| | | D HUMAN SERVICES | | | | FOR | APPROVED |
|--------------------------|--|--|--------------------|-----|---|---------------------------|----------------------------|
| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NC | <u>). 0938-0391</u> |
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , í | | CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
| | | 345492 | B. WING | | | | C / 31/2015 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 2 | 14 COCHRAN AVENUE | | |
| NCSIAIE | VETERANS NURSING F | IOME | | E | 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) COMPLETION DATE |
| F 281 SS=D | 483.20(k)(3)(i) SERV PROFESSIONAL STA | ICES PROVIDED MEET ANDARDS | F | 281 | | | 9/1/15 |
| | | d or arranged by the facility al standards of quality. | | | | | |
| | by: Based on observation interviews the facility Medication Administra accurately transcribed doctor ' s order for Ati and Resident # 2) of t whose medications w included: 1. Record review reve admitted to the facility diagnoses which inclu- the following: Cerebro Fibrillation, Vascular [| is not met as evidenced n, record review, and staff failed to assure that the ation Record had been d to reflect the medical van for two (Resident # 1 wo sampled residents ere reviewed. The findings ealed Resident # 1 was o on 4/17/15 with multiple uded but were not limited to ovascular Accident, Atrial Dementia, and a Seizure | | | GOOD FAITH ATTEMPT STATEMENT This time line investigation and plan of correction constitutes a written allegatio of substantial compliance with Federal and Medicaid requirements. Preparatio and/or execution of this correction do n constitute admission or agreement by th provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely becau it is required by the provision of the stat and federal law in order to remove | on n ot he se | |
| | (Minimum Data Set) a as having impaired co Record review reveal transferred to the hos initial admission to the as follows: The reside hospital on 6/21/15 ar on 7/7/15. The reside hospital on 7/8/15 and 7/13/15. Also on 7/18 | ed the resident had been pital multiple times since his e facility. Specific dates were ent was admitted to the nd readmitted to the facility nt was admitted to the d returned to the facility on /15 the resident was ital Emergency Room and | | | substantial noncompliance. It also demonstrates our good faith and desire continue to improve the quality of care and services to our residents. IMMEDIATE ACTION Medication administration records were reconciled with the narcotic sheets to validate that all residents had received their medications appropriately. METHOD TO IDENTIFY OTHERS The Clinical management team | | |
| | 7/13/15 the resident v Ativan 0.5 mg (milligra needed) for anxiety a hospital discharge me | return to the facility on vas ordered to receive ams) every day PRN (as ccording to the 7/13/15 edication list. Review of the SUPPLIER REPRESENTATIVE'S SIGNATURE | | | conducted an audit of all new admissions/readmissions for the previo 30 days to ensure all medications were transcribed correctly was started on 8/14/2015. | | (X6) DATE |

Electronically Signed

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.

08/22/2015

| | OF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | | | CONSTRUCTION | OMB NC | |
|---------------|-------------------------|--|---------------|----|---|------------|-----------|
| | CORRECTION | IDENTIFICATION NUMBER: | , <i>i</i> | | CONSTRUCTION | 1 Y / | LETED |
| | | | A. DOILDING | ° | | | С |
| | | 345492 | B. WING | | | 07/31/2015 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | 1 077 | 51/2015 |
| | | | | | 4 COCHRAN AVENUE | | |
| NC STATE | E VETERANS NURSING | НОМЕ | | | YETTEVILLE, NC 28301 | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | | (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | COMPLETIC |
| F 281 | Continued From pag | e 1 | F 28 | 81 | | | |
| | facility 's physician c | orders revealed the Ativan | | | 100% medication administration record | d | |
| | was incorrectly trans | | | | audit was completed on | | |
| | | ication when the resident | | | 8/5/2015.Identified issues will be revie | wed | |
| | | e facility on 7/13/15. On the | | | with the facility physician. | | |
| | | ent July MAR the Ativan was | | | | | |
| | | eduled medication to be | | | | | |
| | | AM and there was no | | | SYSTEMIC CHANGES | | |
| | | ow the facility had detected r and attempted to rectify it. | | | 1.Education began on 8/5/2015 by the DHS and/or the clinical nurse | | |
| | - | R there were multiple days | | | management team for all Licensed | | |
| | - | cumented they gave the | | | Nurses on medication administration. | | |
| | | s were blank. Specifically, | | | 2.Education will be conducted by the | | |
| | - | lays the resident was | | | Southeastern Regional Area Health | | |
| | documented as receipt | iving the Ativan as indicated | | | Education Center as to medication | | |
| | | /17/15, 7/19/15; 7/20/15; | | | administration and ethics on 8/31/2015 | 5. | |
| | | 3/15; 7/24/15; 7/27/15; | | | 3. Education on medication administra | ition | |
| | | . On the following dates | | | with emphasis on documentation of | | |
| | | the dates of 7/25/15 and | | | medication in the Medication Record a | ind | |
| | | for the date of 7/29/15 7/30/15 making it difficult to | | | Narcotic sheets will be conducted by United Pharmacy Services on 8/25/20 | 15 | |
| | | se was documenting she | | | 4.Clinical Management team will revie | | |
| | | t. On 7/18/15 the resident | | | the Medication Administration Records | | |
| | was documented as | | | | and Narcotic count sheets for accurate | | |
| | | M Nurse # 1 was interviewed | | | and complete documentation weekly x | : 4 | |
| | in regards to the resi | dent ' s Ativan which still | | | weeks then monthly thereafter. | | |
| | | R as a regularly scheduled 8 | | | | | |
| | | e # 1 stated she thought the | | | MONITORING PROCESS | | |
| | | l (as needed) but offered no | | | Narcotic sheets are reconciled with | | |
| | | had been documented as | | | Medication Administration Records to | | |
| | not clarified to read o | lays, omitted some days, and | | | ensure medications are accuratley documented on the Medication | | |
| | | sident 's MAR. By law Ativan | | | Administration Record. Medication | | |
| | | olled medication and nurses | | | Administration Records are reviewed | with | |
| | | when they remove an Ativan | | | the Narcotic sheets to ensure accurate | | |
| | | torage area prior to the | | | and complete documentation on the | | |
| | | Ativan. The following | | | Narcotic sheets. DHS and Quality | | |
| | | ew revealed the nurses were | | | Assurance nurse will review the finding | gs | |
| | | nt 's MAR they gave the | | | from the Medication Administration | | |
| | 1 A (* | nich there was no evidence | 1 | | Record audit. Findings from the audit | | 1 |

