DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·	FORM	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	. 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			CON	E SURVEY IPLETED
		345492	B. WING				C 19/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NC STAT	E VETERANS NURSI	NG HOME			14 COCHRAN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	FC	000			
F 157 SS=D	through 2/9/15. The 2/19/15 due to an ir		F 1	57			3/20/15
	A facility must imme consult with the res known, notify the re or an interested fan accident involving ti injury and has the p intervention; a signi physical, mental, or deterioration in hea status in either life ti clinical complication significantly (i.e., a existing form of treat consequences, or ti treatment); or a dec	ediately inform the resident; ident's physician; and if esident's legal representative nily member when there is an he resident which results in potential for requiring physician ificant change in the resident's r psychosocial status (i.e., a lth, mental, or psychosocial threatening conditions or ns); a need to alter treatment need to discontinue an atment due to adverse o commence a new form of cision to transfer or discharge the facility as specified in					
	and, if known, the more interested family change in room or a specified in §483.1 resident rights under regulations as specifies this section.	so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of					
		cord and periodically update one number of the resident's					
		DER/SUPPLIER REPRESENTATIVE'S SIGN			TITLE		(X6) DATE
	ically Signed						03/06/2015

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.

PRINTED: 03/20/2015

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/20/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION (2	(X3) DATE S COMPL	
		345492	B. WING	;			, 9/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
NC STAT	E VETERANS NURSI	NG HOME			14 COCHRAN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	This REQUIREMEN by: Based on record re the physician 's off Responsible Party a notified the physicia lab results but the f they did not hear fro residents reviewed resident being adm	ge 1 e or interested family member. NT is not met as evidenced eview and interviews with staff, ice nurse, the resident ' s and the physician the facility an ' s office nurse of abnormal acility failed to follow-up when om the physician for 1 of 3 (Resident #3) resulting in the itted to the hospital with . The facility also failed to	F	157	This plan of correction constitutes a written allegation of compliance for th deficiencies cited. However, submiss of this Plan of Correction is not an admission that a deficiency exists or one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal L	he sion that	
	notify the Responsi results and worsen 3 sampled resident included: 1a. Resident #3 wa facility on 9/18/14 a included Advanced Weakness and Diff Record review reve dated 11/15/14 that Blood Urea Nitroge range 6-23) and Cr range 0.50-1.10). A how well the kidney Review of the clinic s orders dated 1/27 count (CBC), comp urinalysis and a Ch A radiology report of possible right lung I	ble Party of abnormal lab ing of a pressure ulcer for 1 of s (Resident #3). The findings s originally admitted to the nd had diagnoses that Dementia, Generalized iculty Walking. aled laboratory test results revealed the resident ' s n (BUN) was 16 (Normal eatinine was 0.89 (Normal BUN and Creatinine reflect rs are working. al record revealed physician ' /15 for a complete blood lete metabolic panel (CMP) a			 F157D A. For Resident #3: The corrective a was not done as the resident is currer in the hospital. B. The Responsible Party of resident with critical labs/labs with orders for changes in treatment and/or worsening pressure ulcers will be notified and resident's physician/physician extend will be notified of critical/abnormal lai C. A 100% audit was completed on L drawn on 1/27/15 to verify all abnorm lab results were reported to the physican dresponsible party. D. A 100% audit will be completed on drawn from 1/28/15 to 2/9/15 for active residents, to verify all abnormal labs reported to the physician and all critical labs/labs with orders for changes in treatment were reported to the responsible party. E. A 100% audit was completed to we that the responsible party was notified and any worsening pressure ulcers. 	ently ts ing of der bs. abs nal sician n labs ive were cal erify	

Facility ID: 970225

		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION		E SURVEY PLETED
						(0
		345492	B. WING			02/	19/2015
NAME OF	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
NC STAT	E VETERANS NURSI	NG HOME			14 COCHRAN AVENUE AYETTEVILLE, NC 28301		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	K	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETIO
F 157	Continued From pa	age 2	F 1	57			
		hat read: "Faxed & called in					
		wed by the initials of the			2.		
		and called in the report. A			A. New process for notification of		
		d 1/29/15 read: "New orders			physician concerning abnormal/crit	tical	
		one r/t (related to) CXR (chest e was a hand written physician			labs: Nursing will no longer call the phys	ioion'o	
		(TO) dated 1/29/15 for an			office nurse concerning abnormal/		
		' days with the following			labs.	ontiour	
		lame of physician/name of			When there is a critical lab the phy	sician	
		name of nurse at facility that			will be notified on the day the resul		
	took the order. "				received for additonal orders if indi		
	A loberatory (lob) w	a with a bast revealed blood for			When there is an abnormal lab the		
		esults sheet revealed blood for Count and Comprehensive			physician/physician extender will be notified by the next day for addition		
		MP) was collected on 1/28/15			orders if indicated.	iai	
		sults included a white blood			The Nurse who notified the physici	an of	
		f 19.5H (H meaning high). The			the critical/abnormal labs will docu		
		listed as 4.0-10.5. A high WBC			on the lab result the physician's res		
		The BUN was 85H (normal			The labs with the documented resp	onses	
	j j	reatinine was 1.66H (normal			will then be faxed to the	mthe e r	
		An elevated BUN and dicate dehydration. The lab			physician/physician extender for fu review.	linei	
		labs were printed in the facility			B. All nurses will be in-serviced and	d new	
		AM. There was information			nursing employees will be in-service		
	stamped on the she	eet that read: "FAXED JAN			prior to providing direct resident ca	re	
		vas not a time or initials of the			concerning reporting critical/abnorr		
	•	the information. There was no			labs to the physician and all critical		
		he nurse ' s notes of the ts or that the physician was			labs/labs with orders for changes in treatment and/or worsening in pres		
		Its. There were no additional			ulcers are reported to the responsi		
		s related to the lab results after			party.	510	
		dated 1/29/15. There were no			C. Nurses who are non-compliant	with	
		ess notes from 1/27/15 until			reporting abnormal labs to the physical		
		ysician gave an order to send			and all critical labs/labs with orders		
	the resident to the	nospital.			changes in treatment and worsenin		
	The Physician cori	ng for the resident in the facility			pressure ulcers are reported to the responsible party will be counseled		
		ew on $2/10/15$ at 3:55 PM that			nursing administration and receive		
		the lab results because he			additional education when indicate		

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		AND HUMAN SERVICES				FORM	03/20/201 APPROVEI 0938-039
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SUR COMPLET	
		345492	B. WING				C 19/2015
NAME OF	PROVIDER OR SUPPLIER	• •		STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
NC STAT	E VETERANS NURS	NG HOME			COCHRAN AVENUE ETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	gave an order for a count. The Physicia what his response Creatinine was and medical record. In a separate interv Physician stated he documentation reg. BUN and Creatinin like it was addresse resident on an antil The Physician state BUN and Creatinin the staff to increase intravenous (IV) flu would send the res asked if he was aw drinking very well th aware the resident The physician was time but did not ans On 2/11/15 at 2:55 conducted with the Nurse stated her jor receive faxed inform messages to the ph had documentation and the physician ' Nurse stated she re on the morning of chest x-ray. The Nur results of the x-ray on 1/29/15 she call an antibiotic. The N receive any phone 1/29/15 or 1/30/15	ntibiotics for the high white an stated he could not recall to the elevated BUN and I would need to review the view on 2/11/15 at 2:08 PM the e could not find any physician arding the resident ' s elevated e. The Physician stated he felt ed because he had put the piotic for the high white count. ed for the resident ' s elevated e he normally would have told e fluids by mouth or start ids and if that did not work ident to the hospital. When vare the resident was not ne Physician stated he was refused care and medications. asked the question a second	F 1	3 A fc c o la tru b T A pfc n n e la o c 4 3 2 1 T c C A p u n p4 3 2 1 T	A. A monitoring form has been de or the notification of the physicia concerning abnormal labs and no of the responsible party of critical abs/labs with orders for changes reatment and new/worsening in filcers. The monitoring will be cor- by the Interdisciplinary Team mer The monitoring will occur as follo at least 3 patients per unit (total of patients) with critical labs/labs with or changes in treatments will be nonitored as stated below along notification of the physician/physi extender for critical labs and abne abs. Notification of the responsite of critical labs/labs with orders for thanges in treatment for a duration abs. Notification of the responsite of critical labs/labs with orders for thanges in treatment for a duration abs. Notification of the responsite of critical labs/labs with orders for thanges in treatment for a duration abs. Notification of the responsite of critical labs/labs with orders for thanges in treatment for a duration abs. Notification of the responsite of critical labs/labs with orders for thanges in treatment for a duration abs. Notification of the responsite of critical labs/labs with orders for thanges in treatment for a duration at times per week for 4 weeks time per week for 4 weeks then monthly for 3 months or un- compliance by the Quality Assura- to a duration of: times per week for 4 weeks times per week for 4	n bification in pressure npleted nber(s). ws: of 9 th orders with cian ormal le party on of: til major ince of 9 will be onsible	

