STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345492	A. BUILDING ______ B. WING ______	08/17/2023

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NC STATE VETERANS HOME - FAYETTEVILLE	**214 COCHRAN AVENUE FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 8/14/2023 through 8/17/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 08/14/2022 through 08/17/2022. Event ID#E3YD11.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews the facility failed to accurately code a resident's oral/dental status on an annual Minimum Data Set for 1 of 20 (Resident #45) residents reviewed for resident assessments. Findings included: Resident #45 was admitted into the facility on 12-03-2020 with a re-entry on 3-26-2023 with diagnoses of a cerebrovascular accident. A review of Resident #45's last dental visit on 10-7-22 indicated the resident requested root tips be taken out so he could get dentures. The dentist recommended oral surgery extraction of 12 nonviable teeth and informed the resident he could then be evaluated for dentures.	F 641	This timeline investigation and plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law to remove substantial noncompliance. It also demonstrates our good faith and desire to continue to improve the quality of care and services for our residents. Step 1.	9/11/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/08/2023

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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F 641	Continued From page 1 A review of Resident #45's most recent Annual Minimum Data Set (MDS) dated 6/22/2023 revealed he was noted to be moderately cognitively impaired and had no oral/dental problems noted. An interview with Resident #45 was conducted on 8/14/2023 at 12:13 PM., he stated that there were some broken teeth, he had root tips in other areas, and still others were completely gone. He stated that he had not had any oral pain that he had seen the dentist in October 2022 and had inquired about dentures. A limited observation conducted on 8/14/2023 at 12:30 PM of Resident #45's oral cavity revealed several missing teeth and a chipped front tooth. An interview with MDS Coordinator was conducted on 8/16/23 at 10:15 AM which revealed that she marked the MDS according to the observations filled out by the nurses on the floor. She acknowledged that there were issues with Resident #45's teeth and the Annual MDS dated 6/22/2023 was coded incorrectly. She also acknowledged that it was her responsibility to ensure that the MDS was filled out accurately in all areas. An interview was conducted with the Director of Nursing and Administrator on 8/17/2023 at 9:15 AM. Tthey expressed that the MDS should be filled out accurately and that accuracy should be verified prior to submission.	F 641	a. Section L of the assessment with deficiency found for Resident # 45 was modified by the Case Mix Coordinator (CMC) on 8/31/2023 to comply with RAI Manual/Medicaid/Federal Guidelines. Step 2. a. All patients have potential to be affected. A complete 100% audit of comprehensive assessments section L for the past 3 months was conducted by the Case Mix Coordinator (CMC) and/or nurse manager by 9/07/2023. There were 14 out of 22 comprehension assessments Section L found inaccurate and modified on 9/7/2023 by CMC. Step 3. a. Education was completed by the Clinical Reimbursement Coordinator (CRC) for the Case Mix Coordinators on completing the Minimum Data Set (MDS) accurately, with emphasis on section L and oral assessments on 9/07/2023. Any Case Mix Coordinator who has not received education by 9/11/23 will be removed from the schedule until the education is completed. This education will be added to orientation for any licensed nurses who are hired in the MDS department. b. A Section L oral assessment audit tool (comparing the oral assessment with the MDS coding) will be implemented by the Case Mix Coordinator and/or nurse manager will be implemented as follows:	

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F 641	Continued From page 2	F 641	five times per week for 4 weeks, then two times per week for 4 weeks, then monthly for three months. Step 4. a. Monitoring will be done by the Case Mix Coordinator, Director of Health Services and/or Administrator to ensure accuracy of section L of the MDS and oral assessments. Monitoring will occur five times per week times 4 weeks, then two times per week times 4 weeks, and monthly until compliance is sustained. Results of the monitoring, with tracking and trending, will be reported by the Director of Health Services and/or nurse manager monthly to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes. Compliance date: 9/11/2023	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		9/11/23

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F 656	Continued From page 3 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with resident and staff, and medical record review the facility failed to develop a comprehensive care plan to include dental issues for 1 of 20 residents	F 656	Step 1. a. Oral assessment was conducted by the Case Mix Coordinator (CMC) on Resident	

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(Resident #45) reviewed for comprehensive care planning.

Findings included:

Resident #45 was admitted into the facility on 12-03-2020 with a re-entry on 3-26-2023.
A review of Resident #45's last dental visit on 10-7-22 resident requested root tips be taken out so he could get dentures, dentist recommended oral surgery extraction of 12 nonviable teeth and informed resident he could then be evaluated for dentures.

A review of Resident #45's most recent annual Minimum Data Set (MDS) dated 6/22/2023 revealed he required extensive assistance with personal hygiene of one staff member and was independent with oral hygiene. He had an impairment on one side of his lower extremities, no impairment in his upper extremities. He was also noted to be cognitively moderately impaired, on a therapeutic diet and had no oral/dental problems noted.

A review of Resident #45's comprehensive care plan edited on 7/11/2023 did not have a care plan related to dental issues related to chewing, swallowing, and missing or chipped teeth.