Facility ID: 970225

If continuation sheet Page 2 of 23

| | | | | | | <u>D. 0938-03</u> |
|--------------------------|---|---|---------------------|---|---------|---------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | | E SURVEY PLETED |
| | | | | | С | |
| | | 345492 | B. WING | | 07 | /31/2015 |
| NAME OF P | ROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| | VETERANS NURSING | | : | 214 COCHRAN AVENUE | | |
| NC STATE | VETERANS NURSING | HOME | I | FAYETTEVILLE, NC 28301 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETIO DATE |
| F 281 | Continued From page | e 2 | F 281 | | | |
| | | e medication and did so. | 1 201 | be presented by the Quality Assu | rance | |
| | | available, stored Ativan pills | | nurse to the monthly QAPI comm | | |
| | | lurse # 1 on 7/30/15 at 1:35 | | | | |
| | | Ativan doses left on the | | | | |
| | current Ativan card in use and this matched the resident 's " Controlled Drug Receipt and | | | | | |
| | | | | | | |
| | | n Form, " which would ontrolled Drug Receipt and | | | | |
| | | Form " was accurate. As | | | | |
| | | es had signed they had | | | | |
| | | an at 8 AM on the above | | | | |
| | | e resident ' s MAR. Review | | | | |
| | | Controlled Drug Receipt and | | | | |
| | - | orm " revealed the Ativan | | | | |
| | had been signed out | card only on four of the ten | | | | |
| | | led they gave it. Theses | | | | |
| | - | 7/22/15; 7/23/15; and | | | | |
| | · · · | indicate that the nurses were | | | | |
| | initialing they adminis | stered the Ativan on the MAR | | | | |
| | | cord of proof they had done | | | | |
| | | ent's Ativan "Controlled | | | | |
| | | cord of Disposition Form " | | | | |
| | | It the Ativan was signed out ut as noted above there was | | | | |
| | | nt 's MAR for the 25th. | | | | |
| | | she thought the Ativan was | | | | |
| | | d had no further explanation | | | | |
| | | AR not reconciling with the | | | | |
| | " Controlled Drug Re | | | | | |
| | | r why the medication still | | | | |
| | AM medication. | R as a regularly scheduled 8 | | | | |
| | | f Nursing) was interviewed at | | | | |
| | - | 12:50 PM about the inability | | | | |
| | | n doses on hand with the | | | | |
| | resident 's MAR. The | DON verified that nurses | | | | |
| | li ii i e | | 1 | 1 | | 1 |
| | | ng they were giving the nich they really had not | | | | |

Facility ID: 970225

If continuation sheet Page 3 of 23

| | | ND HUMAN SERVICES MEDICAID SERVICES | | | | FC | TED: 08/28/2015 DRM APPROVED NO. 0938-0391 |
|--------------------------|--|---|--|-----|---|-------------------------------|--|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 345492 | B. WING | | | | C 07/31/2015 |
| NAME OF P | ROVIDER OR SUPPLIER | • | • | STF | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | LOME | | 214 | COCHRAN AVENUE | | |
| NC STATE | E VETERANS NURSING H | HOME | | FA | YETTEVILLE, NC 28301 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 281 | talked with the nurses the impression that it though it was on the l medication. The DOI nurses would then sig yet not administer it. questioned why the m order if they thought i continued to see it on scheduled medication not been aware of the The DON stated that as the nurses remove medications they wou an acceptable manne from the administration they could recall and prepared and adminis 2. Record review reve admitted to the facility had multiple diagnose not limited to the follo Hypertension, Depres Joint Disease, and Hi Review of the physici resident was ordered (milligrams) twice per scheduled basis. The dated as 4/7/15. Review of Resident # at 9:15 AM revealed in administered the resi every day of the mon available, stored Ativa Nurse # 1 on 7/31/15 Ativan pills left on the and this matched the | DON stated that she had s and the nurses were under was a PRN medication even MAR as an 8 AM scheduled N was questioned why the gn they gave the Ativan and The DON was also nurses had not clarified the it was PRN and yet the MAR as a regularly h. The DON stated she had e problem until the survey. it was her expectation that ed and prepared the uld somehow flag the MAR in er so when they returned on of multiple medications verify they had actually stered each medication. ealed Resident # 2 was y on 5/29/12. The resident es which included but were owing: Dementia, ssion, Severe Degenerative istory of Left Hip Fracture. ian orders revealed the to receive Ativan 0.5 mg | F | 281 | | | |

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM APPROVED OMB NO. 0938-0391 | | |
|--------------------------|--|--|---------------------|---|----------------------------|------------------------------------|----------------------------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | | (X3) DATE COMF | | |
| | | 345492 | B. WING | | | | 31/2015 | |
| NAME OF P | ROVIDER OR SUPPLIER | | [| STREET ADDRESS, CITY, STATE, ZIP COL | DE | | | |
| NC STATE | EVETERANS NURSING H | IOME | | 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 Appropria | | (X5) COMPLETION DATE | |
| F 281 F 329 SS=D | indicate that the " Co Inventory Sheet, " wa resident's " Controll Sheet " could not be on the resident's MA had administered the dates and the " Cont Sheet " contained no nurses had removed cart: the 8 AM dose of 7/27/15; the 8 PM dos dose for 7/30/15. The inability to recond the " Controlled Subs was brought to the att 7/31/15 at 9:20 AM at look into it. The DON at 11 AM and 12:50 F nurses had been door the Ativan on days on administered it. 483.25(I) DRUG REG UNNECESSARY DRI Each resident's drug unnecessary drugs. drug when used in ex duplicate therapy); or without adequate mon indications for its use adverse consequence should be reduced or combinations of the re | ntrolled Substance as accurate. Review of the ed Substance Inventory reconciled with four dates JR. Nurses had initialed they Ativan on the following rolled Substance Inventory documentation that the the medication from the f 7/26/15; the 8 AM dose of se of 7/28/15; and the 8 AM cile the resident ' s MAR with stance Inventory Sheet " tention of the DON on nd she stated she would was interviewed at 7/31/15 PM and verified that the umenting they were giving which they really had not SIMEN IS FREE FROM JGS regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate g or in the presence of es which indicate the dose discontinued; or any | F 2 | | | | 9/1/15 | |