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PRINTED: 03/20/2015

	-	AND HUMAN SERVICES			F	ORM .	03/20/201 APPROVEI <u>0938-039</u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X	COM	E SURVEY PLETED	
		345492	B. WING			(02/1	, 9/2015	
	PROVIDER OR SUPPLIER	NG HOME		2	TREET ADDRESS, CITY, STATE, ZIP CODE 14 COCHRAN AVENUE AYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIOI DATE	
F 157	Continued From pa due to the abnorma	al chest x-ray.	F 1	57	Committee.			
	Nursing (DON) and on 2/11/15 at 3:40 I lab results were to physician 's office directly to the physi hours. The DON st have been called to Nurse #1 stated in PM that she worker 1/29/15. The Nurse x-ray report and ca abnormal report. The review the lab resu 1/29/15. The Nurse work and would have physician 's office Creatinine had she was no documenta Responsible Party	onducted with the Director of I the C Wing Unit Coordinator PM. The DON stated critical be faxed and then called to the during office hours and a call ician when outside office ated the lab results should o the physician. an interview on 2/11/15 at 4:05 d on the 7AM-3PM shift on e stated she faxed the chest lled the office regarding the he Nurse was observed to Its printed at the facility on e stated she never saw the lab ve definitely called the with the high BUN and seen the lab results. There tion in the nurse 's notes the (RP) was notified that lab work or of the abnormal lab results.			4. The Interdisciplinary Team member (Managers, RN, Clinical Competency Coordinator, RN, Wound Care Nurse Quality Assurance Coordinator, RN, Director of Nursing, RN, and/or Administrator)will review notification to responsible party and notification to physician/extender. Results of monito with tracking and trending will be repor- by the Quality Assurance Coordinator (RN) monthly to the Quality Assurance Committee for recommendations and suggestions for improvements or changes.	e, to pring prted r ce		
	AM that he mostly will improvement) Nurse was up to date and morning. The Nurse labs with a faxed stated he nurse stated he and print all unprint Nurse stated on the off 31 lab results ar machine at one tim physician 's office. put all the lab result	an interview on 2/12/15 at 8:14 worked with the QI (Quality se, made sure the lab book printed off all the labs in the e stated he stamped all the tamp that included the date. The could go to the computer ted labs at one time. The e morning of 1/29/15 he printed and put them all in the fax the and faxed them to the The Nurse stated he usually ts for each hall together and urse on the hall. The Nurse						

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	03/20/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY IPLETED
		345492	B. WING _				C 19/2015
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
NC STAT	TE VETERANS NURSI	NG HOME			4 COCHRAN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	stated he did not do fax them to the phy stated he did not re labs on the morning he was aware the r critical labs to the p hall did this. The Nu happened to the lat the morning of 1/29 The DON stated in 2:30 PM she spoke physician 's office a facility any labs she Resident #3. The D received revealed t received on 1/29/15 the staff should hav physician 's office f results. The DON stated in 4:45 PM the physic results to be faxed followed-up by a ph the lab results to th the nurse orders, if order to the facility. There was a physic 1:00 PM to Dischar due to unable to ard Review of the hosp Physical dated 2/3/ the ER (Emergency 60s/50, heart rate 1	o anything with the labs except visician 's office. The Nurse emember what he did with the g of 1/29/15. The Nurse stated hurses were supposed to call obysician but the nurse on the urse could not explain what bs or who he gave them to on 0/15. an interview on 2/12/15 at e with the nurse at the and asked her to fax to the e had in the system for 0ON stated the labs she the CBC and CMP results 5 were faxed to the physician ' at 7:42 AM. The DON stated we made a phone call to the regarding the abnormal lab to the nurse in his office none call and the nurse relayed the physician who would give any and the nurse called the cian 's order dated 2/3/15 at rge the resident to the hospital	F 15	57			

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TATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		345492		NG	0.2	C	
NAME OF	PROVIDER OR SUPPLIER	010102		STREET ADDRESS, CITY, STATE, ZIP CODE		/19/2015	
	E VETERANS NURSI	NG HOME		214 COCHRAN AVENUE FAYETTEVILLE, NC 28301	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
F 157	wants full code for the ICU (intensive of management. Phys Patient is now awal commands and loo Laboratory Data: W count) 27,000, sodi chloride 111, BUN 1+ blood, trace of k esterase, WBC mo bacteria. Chest x-ra 1. Altered Mental S secondary to sever hypotension, lactic Possibly the source Acute renal failure, dehydration and lac infection possibly th hip decubitus ulcer responded to the IN ER. " Hospital reco and cultures of the and buttocks were resident was in the Culture results of th reported on 2/5/15 heavy growth of no records revealed of underwent a surgic of the sacral ulcer i tissues, muscle and by 11cm by 3cm ar decubitus including tissues that measu wound vac (vacuur	ry dehydrated. The family still this patient so patient will go to care unit) for further sical Examination: General: ke, following simple ks very dehydrated. /BC (serum white blood cell fum 146, potassium 5.3, 101, creatinine 3.6. Urinalysis: tetones, 3+ leukocyte re than 180, RBC 120, 3+ ay unremarkable. Assessment: tatus and is lethargic possibly	F 1	57			

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		AND HUMAN SERVICES			FORM	03/20/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATI COM	E SURVEY IPLETED
		345492	B. WING			C 19/2015
NAME OF I	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
NC STAT	E VETERANS NURSI	NG HOME		214 COCHRAN AVENUE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	facility on 9/18/14 a included Advanced Weakness and Diff Review of the clinic s orders dated 1/27 count (CBC) and a (CMP). There was 's notes that the RI Review of laborator 1/28/15 included a comprehensive me documentation in th Responsible Party of Review of the lab re 1/29/15 at 5:18 AM blood cell (WBC) co Nitrogen (BUN) and would indicate pose Creatinine could ind no documentation t The Unit Coordinate interview on 2/10/19 notified when lab w the lab work and ar condition. Nurse #1stated in a PM that she worked 1/29/15. The Nurse lab results printed in AM. The Nurse stat results.	s originally admitted to the and had diagnoses that Dementia, Generalized ficulty Walking. cal record revealed physician ' 7/15 for a complete blood complete metabolic panel no documentation in the nurse P was notified. ry (lab) studies drawn on complete blood count and a tabolic panel. There was no ne nurse 's notes the	F 157			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/20/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		345492	B. WING				C 1 9/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NC STAT	E VETERANS NURSI	NG HOME			14 COCHRAN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	(Quality Improveme lab book was up to labs in the morning through the labs bu lab results for Resid did not do anything them to the physicia he divided the repo give them to the nu stated he did not re with the labs on the The Director of Nur 12/12/15 at 4:45 PM notified of a change The RP stated in ar AM he did not recei work performed wh facility. The RP stat visited the resident C-Wing there was w the family regarding 1c. Resident #3 wa facility on 9/18/14 a included Advanced Weakness and Diff A nurse ' s note dat revealed a nursing that Resident #3 ha upper buttocks. The assessed by the tre measured 1.5 centi note revealed the 7 A nurse ' s note dat	rked mostly with the QI ent) Nurse and made sure the date and printed off all the . The Nurse stated he glanced t did not notice the abnormal dent #3. The Nurse stated he with the labs except to fax an 's office. The Nurse stated rts by halls and normally would rse on the hall. The Nurse member exactly what he did morning of 1/29/15. sing stated in an interview on <i>A</i> that the RP should be e in the resident 's condition. In interview on 2/19/15 at 9:50 (ve notification of abnormal lab ile the resident was in the ed various family members in the facility and while on the very little communication with g the resident 's care. s originally admitted to the nd had diagnoses that Dementia, Generalized	F 1	157			