An interview with Resident #45 was conducted on 8/14/23 at 12:13 PM. He revealed that his teeth were in bad shape, he stated that there were some broken, he had root tips in other areas, and still others were completely gone. He stated that he had not had any oral pain and he had seen the dentist in October 2022 for an exam and had inquired about dentures. He further revealed that he was careful with his food choice for meals

F 656

#45 on 8/17/2023.

b. The care plan was updated for Resident #45 on 8/17/2023 by the Case Mix Coordinator.

Step 2.

a. All residents have the potential to be affected. CMC and/or nurse manger completed a 100% audit of comprehensive care plans ensuring any dental issues identified have been accurately documented in the care plan by 9/07/2023. There were 14 out 22 care plans that required updates on 9/7/2023.

Step 3.

a. On 9/07/2023 the Clinical Reimbursement Coordinator provided education for the Case Mix Coordinators on developing/implementing comprehensive care plans. Any Case Mix Coordinator who has not received education by 9/11/2023 will be removed from the schedule until education is completed. This education will be added to orientation for any licensed nurse hired in MDS department.

b. A care plan audit tool will be implemented by the Case Mix Coordinator and/or nurse manager to monitor accuracy of the care plan for dental issues and will be implemented as follows: five times per week for 4 weeks, then two times per week for 4 weeks, then monthly for three months.

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F 656	Continued From page 5 because some of it he could not chew. He stated that he has not lost any weight and was able to brush his own teeth. A limited observation of Resident #45's oral cavity revealed several missing teeth and a chipped front tooth. He stated that he does attend his care plan meetings and that his dental issues were not discussed and he did not bring it up during the meeting. An observation of Resident #45 on 8/15/2023 at 12:45 PM while eating revealed no issues with chewing or swallowing his food. It was noted that he is on a regular therapeutic diet of no added salt. A review Resident #45's weights from March 2023 to August 2023 revealed no significant weight loss. An interview was conducted on 8/16/23 at 10:23 AM with the MDS coordinator who revealed that the annual MDS dated 6/22/23 had not been coded for dental issues so it was not triggered to be care planned. She agreed there was not a care plan regarding his oral status. An interview was conducted with the Director of Nursing and Administrator on 8/17/2023 at 9:15 AM they expressed that the MDS should be filled out accurately and that accuracy should be verified prior to submission and care plans should be comprehensive and reflect all the resident's needs	F 656	Step 4. Monitoring will be done by the Case Mix Coordinator, Director of Health Services and/or Administrator to ensure accuracy of the comprehensive care plan regarding dental issues. Monitoring will occur five times per week times 4 weeks, then two times per week times 4 weeks, and monthly until compliance is sustained. Results of the monitoring, with tracking and trending, will be reported by the Director of Health Services and/or nurse manager monthly to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes. Compliance Date: 9/11/2023	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		9/11/23

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F 657	Continued From page 6 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interviews of staff, the facility failed to revise residents' care plans for 2 of 18 residents reviewed for care plan revision (Resident #11 and #53). Resident #11's care plan was not revised related to ongoing prophylactic antibiotic treatment and Resident #53's care plan was not revised related to psychotropic drug use. Findings included: 1. Resident #11 was admitted to the facility on 5/18/19 with the diagnosis of benign prostatic	F 657	Step 1. a. Resident #11s care plan was updated on 8/17/2023 by the Case Mix Coordinator (CMC) changing antibiotics to prophylactic anti infectant medication. Step 2. a. All residents with potential to be affected. The Infection Preventionist and/or nurse manager conducted a 100%	

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hypertrophy (BPH).

A review of Resident #11's physician orders from 1/1/23 to 8/17/23 revealed there was no current ongoing prophylactic antibiotic order.

The quarterly Minimum Data Set (MDS) dated 7/10/23 documented the resident had an intact cognition. The resident's diagnoses were cerebral vascular accident and BPH. There was no antibiotic administered during the 7-day lookback period.

Resident #11's care plan dated 7/21/23 had an identified problem that the resident was taking a prophylactic antibiotic ongoing related to history of recurrent urinary tract infection. The intervention was to administer the prophylactic medication as ordered.

Resident #11 had a physician order dated 7/21/23 for Cephalexin, an antibiotic, 500 mg twice a day for 7 days which was completed and discontinued on 7/29/23.

On 8/17/23 at 10:30 am an interview was conducted with the MDS Coordinator. She stated she mistakenly thought Resident #11 was on a prophylactic antibiotic and would revise his care plan.

2. Resident #53 was admitted to the facility on 12/6/19 with the diagnosis of dementia.

A review of Resident #53's physician order history from 2/1/23 to 8/17/23 revealed the last antipsychotic medication order ended on 2/6/23. There were no antipsychotic or psychotropic medication orders.

