DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345560	A. BUILDING ______ B. WING ______	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS HOME-KINSTON	2150 HULL ROAD KINSTON, NC 28504

(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 08/19/24 through 08/22/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #P4BV11.	E 000		
F 000	INITIAL COMMENTS A recertification and survey was conducted from 08/19/24 through 08/22/24. Event ID# P4BV11.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		9/19/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/05/2024

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 578	Continued From page 1 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to have accurate advanced directive documentation throughout the medical record for 2 of 7 residents reviewed for advanced directives (Residents #20 and #86). The findings included: 1. Resident #86 was admitted to the facility on 11/30/23 with diagnoses that included dementia and hypertension. The electronic medical record profile indicated Resident #86's code status as a full code. Review of Resident #86's physician orders dated 11/30/23 revealed he had an active full code order in place. Review of Resident #86's revised active care plan dated 6/29/24 revealed a goal which stated, "If the patient/resident's heart stops, or if the patient/resident stops breathing, CPR WILL NOT	F 578	The facility failed to have accurate advanced directive documentation throughout the medical records for 2 of 7 residents reviewed for Advance Directives. The Director of Nursing reviewed the medical record of resident #86 on 8/20/2024 and determined the resident to be a full code per the physical order. The care plan dated 6/29/24 stated that CPR would not be initiated in honor of DNR wishes through the next review period. The Director of Nursing determined the physician order to be correct stating the resident was full code. The Director of Nursing updated resident #85 care plan on 8/20/24 at 4:30 pm to reflect the resident is a full code. The Director of Nursing reviewed the medical record of resident #20 on 8/20/24	

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F 578	Continued From page 2 be initiated in honor of the DNR wishes through the next review period". An interview was conducted 8/20/24 at 3:40 PM with Nurse #1 who reported Resident #86 had a code status of full code. An interview was conducted on 8/20/24 at 4:16 pm with the Director of Nursing (DON). She stated the Registered Nurse (RN) Supervisor present at time of a resident's admission confirms code status. The DON could not explain why Resident #86's care plan showed a discrepancy regarding his code status. She reported it would be corrected as soon as possible. An interview was conducted on 8/20/24 at 4:16 pm with the Social Worker (SW). She stated the documentation of a resident's care plan (CP) is reviewed, discussed, and updated quarterly in CP meetings. The SW could not explain why Resident #86's care plan showed a discrepancy regarding his code status. 2. Resident #20 was admitted to the facility on 10/04/2023 with diagnoses that included paroxysmal atrial fibrillation, osteoarthritis, generalized muscle weakness, and difficulty in walking. The electronic medical record profile indicated Resident #20's code status as a Do Not Resuscitate (DNR). Review of Resident #20's physician orders dated 3/31/2024 revealed he had an active DNR order in place. The DNR book kept at the nurse's station on	F 578	and determined the resident to be a Do Not Resuscitate per the physical order. The care plan dated 7/24/24 showed a focus area of attempt resuscitation. The Director of Nursing updated resident #20 care plan on 8/20/24 at 5:44 pm to reflect the resident□s code status to be do not resuscitate. On 8/20/24, the Social Worker was re-educated by the Administrator on how to conduct a code status audit. The Social Worker, Director of Nursing, Performance Improvement Nurse and Infection Preventionist were educated on the NCSVH-Kinston Resident Code Status audit tool. On 8/20/24, the Director of Nursing, Performance Improvement Nurse and Infection Preventionist completed an audit of all active residents to ensure the code status of all residents was correct and was also reflected accurately in their care plan using the NCSVH-Kinston Resident Code Status audit sheet created 8/20/24. No other discrepancies were noted in the audit process. The Performance Improvement Nurse will use the NCSVH-Kinston Resident Code Status report to audit the code status of all active residents weekly x 8 weeks. The results of the audits will be reviewed with the Executive Quality Assurance Team no less than monthly x 2. Date of Compliance September 19, 2024	

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F 578	Continued From page 3 Resident #20's hall/wing was reviewed. An effective, executed DNR status form was found. Review of Resident #20's revised active care plan dated 07/24/2024 at 6:42 PM showed a focus area of do not attempt resuscitation. Further review of Resident #20's revised active care plan dated 07/24/2024 at 6:42 PM indicated a focus area of attempt resuscitation. An interview was conducted on 8/20/24 at 4:16 pm with the Director of Nursing (DON). She stated the Registered Nurse (RN) Supervisor present at time of a resident's admission confirms code status. The RN supervisor would get a physician's order and consent form for DNR. The DON could not explain why Resident #20's care plan showed a discrepancy regarding his code status, adding the nurse who revised the care plan should have discontinued the full code status. An interview was conducted on 8/20/24 at 4:16 pm with the Social Worker (SW). She stated the documentation of a resident's care plan (CP) is reviewed, discussed, and updated quarterly in CP meetings. The SW could not explain why Resident #20's care plan showed a discrepancy regarding his code status.	F 578		
F 641 SS=B	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:	F 641		9/19/24