Facility ID: 970225

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		AND HUMAN SERVICES				FOR	D: 03/20/2015 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DA	TE SURVEY
		345492	B. WING			02	C 2/ 19/2015
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
NC STAT	E VETERANS NURSI	NG HOME			214 COCHRAN AVENUE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	Continued From pa	ige 9	F ′	157	7		
		in breakdown on her bottom. an orders dated 12/15/14 for kin breakdown.					
	2/11/15 at 11:10 AM the right upper buttor resident was very c and refused care. T the resident frequer 1/27/15 she went in resident agreed. The saw the area on the become much large The Treatment Nurs the building and got resident. The Treatment physician measured buttocks/sacral area and staged at a sta	1 stated in an interview on A the resident had an area on ocks. The Nurse stated the confused, could be combative The Treatment Nurse stated ntly refused wound care but on n to do a treatment and the ne Treatment Nurse stated she is right upper buttocks had er to include the sacral area. se stated the physician was in t him to come in to see the ment Nurse stated the d the area on the right upper a at 6.1cm by 5.6cm by 1.1cm ige III pressure ulcer. The tated the physician ordered a he area.					
	2/11/15 at 1:00 PM Responsible Party (pressure ulcer. The show the RP had be	1 stated in an interview on she did not notify the (RP) of the worsening of the ere were no nurse ' s notes to een notified of the worsening er or the new treatment.					
	12/12/15 at 4:45 PM	rsing stated in an interview on M that the RP should have a change in the resident ' s					
	AM he was not info ulcers or worsening	n interview on 2/19/15 at 9:50 ormed of significant pressure g of pressure ulcers while the facility. The RP stated various					

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		G	COMPLETED
		345492			С
	PROVIDER OR SUPPLIER	343492	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	02/19/2015
NAME OF I	ROVIDER OR SUPPLIER			214 COCHRAN AVENUE	
NC STAT	E VETERANS NURS	ING HOME		FAYETTEVILLE, NC 28301	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTION
F 157	Continued From pa	age 10	F 15	7	
-		sited the resident in the facility	1 10	·	
		-Wing and there was very little			
		h the family regarding the			
- 044	resident 's care.		= 0.4		0/00/45
F 314 SS=D		PRESSURE SORES	F 31	4	3/20/15
55=D		RESSORE SORES			
	Based on the com	prehensive assessment of a			
		/ must ensure that a resident			
		ility without pressure sores			
		ressure sores unless the condition demonstrates that			
		able; and a resident having			
		eives necessary treatment and			
		e healing, prevent infection and			
	prevent new sores	from developing.			
	This REQUIREME	NT is not met as evidenced			
	by:				
		eview, staff and family		F314D	
		ity failed to provide treatment r as ordered by the physician		A. Resident #3's wound dressing	should
		residents reviewed for		have ben changed the morning s	
		esident #3). The findings		to the hospital, TX BID.	
	included:			B. Resident #3 will receive wound	
				dressing changes as ordered by	he
		riginally admitted to the facility diagnoses that included		physician. C. Residents with pressure ulcers	s havo
		ia, Generalized Weakness and		the potential to be affected.	
	Difficulty Walking.	-,		D. Residents with pressure ulcers	s will
				receive dressing changes as orde	ered by
		essment (CAA) dated 9/25/14		the physician.	
		Dementia revealed the e cognitive impairment with		2.	
		nce. The CAA revealed the		A. A 100% audit has been comple	eted to
		o communicate simple needs.		verify that the Treatment Adminis	
		ies of Daily Living (ADLs)		Record (TAR) matches the physic	

Facility ID: 970225

If continuation sheet Page 11 of 29

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLE		X3) DATE	0938-039 SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COMP	PLETED
		345492	B WING			C	
	PROVIDER OR SUPPLIER	545452	D. WING -		REET ADDRESS, CITY, STATE, ZIP CODE	02/1	9/2015
	NOVIDER OR SOFFEIER				4 COCHRAN AVENUE		
NC STAT	E VETERANS NURSI	NG HOME			YETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 314	Continued From pa	age 11	F 3	14			
		ent did not like to get out of bed	10		orders.		
		n of activity and required					
		ce with ADLs. The CAA for			3.		
		e revealed the resident could energy to use the bathroom			A. The Director of Nursing (RN) in-serviced the Wound Care Nurses		
		not want to go to the bathroom			(RN/LPN) concerning transcription of	fnew	
		se her incontinent brief			treatments orders, reconciliation of	THC W	
		n breakdown. The CAA for			treatment orders during the monthly		
		vealed the resident had no			turnover and providing treatments pe	er the	
		admission but was at risk due			physicians order.		
		and urinary incontinence. The			B. Any Wound Care Nurse (RN/LPN)		
		esident could reposition to extensive assistance			is non-compliant with transcription of treatment orders, reconciliation of	new	
		cooperation. The CAA revealed			treatment orders during the monthly		
		ontinuously encouraged to get			turnover and providing treatments pe	er the	
	out of bed for at lea	ast an hour.			physicians order will receive counseli and re-education as indicated.	ing	
	The resident ' s Ca	re Plan dated 11/25/14					
		ent refused care such as baths			4.		
		Care Plan instructed staff to			A. A monitoring form has been develo		
		res to the resident and if			for transcription of new treatment ord	ders	
		llow the resident time and Id try again. The Care Plan			and providing treatments per the physician's order. The monitoring will	lbo	
		ated 11/28/14 that revealed			completed by the Interdisciplinary Tea		
		erbally abusive with the staff			Member(s).	am	
		are. The Care Plan directed			The monitoring will occur as follows:	:	
	staff to provide a no				At least 3 patients per unit (total of 9		
		pate care needs and reinforce			patients) with new treatment orders v	will be	
		The Care Plan directed staff to ter time when agitated. The			verified against the treatment administration record for accuracy of		
		a potential for skin			transcription for a duration of:		
		ensure resident was clean, dry			4 times per week for 4 weeks		
	and odor free and a	assist resident with			3 times per week for 4 weeks		
		every 2 hours. The Care Plan			2 times per week for 4 week		
		sess skin daily with AM care			1 time per week for 4 weeks		
		entry dated 12/15/14 revealed learing to the right upper-mid			Then monthly for 3 months or until m compliance by the Quality Assurance		
		ivide treatment as ordered.			Committee.	-	