F 657

audit of all antibiotic orders and compared to the care plan, this was completed 9/07/2023. There were 4 care plans out of 86 reviewed that were corrected for antibiotics/prophylactic anti-infective. Social Services Director, Assistant Director of Health Services and/or nurse manager conducted a 100% audit completed 9/07/2023 of all current and discontinued orders back 90 days, for psychotropic medications and compare to the current care plan. There were nine care plans out of 86 reviewed that were corrected for current or discontinued psychotropic medications.

Step 3.

a. Education will be done by the Clinical Reimbursement Coordinator (RN) for the CMC developing/implementing comprehensive care plans by 9/10/2023. Any Case Mix Coordinator not educated by 9/11/2023 will be removed from the schedule until education is completed. This education will be added to orientation for all licensed nurses hired for the MDS department.

b. The Quality Assurance and Performance Improvement Nurse and/or Nurse Manager will pull the Facility Activity Report from electronic health record (EHR) to be reviewed Monday-Friday, which includes new and discontinued orders starting 9/5/2023. During this time, the care plan will be reviewed and updated according to orders.

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F 657	Continued From page 8 Resident #53's quarterly Minimum Data Set (MDS) dated 7/10/23 documented the resident was unable to participate in the brief interview of his mental status. The active diagnosis was dementia. The resident had not received any antipsychotic, antianxiety, or antidepressant medication during the 7-day lookback period. Resident #53's care plan started on 12/19/19 and updated on 7/20/23 documented an identified problem of psychotropic drug use at risk for adverse reaction. The intervention was to administer the medication as ordered. On 8/17/23 at 10:30 am an interview was conducted with the MDS Coordinator. She stated Resident #53 was not on an antipsychotic or psychotropic medication and she would revise his care plan.	F 657	c. A care plan audit tool will be implemented by the Case Mix Coordinator and/or Nurse Manager to monitor accuracy of the care plan for new orders for antibiotics and psychotropics and will be implemented as follows: 5 times per week for 4 weeks, then 2 times per week for 4 weeks, then monthly for three months. Step 4. Monitoring will be done by the Case Mix Coordinator, Director of Health Services and/or Administrator to ensure accuracy of the comprehensive care plan regarding antibiotic and psychotropic medications. Monitoring will occur five times per week times 4 weeks, then two times per week times 4 weeks, and monthly until compliance is sustained. Results of the monitoring, with tracking and trending, will be reported by the Director of Health Services and/or nurse manager monthly to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes. Compliance Date: 9/11/2023	
F 867 SS=D	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	F 867		9/11/23

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F 867	Continued From page 9 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 §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	F 867		

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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.

§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

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F 867	Continued From page 11 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 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 record review and staff interviews the facility's Quality Assurance and Assessment (QAA) Committee failed to maintain implemented procedures and monitor implemented procedures previously put int place following the 4/8/2022 recertification survey. This was for one recited deficiency in the area of comprehensive resident centered care plan (F656). This deficiency was cited again on the recertification conducted of 8/17/2023. This continued failure during two federal surveys of record show a pattern of the	F 867	" Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 8/18/23, the Administrator had an Ad HOC Quality Assurance and Performance Improvement Committee (QAPI) meeting with the interdisciplinary team (IDT) to discuss the one repeat tags, F 656. A root cause analysis identified that the facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345492	A. BUILDING ______ B. WING ______	08/17/2023

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facility's inability to sustain an effective QAA program.

Findings included:

This tag is cross referenced to:

F656: Based on observations, interviews with resident and staff, and medical record review the facility failed to develop a comprehensive care plan to include dental issues for 1 of 20 residents (Resident #45) reviewed for comprehensive care planning.

During the recertification and complaint investigation of 4/8/2022 the facility was cited for failure to develop a comprehensive care plan for 2 of 24 residents sampled for care plans (Resident #40 and Resident #219).

An interview with the Administrator, who heads the QAA committee, was conducted on 8/17/2023 at 1:02 PM. She stated that deficiencies were addressed by the department heads responsible for the deficiencies. The Case Mix Director oversaw the monitoring and brought findings to the QAA committee for discussion and revisions. She further revealed that care planning was being monitored for completeness and accuracy and ultimately it was the inaccuracies on the Minimum Data Set which caused this deficiency.

F 867

has gone through increased turnover in leadership, extended vacancies in key managing/monitoring positions and partner ownership in these identified areas.

" 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 8/21/23 the Administrator reviewed surveys for April 8, 2022, to identify ongoing trends. The areas identified as ongoing trends are to be addressed in the monthly QAPI meetings.

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

On 8/23/23 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. CASPER reports were distributed for on-going reference.

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 _9/11/2023__.
Managers that have not completed the

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F 867	Continued From page 13	F 867	training by _9/11/2023__ 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 656 monthly until 3 consecutive months of compliance is maintained then quarterly thereafter. The Quality Assurance and Performance Improvement committee will meet monthly 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 (F656). This will ensure the facility is identifying areas of non-compliance and addressing them as needed to prevent further deficient practice. 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	

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F 867	Continued From page 14	F 867	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. Compliance Date: 9/11/2023	