Facility ID: 970225

If continuation sheet Page 5 of 23

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | 1 APPROVED 0. 0938-0391 |
|--------------------------|--|---|---------------------|--|--|-----------------------------|----------------------------|
| STATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE | |
| | | 345492 | B. WING _ | | | (07/: | C 31/2015 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 2 | 14 COCHRAN AVENUE | | |
| NC STATE | VETERANS NURSING H | IOME | | F | AYETTEVILLE, NC 28301 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | EFIX (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) COMPLETION DATE |
| F 329 | therapy is necessary as diagnosed and door record; and residents drugs receive gradual behavioral interventio contraindicated, in an drugs. This REQUIREMENT by: Based on observation staff/family interviews Ativan administration doses were necessar for two (Resident # 1 sampled residents wh reviewed. The finding 1. Record review revea admitted to the facility diagnoses which inclu the following: Cerebro Fibrillation, Vascular ID Disorder. The residen (Minimum Data Set) a as having impaired co Record review reveal transferred to the hos initial admission to the as follows: The reside hospital on 6/21/15 ar on 7/7/15. The reside | to treat a specific condition cumented in the clinical who use antipsychotic dose reductions, and ns, unless clinically effort to discontinue these fort to discontinue these is not met as evidenced n, record review and the facility failed to provide monitoring to assure the y and correctly administered and Resident # 2) of two toose medications were s include: ealed Resident # 1 was on 4/17/15 with multiple ided but were not limited to by ascular Accident, Atrial Dementia, and a Seizure t was coded on his MDS assessment, dated 4/24/15 ognitive abilities. ed the resident had been pital multiple times since his e facility. Specific dates were ent was admitted to the not readmitted to the facility in twas admitted to the d readmitted to the d returned to the facility on | F3 | 329 | GOOD FAITH ATTEMPT STATEMENT This time line investigation and plan of correction constitutes a written allegatio of substantial compliance with Federal and Medicaid requirements. Preparatio and/or execution of this correction do n constitute admission or agreement by t provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely becau it is required by the provision of the sta and federal law in order to remove substantial noncompliance. It also demonstrates our good faith and desire continue to improve the quality of care and services to our residents. IMMEDIATE ACTION Medication administration records were reconciled with the narcotic sheets to validate that all residents had received their medications appropriately. | on ot he ise te | |
| | evaluated at the hosp returned that same da | ital Emergency Room and ay. | | | METHOD TO IDENTIFY OTHERS | | |

Facility ID: 970225

If continuation sheet Page 6 of 23

| - | | MEDICAID SERVICES | | | | 0938-03 |
|--------------------------|-------------------------------|---|---------------|--|--|-------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` <i>`</i> | PLE CONSTRUCTION G | (X3) DATE S COMPLI | |
| | | 345492 | B. WING | | С | |
| | | 545452 | | | | 1/2015 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, Z | IP CODE | |
| NC STATE | E VETERANS NURSING | HOME | | 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301 | | |
| | SUMMARY ST | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN | | (X5) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI | ACTION SHOULD BE TO THE APPROPRIATE | COMPLETIC DATE |
| F 329 | Continued From pag | e 6 | F 32 | 29 | | |
| | 1.0 | nt ' s current care plan | | The Clinical manageme | nt team | |
| | | entified "Resident is at risk | | conducted an audit of al | | |
| | | antianxiety drug use " as a | | admissions/readmission | - | |
| | | set date of 7/15/15 noted on | | 30 days to ensure all me | • | |
| | | were multiple care planned | | transcribed correctly wa | | |
| | | ncluded but were not limited | | 8/14/2015. | | |
| | to " Administer Resi | dent 's medication as | | 100% medication admin | istration record | |
| | ordered by physician | and " monitor resident ' s | | audit was completed on | | |
| | behavior. " | | | 8/5/2015.Identified issue | es will be reviewed | |
| | On 7/30/15 at 6:17 P | M NA (Nurse Aide) # 1 was | | with the facility physiciar | ו. | |
| | observed to go into F | Resident # 1 ' s room to set | | | | |
| | up his evening meal | tray. The NA could be heard | | | | |
| | outside from the hall | way setting the tray before | | SYSTEMIC CHANGES | | |
| | | A stepped out of the room | | 1.Education began on 8 | | |
| | | ered and found the resident | | DHS and/or the clinical i | | |
| | | ng a hard time staying awake | | management team for a | | |
| | | eyes while he ate. The | | Nurses on medication a | | |
| | | ons on his tray. The resident | | 2.Education will be conc | | |
| | | and the other had been | | Southeastern Regional | | |
| | | ice cream. The handle of the | | Education Center as to | | |
| | | ded upwards from the center | | administration and ethic | | |
| | | . Using one of his two | | 3. Education on medicat | | |
| | - | was attempting to scoop the | | with emphasis on docun | | |
| | | cup by dipping around the | | medication in the Medic | | |
| | - | down into the ice cream. The | | Narcotic sheets will be c | 2 | |
| | | ing to try to use one spoon other spoon, and his eyes | | United Pharmacy Servic 4.Clinical Management | | |
| | | attempted to do this. NA # | | the Medication Administ | | |
| | | he resident at 6:30 PM and | | and Narcotic count shee | | |
| | | resident. NA # 1 sat down to | | and complete document | | |
| | | also noted him to be | | weeks then monthly the | - | |
| | | ted she would go get a wash | | | | |
| | | ace to see if he would | | MONITORING PROCES | SS | |
| | | 1 was asked if she had | | Narcotic sheets are reco | | |
| | | nt to have any behavior | | Medication Administration | | |
| | | e had not. The NA stated he | | ensure medications are | accuratley | |
| | usually would feed hi | imself and she would check | | documented on the Mec | - | |
| | on him periodically. | | | Administration Record. | Vedication | |
| | | | | | | |