Facility ID: 970225

If continuation sheet Page 12 of 29

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
	345492	B. WING) 19/2015
PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
E VETERANS NURSI	NG HOME					
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL					(X5) COMPLETION DATE
Continued From pa	ge 12	F 3	14			
physician if no impr monitor area for inc of symptoms of infe physician if present A nurse 's note dat nursing assistant re- resident had skin of The note revealed to the area at 1.5 cent described as skin s There was a physic clean the open area with normal saline a and cover with dry g every 3 days and as A Quarterly Minimu Assessment dated verbal behavioral sy others and rejection revealed the reside assistance with bec toileting and extens hygiene. The MDS impairment of the u MDS revealed the r pressure ulcers (PU had moisture assoc revealed a pressure and nonsurgical dre ointment/medication A wound note dated	The section and the section and to notify the section and to the nurse the pening on the upper buttocks. The treatment nurse measured timeters (cm) by 1.5 cm and shearing to the upper buttocks. The treatment nurse measured timeters (cm) by 1.5 cm and shearing to the upper buttocks. The treatment nurse measured timeters (cm) by 1.5 cm and shearing to the upper buttocks. The treatment nurse measured the sector dressing gauze, secure and change sneeded. The MDS sector dressing the sector dressing the sector dressing and the sector was not peper or lower extremities. The sector was at risk for J), had no unhealed PU and clated skin damage. The MDS are reducing device for the bed sessings and the application of ns.			per unit (total of 9 patients) to ensure dressing has been changed and that treatment administration record has supporting documentation for a dura of: 4 times per week for 4 weeks 3 times per week for 4 weeks 2 times per week for 4 weeks 2 times per week for 4 weeks 1 time per week for 4 weeks Then monthly for 3 months or until n compliance by the Quality Assurance Committee. B. The Interdisciplinary Team memb (Unit Managers, RN, Clinical Compe Coordinator, RN, Wound Care Nurse Quality Assurance Coordinator, RN, Director of Nursing, RN, and/or Administrator)will review the reconci of treatment orders during the month turnover monthly times 3 months. Results of monitoring with tracking a trending will be reported by the Qual Assurance Coordinator (RN) monthl the Quality Assurance Committee for	e the t the ation najor e ber etency e, liation hly and lity y to yr	
	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER E VETERANS NURSI SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From pa physician if no impr monitor area for inc of symptoms of infe physician if present A nurse ' s note dat nursing assistant re resident had skin o The note revealed t the area at 1.5 cent described as skin s There was a physic clean the open area with normal saline a and cover with dry every 3 days and a A Quarterly Minimu Assessment dated verbal behavioral s others and rejection revealed the reside assistance with bec toileting and extens hygiene. The MDS impairment of the u MDS revealed the re source and nonsurgical dre ointment/medicatio	DF CORRECTION IDENTIFICATION NUMBER: 345492 PROVIDER OR SUPPLIER E VETERANS NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 physician if no improvement in 2 weeks and to monitor area for increased breakdown and signs of symptoms of infection and to notify the physician if present. A nurse 's note dated 12/15/14 revealed a nursing assistant reported to the nurse the resident had skin opening on the upper buttocks. The note revealed the treatment nurse measured the area at 1.5 centimeters (cm) by 1.5 cm and described as skin shearing to the upper buttocks. There was a physician 's order dated 12/15/14 to clean the open area to the right upper buttocks with normal saline and apply a xeroform dressing and cover with dry gauze, secure and change every 3 days and as needed. A Quarterly Minimum Data Set (MDS) Assessment dated 12/18/14 revealed there were verbal behavioral symptoms directed toward others and rejection of care daily. The MDS revealed the resident required extensive assistance with bed mobility, total assistance with toileting and extensive assistance with personal hygiene. The MDS revealed there was no impairment of the upper or lower extremities. The MDS revealed the resident was at risk for pressure ulcers (PU), had no unhealed PU and had moisture associated skin damage. The MDS revealed a pressure reducing device for the bed and nonsurgical dressings and the application of ointment/medications. A wound note dated 12/29/14 revealed the resident was placed on an air mat	RS FOR MEDICARE & MEDICAID SERVICES TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A: BUILD 345492 B: WING PROVIDER OR SUPPLIER E VETERANS NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 physician if no improvement in 2 weeks and to monitor area for increased breakdown and signs of symptoms of infection and to notify the physician if present. A nurse 's note dated 12/15/14 revealed a nursing assistant reported to the nurse the resident had skin opening on the upper buttocks. The note revealed the treatment nurse measured the area at 1.5 centimeters (cm) by 1.5 cm and described as skin shearing to the upper buttocks. There was a physician 's order dated 12/15/14 to clean the open area to the right upper buttocks. There was a physician 's order dated 12/15/14 to clean the open area to the right upper buttocks. A Quarterly Minimum Data Set (MDS) Assessment dated 12/18/14 revealed there were verbal behavioral symptoms directed toward others and rejection of care daily. The MDS revealed the resident required extensive assistance with bed mobility, total assistance with toileting and extensive assistance with personal hygiene. The MDS revealed there was no impairment of the upper or lower extremities. The MDS revealed the resident was at risk for pressure ulcers (PU), had no unhealed PU and had moisture associated skin damage. The MDS revealed a pressure reducing device for the bed and nonsurgi	RS FOR MEDICARE & MEDICAID SERVICES TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: A 345492 B. WING	RS FOR MEDICARE & MEDICAID SERVICES ON COP DEFICIENCIES (X1) PROVIDERSUPPLIER/CLM (X2) MULTIPLE CONSTRUCTION A BUILDING A BUILDING 345492 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 214 COHRAM AVENUE FAYETTEVILLE, NC 28301 PROVIDER'S PLAN OF CORRECTIVE ACTION NUMBER D (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Continued From page 12 physician if no improvement in 2 weeks and to monitor area for increased breakdown and signs of symptoms of infection and to notify the physician if present. F 314 A nurse 's note dated 12/15/14 revealed a nursing assistant reported to the nurse the resident had skin opening on the upper buttocks. F 314 There was a physician 's order dated 12/15/14 to clean the open area to the fight upper buttocks. F 4 weeks 3 times per week for 4 weeks A Quarterly Minimum Data Set (MDS) revealed the resident required extensive assistance with bed mobility, total assistance with toilefing and extensive assistance with personal had moisture associated skin damage. The MDS revealed the resident twas at risk for pressure ulcers (PU), had no unhealed PU and had moisture associated skin damage. The MDS revealed the resident the asplication of ointment/medications. B. The Interdisciplinary Team memb (Unit Managers, RN, Clinical Compu Coordinator, RN, Wound Care Nur	RESERN MEDICARE & MEDICAID SERVICES OND NO. OP DEFICIENCES OND NO. STREET ADDRESS, CITY, STATE, ZIP CODE 214 COCHRAN AVENUE PROVIDER OR SUPPLIER. STREET ADDRESS, CITY, STATE, ZIP CODE E VETERANS NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE SUMMAPY STATEMENT OF DEFICIENCES D REQULATORY OR LSC DENTIFYING INFORMATION PROVIDERS PLANGE CONSENTION HOULD E Continued From page 12 PROVIDER OF DATE ON HOULD E physician if no improvement in 2 weeks and to monitor area for increased breakdown and signs of symptoms of infection and to notify the physician if present. F 314 A nurse's note dated 12/15/14 revealed a nursing assistant reported to the nurse the acescribed as skin shearing to the upper buttocks. F 314 There was a physician 's order dated 12/15/14 to clean the open area to the right upper buttocks. F 11 There was a physician 's order dated 12/15/14 to clean the open area to the right upper buttocks. Then monthly for 3 worder dated 12/18/14 revealed there were verbal behavioral symptoms directed toward others and resident meas areaded. The Interdisciplinary Team member (Unit Managers, RN, Clinical Competency Coordinator, RN, Wound Care Nurse, Quality Assurance Coordinator (RN) monthly to the Quality Assurance Coordinator, RN, Director of Nursing, RN, and/or A wound note dated 12/29/14 revealed the resident was placed on an air matitress The Interdisciplinary Team member (U

		AND HUMAN SERVICES				FORM	03/20/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345492	B. WING				C 19/2015
NAME OF	PROVIDER OR SUPPLIER	-		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
NC STAT	E VETERANS NURSI	NG HOME			I4 COCHRAN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	to allow incontinent to staff. Treatment Nurse # 2/11/15 at 11:10 AM and combative from January 2015 and f The Treatment Nurse in to do the treatment The Treatment Nurse treatment and realize much larger to inclu- stated the physician him to see the reside physician measured 5.6cm by 1.1cm wite exudate. The Treat physician ordered a wound. A physician ' s prog revealed the reside sacral ulcer that me was no depth listed There was a physic clean the sacral are antibiotic ointment to cover with gauze ar Review of the Treat (TAR) revealed the treatments on Janu 23, 2017. According allowed the treatment 2015 and refused w 2015. The TAR reve	of care, medications, refusing care and was verbally abusive 1 stated in an interview on 1 the resident was confused in the middle to the end of requently refused wound care. se stated on 1/27/15 she went ent and the resident agreed. se stated she started the zed the area had become ude the sacral area. The Nurse in was in the building and got dent. The Nurse stated the d the wound at 6.1cm by th no tunneling and light ment Nurse stated the a different treatment for the ress note dated 1/27/15 in thad a Stage IV non-infected easured 6.1cm by 5.6cm (there in the notes).	F 3	14			

