of 1 dry storage room; and failed to ensure a pipe in 1 of 1 walk-in freezer was free from leaks.

F761: Based on observations and staff interviews the facility failed to secure medication cart keys for 2 of 3 medication carts (Charlie Unit and Delta Unit medication carts) and failed to secure 1 of 3 medication carts observed to be unlocked and unattended by nursing staff (Bravo Unit medication cart).

During the recertification and complaint investigation conducted 05/12/23 the facility failed to remove expired medications from 2 medication carts and 1 medication room.

F583: Based on observations and staff interviews the facility failed to safeguard protected health information (PHI) for 6 of 6 resident (Residents #3, #4, #5, #6, #7, and #8) observed for privacy and confidentiality, by leaving confidential PHI exposed on an unattended medication cart, in an area accessible to the public.

During the recertification and complaint investigation conducted 11/12/21 the facility failed to protect the private health information for 2 of 2 residents by leaving confidential medical information unattended and exposed in an area

F 867

to review the tracking and trending analysis of areas that led to the repeat tag/deficiency.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The administrator will lead Quality Assurance and Performance Improvement meetings monthly with emphasis and focus on areas that have led to repeated deficiency (F583, F725, F 812 and F 761). This will ensure the facility is identifying areas of non-compliance and addressing them as needed to prevent further deficient practice related to meaningful change assessments. A member of the regional team that includes the senior nurse consultant, clinical reimbursement consultant or Area Vice President will attend QAPI meetings for the next 3 months and then quarterly for three quarters to ensure the QAPI process is effective. The administrator will report to the Quality Assurance and Performance Improvement Committee any areas of non-compliance monthly for 3 months and then quarterly and/or as needed for three quarters for further recommendations until compliance is sustained.

Date of Compliance: August 10, 2023

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F 867	Continued From page 47 accessible to the public. An interview with Administrator #1 on 07/12/23 at 4:17 PM revealed the quality assurance (QA) team met monthly and included the Medical Director, administrative staff, and most department managers. He stated the facility had several performance improvement plans in place and were working on them simultaneously and he believed that would help them achieve and maintain compliance long term.	F 867		