Facility ID: 970225

| | S FOR MEDICARE & | (X1) PROVIDER/SUPPLIER/CLIA | | | CONSTRUCTION | | O. 0938-03 |
|--------------------------|--------------------------|---|---------------------|--|---|------------|---------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | · / | E SURVEY IPLETED |
| | | | A. BUILDIN | NG | | С | |
| | | 345492 | B WING | B. WING | | 07/31/2015 | |
| | ROVIDER OR SUPPLIER | 040402 | | | REET ADDRESS, CITY, STATE, ZIP CODE | 0 | //31/2015 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | | | |
| NC STATE | VETERANS NURSING | НОМЕ | | | 4 COCHRAN AVENUE | | |
| | | | | FA | · | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETIO DATE |
| F 329 | 29 Continued From page 7 | | F 3 | 29 | | | |
| | | cian orders and MARS | | | the Narcotic sheets to ensure accurate | e | |
| | (medication administ | | | and complete documentation on the | - | | |
| f | · · | c dates to be noted: Review | | | Narcotic sheets. DHS and Quality | | |
| | of the resident 's Ma | | | Assurance nurse will review the findir | ngs | | |
| | monthly orders and t | | | from the Medication Administration | | | |
| | MARS revealed the r | | | Record audit. Findings from the audi | | | |
| | | g (milligrams) every day PRN | | | be presented by the Quality Assurance | | |
| | | ety. The PRN Ativan was | | | nurse to the monthly QAPI committee |) . | |
| | | g administered only one time | | | | | |
| | | 15. This date was noted to be | | | | | |
| | | sident 's readmission date of | | | | | |
| | | ed to receive the Ativan again of 0.5 milligram and again on | | | | | |
| | | xiety. According to the MAR | | | | | |
| | | documented as receiving | | | | | |
| | | or 7/8/15 before he was | | | | | |
| | | ne hospital on 7/8/15. Upon | | | | | |
| | | to the facility on 7/13/15 the | | | | | |
| | | the Ativan again in the | | | | | |
| | | gain on a PRN (as needed | | | | | |
| | basis.) Specifically th | his order was found on the | | | | | |
| | 7/13/15 hospital disc | harge medication list to read | | | | | |
| | |) 0.5 mg tablet Directions: 1 | | | | | |
| | | needed for anxiety. " | | | | | |
| | | 015 most recent physician | | | | | |
| | | Ativan was incorrectly | | | | | |
| | - | ularly scheduled daily | | | | | |
| | | resident was readmitted to | | | | | |
| | - | 5. On the resident 's most | | | | | |
| | - | Ativan was transcribed as a | | | | | |
| | | n to be given every day at 8 | | | | | |
| | | MAR there were multiple es documented they gave | | | | | |
| | | days were blank. These | | | | | |
| | | facility 's compliance date on | | | | | |
| | | ged that medications were | | | | | |
| | | ecific examples are on the | | | | | |
| | | | | | | | |
| | I tollowing ten davs wi | here the resident was | | | | | |

Facility ID: 970225

If continuation sheet Page 8 of 23

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | IO. 0938-039 | |
|---------------|--|--|---------------|--|--------------|--------------------|--|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | · , | PLE CONSTRUCTION | · · · | | |
| IND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | G | COM | MPLETED | |
| | | | | | | С | |
| | | 345492 | B. WING | | 0 | 7/31/2015 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | DE | | |
| | | | | 214 COCHRAN AVENUE | | | |
| NC STATE | E VETERANS NURSING | HOME | | FAYETTEVILLE, NC 28301 | | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF C | ORRECTION | (X5) | |
| PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE | COMPLETION DATE | |
| F 329 | Continued From pag | e 8 | F 32 | 29 | | | |
| | | /17/15, 7/19/15; 7/20/15; | 1 02 | | | | |
| | | 3/15; 7/24/15; 7/27/15; | | | | | |
| | | . On the following dates | | | | | |
| | | r the dates of 7/25/15 and | | | | | |
| | | for the date of 7/29/15 | | | | | |
| | | 7/30/15 making it difficult to | | | | | |
| | | se was documenting she | | | | | |
| | • | t. On 7/18/15 the resident | | | | | |
| | was documented as | | | | | | |
| | | M Nurse # 1 was interviewed | | | | | |
| | | dent 's Ativan. It was | | | | | |
| | observed at this time | | | | | | |
| | | R as a regularly scheduled | | | | | |
| | | ninistered at 8 AM. As noted | | | | | |
| | above the nurses ha | | | | | | |
| | | an at 8 AM on the above | | | | | |
| | noted ten days. Revi | | | | | | |
| | | eipt and Record Disposition | | | | | |
| | | been signed out from the | | | | | |
| | | d substance card only on four | | | | | |
| | | s the nurses initialed they | | | | | |
| | | s were: 7/20/15; 7/22/15; | | | | | |
| | - | . This review revealed the | | | | | |
| | | d administration of the | | | | | |
| | | d not match the controlled | | | | | |
| | | here the nurses would have | | | | | |
| | | for the removal of the drug | | | | | |
| | | ic/controlled substance box | | | | | |
| | | rt. Also, on the Controlled | | | | | |
| | | ecord of Disposition sheet | | | | | |
| | | at the Ativan was signed out | | | | | |
| | on 7/25/15 at 9 AM but as noted above there was a blank on the resident 's MAR for the 25th. | | | | | | |
| | | | | | | | |
| | Nurse # 1 stated that | t she thought the Ativan was | | | | | |
| | | d had no further explanation | | | | | |
| | of the initials on the MAR not reconciling | | | | | | |
| | Controlled Drug Rec | - | | | | | |
| | - | e medication still appeared | | | | | |
| | | | | | | | |