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		& MEDICAID SERVICES	1			0. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		345492	B. WING _		02	C 2/ 19/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
NC STAT	E VETERANS NURSI	NG HOME		214 COCHRAN AVENUE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 314		age 14 The treatment was initialed as Nurse #1 on January 27, 28,	F 3′	14		
	29 and a different r no initials to show t	hurse on the 31st. There were he treatment was done at all initials to show the treatment				
	was done a second 31. Review of the F	time on January 27, 28, 29 or February 2015 TAR revealed				
	dressing to be done The February 2015	15/14 for the Xeroform e every 3 days and as needed. 5 TAR did not contain the new				
	dressing to be done TAR contained the	dated 1/27/15 for the antibiotic e twice a day. The February initials of Treatment Nurse #1				
	February 1, 2015. A	nd the symbol for changed on A wound assessment sheet led the area on the right upper				
	measurements that	gns of infection and revealed t revealed an increase in the ire ulcer. The measurements				
	2015 there was a c	cm by 2.5cm. On February 2, heckmark and the initials of 2. Treatment Nurse #2 stated				
	in an interview on 2 checkmark on the I	2/12/15 at 9:05 AM the February 2015 TAR for 2/2/15 's sacral dressing was dry				
	and intact. The Nur change the dressin	rse stated the order was to g every 3 days and she did not g on 2/2/15. The Nurse stated				
	there was not an or for a treatment to b	der on the February 2015 TAR e done twice a day. On				
	written under the da order dated 2/3/15	' HOSP " (hospital) was ate. There was a physician ' s at 1:00 PM to discharge the				
	indicate a treatmen 3, 2015 prior to bei	bital. There were no initials to thad been done on February ng discharged to the hospital. mation on the TAR and no				
		the resident refused the				

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-					FORM	: 03/20/2015 APPROVED 0938-0391
CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
	345492	B. WING				C 19/2015
R OR SUPPLIER	• •		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RANS NURSI	NG HOME					
ACH DEFICIENC	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE
ued From pa	ige 15	F3	314			
ew on 2/11/19 s assigned to e February 2 to ensure th nent Nurse # 5 at 1:25 PM about one we and pointed and initials by vas correct. R prior to 1/2 . The Nurse eatment N	5 at 1:20 PM Treatment Nurse o check the January 2015 TAR 015 TAR and the physician 's e February TAR was accurate. 2 stated in an interview on she started checking the eek prior to the end of the where she had put a check of the order on the TAR that the The Nurse stated she checked 27/15 when the new order was stated on February 1, 2015 se that put the new TARs in the s supposed to check to ensure tional orders and the new TAR					
onth and were ith the TAR f the actual p after that wh rse was supp upcoming m rses had bee nent Nurse # 5 at 3:19 PM y and she wa iding. The N as already in shing and re	e supposed to check the new rom the previous month as hysician ' s orders. The DON en a new order was received, bosed to write the new order onth ' s TAR. The DON stated en trained to do this. 1 stated in an interview on that February 1, 2015 was a as the only treatment nurse in urse stated the February 2015 the treatment book and she moved the January TAR and					
	A MEDICARE CLENCIES CONCIENT ROR SUPPLIER RANS NURSI SUMMARY STA ACH DEFICIENCY GULATORY OR L UNDEFICIENCY GULATORY OR L GULATORY OR L UNDEFICIENCY GULATORY OR L GULATORY OR L GU	IDENTIFICATION NUMBER: 345492 ROR SUPPLIER RANS NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) ued From page 15 nit Coordinator on the C-Wing stated in an ew on 2/11/15 at 1:20 PM Treatment Nurse s assigned to check the January 2015 TAR e February 2015 TAR and the physician 's to ensure the February TAR was accurate. nent Nurse #2 stated in an interview on 5 at 1:25 PM she started checking the about one week prior to the end of the and pointed where she had put a check and initials by the order on the TAR that the was correct. The Nurse stated she checked R prior to 1/27/15 when the new order was 0. The Nurse stated on February 1, 2015 eatment Nurse that put the new TARs in the ent book was supposed to check to ensure were no additional orders and the new TAR ccurate. irector of Nursing (DON) stated in an ew on 2/11/15 at 3:40 PM the staff started ng the TARs 4-5 days prior to the end of onth and were supposed to check the new with the TAR from the previous month as a the actual physician 's orders. The DON after that when a new order was received, rse was supposed to write the new order upcoming month 's TAR. The DON stated rses had been trained to do this. nent Nurse #1 stated in an interview on 5 at 3:19 PM that February 1, 2015 was a y and she was the only treatment nurse in idding. The Nurse stated the February 2015 ras already in the treatment book and she ashing and removed the January TAR and ued with the order on the February TAR	MEDICARE & MEDICAID SERVICES CIENCIES CON (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 345492 B. WING ROR SUPPLIER ASSUPPLIER RANS NURSING HOME ID PREFI SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) ID PREFI TAG ued From page 15 F 3 nit Coordinator on the C-Wing stated in an ew on 2/11/15 at 1:20 PM Treatment Nurse s assigned to check the January 2015 TAR e February 2015 TAR and the physician 's to ensure the February TAR was accurate. nent Nurse #2 stated in an interview on 5 at 1:25 PM she started checking the about one week prior to the end of the and pointed where she had put a check and initials by the order on the TAR that the was correct. The Nurse stated she checked R prior to 1/27/15 when the new order was the The Nurse stated on February 1, 2015 eatment Nurse that put the new TARs in the ent book was supposed to check to ensure were no additional orders and the new TAR curate. irrector of Nursing (DON) stated in an ew on 2/11/15 at 3:40 PM the staff started ng the TARs 4-5 days prior to the end of onth and were supposed to check the new with the TAR from the previous month as a the actual physician 's orders. The DON after that when a new order was received, rse was supposed to write the new order upcoming month 's TAR. The DON stated rses had been trained to do this. nent Nurse #1 stated in an interview on 5 at 3:19 PM that February 1, 2015 was a y and she was the only treatment nurse in ilding. The Nurse stated the February Z015 ras already in the treatment book and she ishi	RMEDICARE & MEDICAID SERVICES CIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING B. WING 345492 B. WING ROR SUPPLIER 345492 B. WING SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG ued From page 15 F 314 nit Coordinator on the C-Wing stated in an ew on 2/11/15 at 1:20 PM Treatment Nurse s assigned to check the January 2015 TAR e February 2015 TAR and the physician 's to ensure the February TAR was accurate. nent Nurse #2 stated in an interview on 5 at 1:25 PM she started checking the about one week prior to the end of the and pointed where she had put a check and initials by the order on the TAR that the was correct. The Nurse stated she checked R prior to 1/27/15 when the new order was b. The Nurse stated on February 1, 2015 batment Nurse that put the new TARs in the ent book was supposed to check to ensure were no additional orders and the new TAR courate. irector of Nursing (DON) stated in an ew on 2/11/15 at 3:40 PM the staff started ng the TARs 4-5 days prior to the end of onth and were supposed to check the new ith the TAR from the previous month as a the actual physician 's orders. The DON after that when a new order was received, rse was supposed to write the new order upcoming month 's TAR. The DON stated rses had been trained to do this. nent Nurse #1 stated in an interview on 5 at 3:19 PM that February 1, 2015 was a y and she was the only treatment nurse in ilding. The Nurse stated the February 2015 ras already in the treatment book and she	OF HEALTH AND HUMAN SERVICES XMEDICARE & MEDICARD SERVICES CENCIES CENCIES COR SUPPLIER RANS NURSING HOME SUBMARY STATEMENT OF DEFICIENCIES acto DEFICIENCIES acto NUMBER SUBMARY STATEMENT OF DEFICIENCIES acto DEPERTY NUST BE PROCEEDED BY FULL JULATORY OR LSC IDENTIFYING INFORMATION) Ued From page 15 Int Coordinator on the C-Wing stated in an aw on 2/11/15 at 1:20 PM Treatment Nurse as assigned to check the January 2015 TAR and the physician 's to ensure the February TAR was accurate. ent Nurse #2 stated in an interview on 5 at 1:25 PM she started checking the about one week prior to the end of the and pointed where she had put a check and initials by the order on the TAR that the was correct. The Nurse stated on February 1, 2015 batment Nurse that put the new TARs in the ent to 1/27/15 when the new order was the onix or the start stated on a february 2015 TAR and the physician 's to ensure the February 1, 2015 batment Authe was supposed to check the new order was the not 1/27/15 when the new order was the and put a check and the they are order. The Nurse stated on February 1, 2015 batment Nurse that put the new TARs in the ent book was supposed to check the new order was the onder she had put a check and the they are order. The Nurse stated on February 1, 2015 batment Nurse that put the new TARs in the ent book and she supposed to check the new order was the once on the TAR that the was coural. reference of Nursing (DON) stated in an ave order upcoming month 's TAR. The DON stated rese had been trained to do this. rent Nurse #1 stated in an interview on 5 at 3:49 PM that February	OF HEALTH AND HUMAN SERVICES OBE NOCES MEDICARE & MEDICALD SERVICES OMB NO Chinom (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION (X3) DAT COR 345492 B. WING 02/ RANS NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301 02/ SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 012/ SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 02/ SUMMARY STATEMENT OF DEFICIENCIES FAYETTEVILLE, NC 28301 02/ SUMMARY STATEMENT OF DEFICIENCIES GROSS-REFERENCED TO THE APPROPRIATE 02/ SUMMARY STATEMENT OF DEFICIENCIES F314 FAST F314 Init Coordinator on the C-Wing stated in an about one week prior to the end of the and pointed where she had put a check and initials by the order on the TAR that the was correct. The Nurse stated on February 12015 TAR and the physician 's to ensure were no additional orders and the new TAR sin the ent book was supposed to check the new trans in the end of the new order was supposed to check the new trans in the end of the new order was received, rse was supposed to check the new order was received, rse was supposed to check the new trans in the end of the and pointed where she had put a check and the new order was received, rse was supposed to check the new trans in the end of the and pointed where she had put a check and the new order was received, rse was supposed to check the new trans in the end of the and that rebrua