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F 641	Continued From page 4 Based on record review and staff interviews the facility failed to accurately code behaviors (Resident #27) and antiplatelet use (Resident #17) for 2 of 24 resident assessments reviewed. The findings included: 1. Resident #27 was admitted to the facility on 1/23/23 with diagnoses that included dementia. Review of a nursing progress note dated 7/16/24 read in part, Resident #27 "refused ADL (Activities of Daily Living) care, despite needing incontinence care." Resident #27's most recent quarterly Minimum Data Set (MDS) assessment dated 7/22/24 revealed he had severe cognitive impairment. Rejection of care was not indicated. An interview was conducted with MDS (Minimum Data Set) Nurse #1 on 8/21/24 at 4:48 PM who stated the facility social workers are responsible for completing the behavior section of the MDS assessment. During an interview with the Social Work Assistant on 8/21/24 at 4:49 PM she stated Resident #27 should have been coded for rejection of care and it was an oversight. She did not explain how she missed documentation of rejection of care. In an interview with the Administrator on 8/22/2024 at 11:08 a.m., she stated Resident #27's MDS assessment should had been coded correctly for behaviors. 2. Resident #17 was admitted to the facility on 8/17/2023 with diagnoses including myocardial	F 641	Based on the record review and staff interviews, the facility failed to accurately code behaviors for resident #27 and antiplatelet use for resident #17. Resident #27 had a note stating he refused care, even though he needed care. The resident□s most recent Minimum Data Set (MDS) dated 7/22/24 revealed he had severe cognitive impairment, but rejection of care was not indicated in section E of the Minimum Data Set. The Case Mix Director modified the 7/22/24 assessment to reflect rejection of care by the resident on 8/21/24. A Minimum Data Set, section E, audit was completed by the Case Mix Director and the Director of Nursing on 9/6/24 using the MDS Section E Audit Tool. The Social Worker was educated by the Case Mix Director related to the Assessment Reference Date for Section E and where to locate the information The Case Mix Director will use the MDS Section E Audit Tool to audit every assessment weekly x 8 weeks. Correction and re-education will be implemented as determined necessary by the Case Mix Director. The results of the audits will be reviewed with the Executive Quality Assurance Team no less than monthly x 2. Resident #17 had an order dated 8/17/23 for Aspirin Delayed Release 81 milligrams	

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F 641

Continued From page 5

infarction (heart attack).

Physician orders dated 8/17/2023 included Aspirin Delayed Release (an antiplatelet medication that causes blood cells not to clump together to form a clot) 81 milligrams(mg) daily.

A review of the May 2024 Medication Administration Record recorded Resident #17 received Aspirin Delayed Release 81 mg daily from 5/01/2024 to 5/31/2024. Resident #17 continues to receive Aspirin Delayed Release 81 mg daily.

The quarterly Minimum Data Set (MDS) assessment dated 5/22/2024 indicated Resident #17 was cognitively intact and was not coded for antiplatelets.

In an interview with MDS Nurse on 8/22/2024 at 9:58 a.m., she explained Resident #17's MDS dated 5/22/2024 was not coded for antiplatelets because the medication, Aspirin Delayed Release, was a nonsteroidal anti-inflammatory drug (NSAID). After review of the Resident Assessment Instrument (RAI) guidelines, the MDS Nurse stated Aspirin Delayed Release was list as an antiplatelet, and Resident #17's MDS should had been coded for antiplatelets. The MDS Nurse stated not coding Resident #17's MDS for antiplatelets was an oversight on her part.

In an interview with the Administrator on 8/22/2024 at 11:08 a.m., she stated Resident #17's MDS assessment should had been coded correctly for the use of antiplatelets according to the RAI guidelines.

F 641

daily. The Medication Administration Record currently receives Aspirin Delayed Release 81 milligrams. The minimum Data Set dated 5/22/24 was not coded for antiplatelet. The Case Mix Director Modified the 5/22/24 MDS assessment to reflect the resident was taking.

The Director of Nursing and Performance Improvement Nurse completed an audit of all active residents using the MDS Section N Audit Tool on 9/5/24. No other coding errors were noted on the audit. antiplatelet on 8/22/24.

The Case Mix Director was re-educated by Regional Case Mix Director regarding the Resident Assessment Instrument and coding of Section N of the Minimum Data Set using Omnicare Guide for MDS 3.0 Section N: Medications.

The Performance Improvement Nurse and/or the Director of Nursing will complete and audit on all assessments weekly x 8 weeks using the MDS Section N Audit Tool. Assessments will be modified if an error is noted.
The results of the audits will be reviewed with the Executive Quality Assurance Team no less than monthly x 8.

Date of Compliance September 19, 2024