Facility ID: 970225

If continuation sheet Page 9 of 23

| | | ND HUMAN SERVICES MEDICAID SERVICES | | | | FOF | ED: 08/28/20 RM APPROVE O. 0938-039 |
|--------------------------|---|---|--------------------|-----|--|-------------------------------|---|
| STATEMENT C | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 345492 | B. WING | | | 07 | C 7/31/2015 |
| NAME OF PR | ROVIDER OR SUPPLIER | • | • | STI | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 214 | 4 COCHRAN AVENUE | | |
| NCSIALE | VETERANS NURSING | номе | | FA | YETTEVILLE, NC 28301 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 329 | Continued From page | e 9 # 1 was interviewed again on | F | 329 | | | |
| | 7/31/15 at 8:50 AM a resident had any beh | aviors. Nurse # 1 stated she resident to have any | | | | | |
| | behaviors or to be an Nurse # 2 was intervi | nxious. iewed on 7/31/15 at 8:30 PM. | | | | | |
| | 1. Nurse # 2 was que | did help care for Resident # estioned regarding any the resident might have and | | | | | |
| | | sident # 1 was very pleasant nown him to have any | | | | | |
| | NA # 2 was interview and questioned regard | red on 7/31/15 at 8:38 PM rding any behaviors or | | | | | |
| | resident had no beha | nad. NA # 2 stated the aviors at all. Interview with NA dent was concerned over his | | | | | |
| | | oblems with recently but he | | | | | |
| | Interview with the res 7/30/15 at 4:30 PM re | sident ' s responsible party on evealed the responsible party | | | | | |
| | involved in his care. | able about his condition and The family member stated | | | | | |
| | any spunk left anymo | he resident didn ' t have " ore "after multiple recent responsible party was | | | | | |
| | questioned about the | e resident 's history of being d responded that it had | | | | | |
| | needed basis. The re | I to be given on an as esponsible party stated that | | | | | |
| | recently that she felt | n hospitalized so many times he might be depressed but d that he needed the PRN | | | | | |
| | Ativan to be administ returned from the host | tered since he had last spital because he was so | | | | | |
| | - | f Nursing) was interviewed at d 12:50 PM about the inability | | | | | |
| | | n doses on hand with the | | | | | |

Facility ID: 970225

If continuation sheet Page 10 of 23

| | | | | | | IO. 0938-039 |
|--------------------------|-------------------------------|--|-------------|---|-------|----------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | · · · | E SURVEY |
| | | | A. BUILDING | | | С |
| | | 345492 | B. WING | ling | | |
| | ROVIDER OR SUPPLIER | 343432 | | STREET ADDRESS, CITY, STATE, ZIP COD | | 7/31/2015 |
| NAME OF PI | CONDER OR SUPPLIER | | | | E | |
| NC STATE | VETERANS NURSING | НОМЕ | | 214 COCHRAN AVENUE | | |
| | | | | FAYETTEVILLE, NC 28301 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY) | | PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO | | (X5) COMPLETION DATE |
| F 329 | Continued From pag | ie 10 | F 32 | 9 | | |
| | | the reason why the resident | 1 02 | | | |
| | | ceive the Ativan on a regular | | | | |
| | | ted she had reviewed the | | | | |
| | | ad been brought to her | | | | |
| | | eyor on 7/30/15 and that the | | | | |
| | • | nated on 7/13/15 when the | | | | |
| | resident returned to | the facility. The DON stated | | | | |
| | that the facility 's sys | stem for admitting a resident | | | | |
| | | ludes transcribing the | | | | |
| | | nd the steps were as follows. | | | | |
| | | ibe a resident 's medications | | | | |
| | | charge orders to a form | | | | |
| | | edication Reconciliation | | | | |
| | | then given to the physician | | | | |
| | | resident at the facility. The ws the form and decides to | | | | |
| | | scontinue the medications. | | | | |
| | | discontinuation of the | | | | |
| | | on the first form. Then a | | | | |
| | | lent 's medications are | | | | |
| | - | time to a facility physician | | | | |
| | | reconciliation form and | | | | |
| | | ian. The DON showed the | | | | |
| | surveyor Resident # | 1 's reconciliation form when | | | | |
| | the resident was rea | dmitted on 7/13/15 and | | | | |
| | | rred in the first transcription | | | | |
| | | irse transcribed the Ativan as | | | | |
| | U | d medication and not a PRN | | | | |
| | | ospital discharge orders had | | | | |
| | | ON stated that two nurses did | | | | |
| | done correctly, and t | st transcription had been | | | | |
| | | ON stated that she had also | | | | |
| | | of the inability to reconcile | | | | |
| | | ber of Ativan doses on hand | | | | |
| | | MAR. The DON stated that | | | | |
| | | involved. The DON verified | | | | |
| | | | | | | |
| | that the nurses had t | been documenting they were | | | | |