Facility ID: 970225

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
-							С
	PROVIDER OR SUPPLIER	345492	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	02 /′	19/2015
					14 COCHRAN AVENUE		
NC STAT	E VETERANS NURSI	NG HOME		F.	AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314		ige 16 se stated this was her	F 3 [,]	14			
	cultures of the sacr obtained on 2/3/15 Department (ED). T and Physical dated Examination, Extrem sacral decubitus und decubitus with four The results of the w ED were reported of 2/5/15. The results growth of normal sk dated 2/6/15 reveal ulcer including skin muscle and fascia r 3cm and debrideme measuring 4cm by placement of a wou	revealed moderate to heavy kin flora. An operative note ed debridement of the sacral , subcutaneous tissues, measuring 11cm by 11cm by ent of a right hip decubitus 3cm by 2cm and the ind vac (vacuum).					
F 325 SS=D	on 2/9/15 at 7:55 Pl be in much pain prin pressure ulcers on the debridement of resident had signific Fentanyl drip intrave medication used to 483.25(i) MAINTAIN UNLESS UNAVOID	N NUTRITION STATUS DABLE	F 32	25			3/20/15
	resident - (1) Maintains accep	it's comprehensive cility must ensure that a ptable parameters of nutritional ly weight and protein levels,					

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PRINTED: 03/20/2015

		AND HUMAN SERVICES			F	FORM	03/20/2015 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X		E SURVEY PLETED
		345492	B. WING	;		-	, 9/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
NC STAT	E VETERANS NURSI	NG HOME			14 COCHRAN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 325	(2) Receives a ther nutritional problem.	's clinical condition his is not possible; and apeutic diet when there is a	F	325			
	by: Based on record refacility failed to notific recommendations a dietary recommend residents (Resident Resident #3 was ac 9/18/14 and had dia Advanced Dementific Difficulty in Walking The Care Area Asso Loss/Dementia data resident had severe behavior disturband resident could com able to communica Nutrition revealed th her room. The CAA a No Added Salt die from 25-100% of m resident was able to The resident require activities of daily liv revealed the reside breakdown due to i	NT is not met as evidenced eview and staff interviews the fy the physician of all dietary and failed to implement the lations for 1 of 3 sampled t #3). The findings included: dmitted to the facility on agnoses that included a, Generalized Weakness and g. essment (CAA) for Cognitive ed 9/25/14 revealed the e cognitive impairment with be. The CAA revealed the municate verbally and was te simple needs. The CAA for he resident preferred to eat in a revealed the resident was on et and her meal intake was eals. The CAA revealed the o feed herself after tray set-up. re Plan dated 9/25/14 revealed d staff assistance for ing (ADLs). The Care Plan nt had the potential for skin ncontinence. Among the as follows: Report decline in			 F325D 1. A. For Resident #3: The corrective actives was not done as the resident is current in the hospital. B. Residents with Dietary Recommendations will have their physician notified and implemented a ordered. 2. A. The Registered Dietician and Dieta Manager conducted a 100% audit on 3/5/15 of dietary recommendations or made since 12/17/2014. 3. A. A new process for notification of physician concerning dietary recommendations has been impleme Nursing will no longer call the physicia office nurse concerning dietary recommendations. When there is a dietary recommendations. When there is a dietary recommendations if indicate B. The Registered Dietician and Dieta Manager will be in-serviced at this tim and upon hire on ensuring physician of the physician of the physician of the physician office nurse concerning dietary recommendations. 	ntly Is ary n ented. an's tion be ed. ary ne	

Facility ID: 970225

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O		APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMF	SURVEY PLETED
		345492	B. WING			02/1) 9/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NC STAT	E VETERANS NURSI	NG HOME		_	14 COCHRAN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 325	intake to physician,	Offer beverages and Dietician	F 3	25	notified of dietary recommendations	s and	
	Plan revealed a pot				implementation of dietary recommendations. C. Nurses will be in-serviced at this and upon hire on dietary recommendations received on a	time	
	The Care Plan was updated as follows: 11/25/14 Resident rejects care such as refusing baths an grooming. 11/28/14 Resident verbally abusive with staff and resists ADL care.			phyician's order form to ensure the physician/physician extender was n of dietary recommendations and implementation of dietary recommendations. D. Those employees not in complia			
	nursing assistant re resident had skin o buttocks. The note	ed 12/15/14 revealed a eported to the nurse the pening on the upper right revealed the area was eatment nurse and measured			with notification of physician concer dietary recommendations and implementation will be counseled an receive re-education as indicated.	ning	
	upper buttocks. Re	 by 1.5cm skin shearing to view of the physician 's orders ted 12/15/14 for treatment of 			 A. Quality Assurance Checklist has completed/implemented by the Reg Dietician and Dietary Manager for d recommendations to ensure the 	jistered	
	Resident has curre buttocks (shearing)	updated as follows: 12/15/14 nt skin concerns: R upper-mid b. Encourage to allow staff to tments. Pt non-compliant with ally/physically).			physician/physician extender was n and recommendations were implem The monitoring will occur: 4 times per week for 4 weeks 3 times per week for 4 weeks 2 times per week for 4 weeks		
	the resident was or regular texture and note revealed the re the time, had poor refused medication	ent dated 12/17/14 revealed a No Added Salt diet with refused to be weighed. The esident stayed in bed most of intake of food and fluids and s and care. The note revealed of consistently meeting her			Then monthly for 3 months B. The Administrator/Director of Nu will monitor for compliance with diel recommendations to ensure the physician/physician extender was n and recommendations were implem The monitoring will occur monthly ti	tary otified nented.	
	nutritional needs ar place. The note rev was recommended	a multi-vitamin (MVI) was in vealed an appetite stimulant and the recommendation was he Dietary Manager (DM)			months. C. Results of monitoring with tracking trending will be reported by the Reg Dietician monthly to the Quality Ass	ng and jistered	