Facility ID: 970225

If continuation sheet Page 11 of 23

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED D. 0938-0391 | |
|--------------------------|--|--|--------------------|-----|---|-------------------|----------------------------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMF | E SURVEY PLETED | |
| | | 345492 | B. WING | | | C 07/31/2015 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | • | | STREET ADDRESS, CITY, STATE, ZIP CODE | · · | | |
| NC STATE | EVETERANS NURSING H | IOME | | | 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 PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 329 | not administer it. The talked with them and impression that it was DON was questioned sign they gave the Ati it. The DON was also had not clarified the o PRN and yet continue regularly scheduled m unable to give a rease The DON stated the r and she had not beer to the surveyor bringing thus she did not have would be documentin not give. 2. Record review reverse admitted to the facility had multiple diagnose not limited to the facility had mul | DON stated that she had the nurses were under the a PRN medication. The why the nurses would then van and yet not administer questioned why the nurses rder if they thought it was ed to see it on the MAR as a hedication. The DON was on why they had done so. hurses were new nurses, a ware of the problem prior ng it to her attention and an explanation why they g medication doses they did ealed Resident # 2 was on 5/29/12. The resident es which included but were wing: Dementia, asion, Severe Degenerative story of Left Hip Fracture. t's most recent care plan i dentified the resident to ression, Psychosis, xiety. The problem onset 18/15. The care plan also dent was at risk for side chotropic medication use. an orders revealed the to receive Ativan 0.5 mg day on a regularly origin of the order was erved on 7/30/15 at 8:40 | F | 329 | | | | |

Facility ID: 970225

If continuation sheet Page 12 of 23

| | | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | | PLE CONSTRUCTION | | 10. 0938-03 TE SURVEY |
|--------------------------|------------------------|---|---------------------|--|----------------------------|---------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | , <i>'</i> | | · · · | MPLETED |
| | | | | | | С |
| | | 345492 | B. WING | | 0 | 7/31/2015 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COL | | |
| | | | | 214 COCHRAN AVENUE | | |
| NCSIAIE | VETERANS NURSING | номе | | FAYETTEVILLE, NC 28301 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE APPROPRIATE | (X5) COMPLETIO DATE |
| F 329 | Continued From non | - 10 | | | | |
| F 329 | Continued From page | | F 3 | 29 | | |
| | | ean bed linens. Resident # 2 | | | | |
| | | orway during this time and kious when asked if her room | | | | |
| | | d stated she didn ' t want it to | | | | |
| | | w with the acting DON | | | | |
| | | on 7/31/15 at 12:50 PM | | | | |
| | | t exhibited severe anxiety at | | | | |
| | times. | | | | | |
| | The following observ | ation, interviews, and record | | | | |
| | | resident had not been | | | | |
| | receiving the Ativan a | as ordered. An observation of | | | | |
| | | an doses on hand in the | | | | |
| | | done with Nurse # 1 on | | | | |
| | | ind the doses correlated with | | | | |
| | | ance Inventory Sheet. | | | | |
| | | # 2 's July MAR on 7/31/15 | | | | |
| | | nurses had initialed they had ident ' s Ativan twice per day | | | | |
| | | ith. Some of the days the | | | | |
| | | they administered the Ativan | | | | |
| | | ed with the Controlled | | | | |
| | | Sheet to show the nurses | | | | |
| | - | t it as their initials on the | | | | |
| | - | Some specific examples | | | | |
| | | es had initialed they had | | | | |
| | administered the Ativ | an on the following dates: | | | | |
| | the 8 AM dose of 7/2 | 6/15; the 8 AM dose of | | | | |
| | | se of 7/28/15; and the 8 AM | | | | |
| | | ere was no documentation | | | | |
| | | ver removed from the locked | | | | |
| | | ubstance drawer of the | | | | |
| | | ose four times in order that | | | | |
| | the medication be give | | | | | |
| | - | cile the resident 's MAR with | | | | |
| | | ance Inventory Sheet was on of the DON on 7/31/15 at | | | | |
| | - | ted she would look into it. | | | | |
| | | interviewed at 7/31/15 at 11 | | | | |
| | AM and 12:50 PM ar | | | | | 1 |

Facility ID: 970225

If continuation sheet Page 13 of 23

| STATEMENT (| DF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | (X3) DATE SURVEY COMPLETED C 07/31/2015 | |
|--------------------------|---|---|---------------------|---|--|---------------------------|
| | | 345492 | B. WING | | | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD | | |
| NC STATE | VETERANS NURSING H | IOME | | 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETIO DATE |
| F 329 | had been documentir Ativan on days on wh administer it. | e 13 ng they were giving the nich they really did not | F 32 | | | |
| F 514 SS=D | 483.75(I)(1) RES RECORDS-COMPLE LE | TE/ACCURATE/ACCESSIB | F 51 | 4 | | 9/1/15 |
| | resident in accordance standards and practic | ed; readily accessible; and | | | | |
| | resident's assessmer services provided; the | the resident; a record of the nts; the plan of care and | | | | |
| | by: Based on observatio interviews the facility (Resident # 1 and Re residents ' medical re complete in relation to findings included: 1. Record review reve admitted to the facility diagnoses which inclu- the following: Cerebro Fibrillation, Vascular I Disorder. The resider (Minimum Data Set) a as having impaired co | esident # 2) of four sampled ecords were accurate and o their medications. The ealed Resident # 1 was y on 4/17/15 with multiple uded but were not limited to ovascular Accident, Atrial Dementia, and a Seizure ht was coded on his MDS assessment, dated 4/24/15 | | GOOD FAITH ATTEMPT STA This time line investigation an correction constitutes a writte of substantial compliance with and Medicaid requirements. F and/or execution of this corre constitute admission or agree provider of the truth of items a conclusions set forth for the a deficiencies. The plan of corre prepared and/or executed sol it is required by the provision and federal law in order to rer substantial noncompliance. It demonstrates our good faith a | nd plan of n allegation n Federal Preparation ction do not ement by the alleged or illeged ection is lely because of the state move also | |