Facility ID: 970225

		E & MEDICAID SERVICES				0. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY
		345492	B. WING _		02	C / 19/2015
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE	
NC STAT	E VETERANS NURS	ING HOME		214 COCHRAN AVENUE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 325	did not remember y recommendations the recommendations that day or the nex the recommendations the recommendations the following recom- manager for Resid PO (by mouth) inta fluid intake. 2. Star three times per day Standard 2.0 is a h supplement. " Rev revealed no orders supplements in De Medication Adminis for December 2014 appetite stimulant of MVI.	ew on 2/12/15 at 9:10 AM he what nurse he gave the dietary to on 12/17/15. The DM stated ons were usually carried out t day. The DM was not aware ons had not been initiated. al Nutritional Therapy 5 Form dated 12/17/14 revealed mendations from the dietary ent #3: "1. Appetite stimulant. ke 22% average per day. Poor ndard 2.0 90 milliliters (mls) y. Record percent of intake. high protein, nutritional view of the physician 's orders of or an appetite stimulant or cember 2014. Review of the stration Record for Resident #3 4 revealed no entries for an or supplements other than the	F 32	25 Committee for recommend suggestions for improvemend changes.		
	follows: 12/17/14 F poor intake of food appetite stimulant. and supplements a A Quarterly Minimu Assessment dated	are Plan was updated as Refusing to be weighed. Very and fluids. Recommend Encouraged to be weighed as ordered. Im Data Set (MDS) 12/18/14 revealed the resident we impairment and verbal				
	behavioral sympton of care that occurre resident required e mobility, was non-a assistance with toil with personal hygic	ms toward others and rejection ed daily. The MDS revealed the extensive assistance with bed ambulatory and required total leting and extensive assistance ene. The MDS revealed the tinent of bowel and bladder				

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		AND HUMAN SERVICES				FORM	03/20/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		345492	B. WING				C 19/2015
NAME OF	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NC STAT	TE VETERANS NURSI	NG HOME			14 COCHRAN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 325	and was on a thera the resident was at had no unhealed pr revealed the reside skin damage and h for the bed and nor application of ointm On 2/10/15 at 12:33 (DM) stated in an ir demented and neve admission. The DW was her fluid intake would have 2 or 3 h but would not finish tried to encourage I members tried to gu unsuccessful. The resident ice cream would eat several b anymore. The DM s refusing to be weig! In an interview with PM, the Nurse state of the Nutritional Th Form that she faxed physician ' s office of recommendations f PM and the physici the top right hand of stated she worked of facility and was not and did not follow-u recommendations. On 2/12/15 at 4:30 ' s office stated in a	peutic diet. The MDS revealed risk for pressure ulcers but ressure ulcers. The MDS and had moisture associated ad a pressure reducing device nsurgical dressings and the nent/medications. 3 PM, the Dietary Manager netrview the resident was quite er had a great appetite since 1 stated the biggest concern e. The DM stated the resident half empty drinks on her table anything. The DM stated he her to drink and her family et her to drink but were DM stated he would take the he knew she liked and she bites and would not eat stated the resident had been hed since October 2014. Nurse #3 on 2/12/15 at 4:05 ed she put the time at the top nerapy Recommendations d and called the nurse at the with the dietary for Resident #3. The time 2:10 an 's nurse 's name was at corner of the form. The Nurse on different halls within the on the same hall the next day	F 3	325			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/20/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (A	COM	E SURVEY PLETED
		345492	B. WING				C 19/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
NC STAT	E VETERANS NURSI	NG HOME			14 COCHRAN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 325 F 327 SS=D	The Nurse stated s for an appetite stim called the facility wi 2.0 90 mls three tim PM. The physician know who she gave The Director of Nur interview on 2/12/19 physician ' s nurse f recommendation re office on 12/17/15. recommendation fo stimulant. PO (by m day. Poor fluid intak milliliters (mls) three percent of intake. T had a communication 483.25(j) SUFFICIE HYDRATION The facility must pro- sufficient fluid intak and health. This REQUIREMEN by: Based on record re- facility failed to notif lab results that reve- sampled residents of (Resident #3). Resi hospital on 2/3/15 v	2.0 90 mls three times a day. the did not receive a request ulant. The Nurse stated she th an order for the Standard tes a day on 12/17/15 at 5:00 is Nurse stated she did not the order to at the facility. sing (DON) stated in an 5 at 4:45 PM she had the fax her a copy of the dietary ceived at the physician 's The copy of the dietary rm read: "1. Appetite touth) intake 22% average per te. 2. Standard 2.0 90 te times per day. " Record he DON stated they definitely		325	F327D 1. A. For Resident #3: The corrective a was not done as the resident was in hospital. B. Resident's physician/physician extender will be notified of critical/abnormal labs. C. A 100% audit was completed on lab	the	3/20/15

Event ID: 1IQF11

Facility ID: 970225

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	-	AND HUMAN SERVICES					APPROVEI 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE COMF	SURVEY PLETED
		345492	B. WING			C 02/1) 9/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NC STAT	E VETERANS NURSI	NG HOME			14 COCHRAN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 327	Continued From pa	age 22	F 3	327			
	Resident #3 was or on 9/18/14 and had Advanced Dementi The Care Area Ass Loss/Dementia data resident had cognit Dementia with Beha revealed the reside and was able to con CAA for Nutrition da resident was able to Record review reve dated 11/15/14 that Blood Urea Nitroge range 6-23) and Cr range 0.50-1.10). A how well the kidney The resident ' s Car revealed a potentia resident ' s very poor The Care Plan was of food and fluids. A Dietary assessme the resident had po and refused medica A Quarterly Minimu	riginally admitted to the facility diagnoses that included a and Generalized Weakness. essment (CAA) for Cognitive ed 9/25/14 revealed the tive deficits with a diagnosis of avioral Disturbance. The CAA and did communicate verbally mmunicate simple needs. The ated 9/25/14 revealed the o feed herself after tray set-up. ealed laboratory test results t revealed the resident ' s en (BUN) was 16 (Normal reatinine was 0.89 (Normal BUN and Creatinine reflect ys are working. re Plan dated 12/17/14 If or altered nutrition due to the or intake of food and fluids. for staff to encourage intake ent dated 12/17/14 revealed bor intake of food and fluids ations and personal care. m Data Set (MDS) 12/18/14 revealed the resident ye impairment but was			drawn on 1/27/15 to verify all abnorm lab results were reported to the physician/physician extender. D. A 100% audit will be completed on drawn from 1/28/15 to 2/9/15 to verif abnormal labs were reported to the physician/physician extender. 2. A. New process for notification of physician/physician extender concer abnormal/critical labs: Nursing will no longer call the physic office nurse concerning abnormal/cri labs. When there is a critical lab the physician/physician extender will be notified on the day the lab results red for additional orders if indicated. When there is an abnormal lab the physician/physician extender will be notified by the next day for additional orders if indicated. The Nurse who notified the physiciar the critical/abnormal labs will docum on the lab the physician's response. The labs with the documented respo will then be faxed to the physician/physician extender for furth review. B. All nurses will be in-serviced and in ursing employees will be in-serviced and in	n labs fy all ning tian's itical ceived l n of ent onses her new d	
	A Nursing Monthly	ating after tray set-up. Assessment Form dated e resident had a poor appetite.			prior to providing direct resident care concerning reporting critical/abnorma labs to the physician/physician exten C. Nurses who are non-compliant wi	al nder. ith	
	Review of physiciar	n ' s progress notes dated			reporting critical/abnormal labs to the physician will be counseled by nursir		