Event ID: S4K711

Facility ID: 970225

If continuation sheet Page 14 of 23

| | | MEDICAID SERVICES | | | | | |
|--------------------------|--|---|---------------------|-----|---|-------|---------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | ONSTRUCTION | 1 Y / | E SURVEY PLETED |
| | | | A. BUILDIN | NG | | | |
| | | 345492 | B. WING | | | С | |
| | | 545492 | | | | 07 | /31/2015 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| NC STATE | VETERANS NURSING | НОМЕ | | | | | |
| | | | | FAT | ETTEVILLE, NC 28301 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | ĸ | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETIO DATE |
| F 514 | Continued From page | e 14 | F 5 | 514 | | | |
| | | spital multiple times since his | | | continue to improve the quality of care | ė | |
| | initial admission to th | e facility. Specific dates were ent was admitted to the | | | and services to our residents. | - | |
| | | nd readmitted to the facility | | | IMMEDIATE ACTION | | |
| | - | ent was admitted to the | | | Medication administration records we | re | |
| | hospital on 7/8/15 an | d returned to the facility on | | | reconciled with the narcotic sheets to | | |
| | 7/13/15. Also on 7/18 | 3/15 the resident was | | - | validate that all residents had receive | d | |
| | | bital Emergency Room and ay. The following information | | | their medications appropriately. | | |
| | to be noted below wit | th specific details revealed | | | METHOD TO IDENTIFY OTHERS | | |
| | four problems with th | | | · | The Clinical management team | | |
| | | ident #1 ' s medical record: | | | conducted an audit of all new | | |
| | | on error on the resident 's | | | admissions/readmissions for the prev | | |
| | - | one undetected; the resident | | | 30 days to ensure all medications we | e | |
| | | ninistration Record) had | | | transcribed correctly was started on 8/14/2015. | | |
| | · · | times when the resident he did not do so; an old | | | 100% medication administration reco | rd. | |
| | | d Administration Record) | | | audit was completed on | u | |
| | | intended to be in use had | | | 8/5/2015.Identified issues will be revie | ewed | |
| | documentation on da | | | | with the facility physician. | | |
| | | urrent MAR, and there were | | | | | |
| | multiple blanks for m | ultiple medications on the | | | | | |
| | resident 's current M | | | | SYSTEMIC CHANGES | | |
| | | und in regards to the resident | | | 1.Education began on 8/5/2015 by the | Э | |
| | | transcription error: Upon the | | | DHS and/or the clinical nurse | | |
| | | the facility on 7/13/15 the | | | management team for all Licensed | | |
| | | to receive Ativan 0.5 mg | | | Nurses on medication administration. | | |
| | (milligrams) every da anxiety according to | y PRN (as needed) for | | | 2.Education will be conducted by the | | |
| | | n list. Review of the facility 's | | | Southeastern Regional Area Health Education Center as to medication | | |
| | physician orders reve | | | | administration and ethics on 8/31/201 | 5. | |
| | | d as a regularly scheduled | | | 3. Education on medication administra | - | |
| | daily medication whe | | | | with emphasis on documentation of | - | |
| | | ility on 7/13/15. The DON | | | medication in the Medication Record | and | |
| | | was interviewed at 7/31/15 | | | Narcotic sheets will be conducted by | | |
| | | PM about the reason why the | | | United Pharmacy Services on 8/25/20 | | |
| | | d occurred. The acting | | | 4.Clinical Management team will revie | | |
| | | reviewed the record also | | | the Medication Administration Record | | |
| | since it had been bro | ught to her attention by the | | | and Narcotic count sheets for accurat | ^ | 1 |

Facility ID: 970225

If continuation sheet Page 15 of 23

| TATEMENT (| S FOR MEDICARE & | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIF | PLE CONSTRUCTION | | O. 0938-039 E SURVEY |
|--------------------------|-------------------------|--|---------------|--|--------------------------------|-------------------------|
| ND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 3 | COM | PLETED |
| | | 345492 | B. WING | | | C |
| | ROVIDER OR SUPPLIER | 575752 | | STREET ADDRESS, CITY, STATE, ZIP CO | | //31/2015 |
| | CONDER ON OUT FLER | | | 214 COCHRAN AVENUE | | |
| NC STATE | VETERANS NURSING | НОМЕ | | FAYETTEVILLE, NC 28301 | | |
| | SUMMARY ST | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF C | | (X5) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION CONTROL CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | COMPLETIO DATE |
| F 514 | Continued From pag | e 15 | F 51 | 4 | | |
| | | | 1.51 | | n wookly y 4 | |
| | originated on 7/13/15 | and that the initial error had when the resident returned | | and complete documentatio weeks then monthly thereaf | | |
| | - | ting DON stated that the | | MONITORING PROCESS | | |
| | | admitting a resident from the scribing the medications | | Narcotic sheets are reconcil | led with | |
| | - | vere as follows. The staff first | | Medication Administration R | | |
| | | 's medications from the | | ensure medications are acc | | |
| | | ders to a form entitled " | | documented on the Medicat | - | |
| | | Reconciliation Form. " This | | Administration Record. Med | lication | |
| | form is then given to | the physician who will care | | Administration Records are | reviewed with | |
| | for the resident at the | e facility. The physician then | | the Narcotic sheets to ensur | re accurate | |
| | | l decides to either continue | | and complete documentatio | | |
| | | edications. The continuation | | Narcotic sheets. DHS and C | • | |
| | | the medications is noted on | | Assurance nurse will review | - | |
| | | newly admitted resident 's | | from the Medication Adminis | | |
| | | scribed a second time to a | | Record audit. Findings from | | |
| | facility physician orde | | | be presented by the Quality | | |
| | | nd signed by the physician. | | nurse to the monthly QAPI of | committee. | |
| | reconciliation form w | e surveyor Resident # 1 ' s | | | | |
| | | 5 and stated an error | | | | |
| | | ranscription of the Ativan. | | | | |
| | | d the Ativan as a regularly | | | | |
| | | n and not a PRN medication | | | | |
| | | arge orders had been | | | | |
| | | ated that two nurses did not | | | | |
| | | inscription had been done | | | | |
| | • | or had gone undetected | | | | |
| | | are in regards to a nurse | | | | |
| | documenting on the | resident 's old MAR which | | | | |
| | - | on the day which the nurse | | | | |
| | - | it: The resident 's previous | | | | |
| | | ved with the DON. This MAR | | | | |
| | | s 7/7/15 facility admission | | | | |
| | | as sent back to the hospital | | | | |
| | | as confirmed with the DON | | | | |
| | that this MAR should | have only been in use for | | | | |
| | | d a new MAR had been | | | | |