Facility ID: 970225

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		AND HUMAN SERVICES			ON		APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		345492	B. WING			(02 /1	C 19/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NC STAT	E VETERANS NURSI	NG HOME		_	14 COCHRAN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 327	Continued From pa	ge 23	F 3	27			
	resident with docun	e physician evaluated the nentation of wounds including lcer that had worsened with an			administration and receive additional education when indicated.	al	
	done on 1/28/15. T right lung base infilt the bottom of the re that read: "Faxed followed by the initia and called in the re 1/29/15 read: "Ney telephone r/t (relate results. There was telephone order (To antibiotic by mouth following signature: physician/name of nurse at facility that A laboratory (lab) re a Complete Blood (C at 6:00 AM. The res cell count (WBC) of normal range was I would indicate infect (normal range 0.50)	physician ' s nurse/name of			 A. A monitoring form has been dever for the notification of the physician concerning abnormal labs. The mon will be completed by the Interdisciplin Team Member(s). The monitoring will occur as follows At least 3 patients per unit (total of 9 patients) with critical labs/abnormal will be monitored along with notificar physician/physician extender of critic labs/abnormal labs for a duration of 4 times per week for 4 weeks 3 times per week for 4 weeks 2 times per week for 4 weeks 2 times per week for 4 weeks Then monthly for 3 months 4. Results of monitoring with tracking a trending will be reported by the Qua Assurance Coordinator (RN) month the Quality Assurance Committee for recommendations and suggestions improvements or changes. 	itoring inary : labs tion of cal : and lity ly to or	
	on 1/29/15 at 5:18 J stamped on the she 29 2015. " There w person who faxed t documentation in the results or that the p	labs were printed at the facility AM. There was information eet that read: "FAXED JAN vas not a time or initials of the he information. There was no ne nurse 's notes of the lab hysician was notified of the e no additional physician 's					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/20/2015 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345492	B. WING				C 19/2015		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
NC STAT	E VETERANS NURSI	NG HOME	214 COCHRAN AVENUE FAYETTEVILLE, NC 28301						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 327	orders related to the antibiotic order date there was an order hospital. There wer progress notes unti gave an order to se The Dietary Manag on 2/10/15 at 12:33 quite demented and since admission to greatest concern w would have 2 or 3 h but would not finish encouraged her to 6 would try to get her successful. The DM resident ice cream and the resident wo would not eat anym The Physician carin stated in an intervie he must have seen gave an order for a count. The Physicia what his response to Creatinine was and medical record. In a separate interv Physician stated he documentation rega BUN and Creatinine like it was addresse resident on an antik The Physician state	e test results after the ed 1/29/15 until 2/3/15 when to send the resident to the e no additional physician ' s I 2/3/15 when the physician nd the resident to the hospital. er (DM) stated in an interview PM that Resident #3 was d never had a great appetite the facility. The DM stated his as her fluid intake; the resident anything. The DM stated he drink and her family members to drink but they were not 1 stated he would take the that he knew the resident liked buld take several bites and		327					

Facility ID: 970225

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		AND HUMAN SERVICES				FORM	03/20/2015 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345492	B. WING				C 19/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
NC STAT	E VETERANS NURSI	NG HOME			14 COCHRAN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 327	intravenous (IV) flui would send the resi asked if he was aw drinking very well th aware the resident The physician was time but did not ans On 2/11/15 at 2:55 conducted with the Nurse stated her jo receive faxed inforr the physician. The I documentation for a the physician 's resistated she received morning of 1/29/15 x-ray. The Nurse st the x-ray to the phy she called the facili antibiotic. The Nurse any phone calls fron 1/30/15 with regard Nurse stated the fa call the office with a An interview was co Nursing (DON) and on 2/11/15 at 3:40 F lab results were to I office during office I physician when out stated the lab result the physician. Nurse #1 stated in a PM that she worked 1/29/15. The Nurse	ids and if that did not work ident to the hospital. When vare the resident was not ne Physician stated he was refused care and medications. asked the question a second	F 3	.27			

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			PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C			
		A. BUILDIN	G				
		345492	B. WING		02	/19/2015	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	ODE		
NC STAT	E VETERANS NURS	NG HOME		214 COCHRAN AVENUE FAYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 327	Continued From pa	-	F 32	7			
	review the lab resu 1/29/15. The Nurse work and would ha physician 's office	he Nurse was observed to Its printed at the facility on e stated she never saw the lab ve definitely called the with the high BUN and seen the lab results.					
	Nurse #2 stated in AM that he mostly Improvement) Nurs was up to date and morning. The Nurs labs with a faxed s The Nurse stated h and print all unprint Nurse stated on the off 31 lab results at machine at one tim physician ' s office. put all the lab resul would give to the n stated he did not de fax them to the phy stated he did not re labs on the morning	an interview on 2/12/15 at 8:14 worked with the QI (Quality se, made sure the lab book l printed off all the labs in the e stated he stamped all the tamp that included the date. he could go to the computer ted labs at one time. The e morning of 1/29/15 he printed hd put them all in the fax he and faxed them to the The Nurse stated he usually ts for each hall together and urse on the hall. The Nurse o anything with the labs except visician ' s office. The Nurse emember what he did with the g of 1/29/15. The Nurse stated hurses were to call critical lab					
	did this. The Nurse happened to the la the morning of 1/29 The DON stated in	an interview on 2/12/15 at					
	physician 's office facility any labs she Resident #3. The I received revealed to physician 's office	e with the nurse at the and asked her to fax to the had in the system for OON stated the labs she the labs were faxed to the on 1/29/15 at 7:42 AM. The iff should have made a phone					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE SURVEY COMPLETED		
		B. WING _		C 02/19/2015			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COE 214 COCHRAN AVENUE	DDE		
NC STAI	E VETERANS NORSI			FAYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 327	call to the physiciar abnormal lab result The DON stated in 4:45 PM the physic results to be faxed followed-up by a ph the lab results to th the nurse orders, if order to the facility. Review of the nurse Resident #3 becam room and was retur physician saw the r the resident to be d Review of the hosp Physical dated 2/3/ the ER (Emergency 60s/50, heart rate 1 Breathing and oxyg was found to be ve wants full code for the ICU (intensive of management. Phys Patient is now awal commands but not dehydrated. Laboratory Data: W count) 27,000, sodi chloride 111, BUN 1+ blood, trace of k esterase, WBC mo bacteria. Chest x-rate	an interview on 12/12/15 at ian wanted abnormal lab to the nurse in his office ione call and the nurse relayed e physician who would give any and the nurse called the e's notes revealed on 2/3/15 the unresponsive in the dining med to her room where the esident and gave an order for ischarged to the hospital. ital Admission History and 15 revealed the following: " In 7 Room) blood pressure of 00 and temperature 95.6. the saturation were normal but ry dehydrated. The family still this patient so patient will go to care unit) for further sical Examination: General: ke, following simple oriented and looks very (BC (serum white blood cell um 146, potassium 5.3, 101, creatinine 3.6. Urinalysis: etones, 3+ leukocyte re than 180, RBC 120, 3+ ay unremarkable. Assessment: tatus and is lethargic possibly		27			

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If continuation sheet Page 28 of 29

		AND HUMAN SERVICES				FORM	03/20/2015 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
345492			B. WING			C 02/19/2015			
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE	, ZIP CODE				
NC STAT	E VETERANS NURSI	NG HOME	214 COCHRAN AVENUE FAYETTEVILLE, NC 28301						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD O THE APPROPR	BE	(X5) COMPLETION DATE		
F 327	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 Acute renal failure, possibly from septic shock, dehydration and lack of oral intake. 4. Source of infection possibly the sacral ulcer as well as right in decubitus ulcer. Will give IV fluids. Patient responded to the IV fluids that were given in the ER. "		F 3						

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