Facility ID: 970225

If continuation sheet Page 16 of 23

PRINTED: 08/28/2015 FORM APPROVED

| | | MEDICAID SERVICES | | | | IO. 0938-039 | |
|--------------------------|--|---|---------------------|---|------------------------------|----------------------------|--|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | · · · · | TE SURVEY MPLETED | |
| | CONNECTION | IDENTIFICATION NOMBER. | A. BUILDING | 3 | | с | |
| | | | | | | | |
| | | 345492 | B. WING | | | 7/31/2015 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI | DE | | |
| NC STATE | VETERANS NURSING | HOME | | 214 COCHRAN AVENUE | | | |
| | | | | FAYETTEVILLE, NC 28301 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 514 | Continued From pag | e 16 | F 51 | | | | |
| F 514 | | | F 51 | 4 | | | |
| | | 7/15 MAR revealed that on | | | | | |
| | | nurse initialed off on the | | | | | |
| | | in addition to the current | | | | | |
| | | ven medications at 8 PM. | | | | | |
| | | ed through her initials on the | | | | | |
| | | had signed off nine different | | | | | |
| | | s questioned why the nurse | | | | | |
| and DOM | | ning on two different MARs | | | | | |
| | | hat she did not know. The | | | | | |
| | | old MAR typically was kept | | | | | |
| | on the current MAR book, turned backwards, and stapled and the nurse would have had to turn it | | | | | | |
| | forwards and unstapl | | | | | | |
| | | are in regards to the nurses | | | | | |
| | - | administration with no | | | | | |
| | - | istered the Ativan: By law | | | | | |
| | | a controlled medication and | | | | | |
| | | to sign when they remove an | | | | | |
| | | ocked storage area prior to | | | | | |
| | | the Ativan. The following | | | | | |
| | | ew revealed the nurses were | | | | | |
| | | ent 's MAR they gave the | | | | | |
| | | hich there was no evidence | | | | | |
| | - | ne medication and did so. | | | | | |
| | | available, stored Ativan pills | | | | | |
| | | Nurse # 1 on 7/30/15 at 1:35 | | | | | |
| | | Ativan doses left on the | | | | | |
| | | use and this matched the | | | | | |
| | | led Drug Receipt and | | | | | |
| | | n Form, " which would | | | | | |
| | - | ontrolled Drug Receipt and | | | | | |
| | | n Form " was accurate. As | | | | | |
| | | ses had signed they had | | | | | |
| | | an at 8 AM on the above | | | | | |
| | noted ten days on the | e resident ' s MAR. Review | | | | | |
| | | Controlled Drug Receipt and | | | | | |
| | | orm " revealed the Ativan | | | | | |
| | had been signed out | | | | | | |
| | | | | | | | |

Facility ID: 970225

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | F | TED: 08/28/2015 ORM APPROVED NO: 0938-0391 |
|--------------------------|--|--|--|-----|---|-----------|--|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) E | DATE SURVEY OMPLETED |
| | | 345492 | B. WING | | | | C 07/31/2015 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | STF | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 214 | COCHRAN AVENUE | | |
| NCSIAL | VETERANS NURSING I | IOME | | FA | YETTEVILLE, NC 28301 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 514 | dates were: 7/20/15; 7/24/15. This would i initialing they adminis when they had no rec so. Also, on the resid Drug Receipt and Re there were initials that on 7/25/15 at 9 AM b a blank on the reside DON (Director of Nur 7/31/15 at 11 AM and to reconcile the Ativat resident ' s MAR. The had been documentin Ativan on days on wh administered it. In addition to the Ativat current MAR there we when the MAR was re 1:15PM for other nor Specific medications were as follows: Lasiz per day)blanks were on 7/25/15, 7/26/15, 7 anticonvulsant medic ordered twice per day the 8 AM dose on 7/2 (10 mill equivalents to blank was observed of dose of 7/25/15; Mag administered twice per observed for the 8 AM D2 (50,000 Units to b blank was observed f also the nurse circled administration of the | led they gave it. Theses 7/22/15; 7/23/15; and indicate that the nurses were stered the Ativan on the MAR cord of proof they had done ent 's Ativan " Controlled cord of Disposition Form " it the Ativan was signed out ut as noted above there was int 's MAR for the 25th. The sing) was interviewed at 1 12:50 PM about the inability in doses on hand with the e DON verified that nurses ing they were giving the lich they really had not an blanks on the resident 's ere multiple blanks observed eviewed on 7/30/15 at in- controlled medications. and times that were blank x (40 mg dose ordered twice e observed for 8 AM doses 7/27/15, and 7/28/15; the ation of Keppra (1000 mg /)a blank was observed for 25/15; Potassium Chloride o be administered daily)-a on the MAR for the 8 AM nesium Oxide (400 mg to be er day)-a blank was A dose of 7/25/15; Vitamin ie given twice per day)-a for the 8 AM dose of 7/25/15; her initials for the Vitamin D2 on the 8 PM 9/15, and the 8 AM dose of | F | 514 | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | RINTED: 08/28/2015 FORM APPROVED MB NO. 0938-0391 |
|--------------------------|--|---|-------------------|-----|---|----------|---|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | CONSTRUCTION | (X | 3) DATE SURVEY COMPLETED |
| | | 345492 | B. WING | | | | C 07/31/2015 |
| NAME OF P | ROVIDER OR SUPPLIER | • | • | STF | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | IOME | | 214 | COCHRAN AVENUE | | |
| NC STAT | E VETERANS NURSING H | IOME | | FA | YETTEVILLE, NC 28301 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 514 | would have indicated given or it was held a on the back of the M/ documented. 2. Record review reve admitted to the facility had multiple diagnose not limited to the follo Hypertension, Depres Joint Disease, and Hi Review of the physici resident was ordered (milligrams) twice per scheduled basis. The dated as 4/7/15. Review of Resident # at 9:15 AM revealed f administered the resi every day of the mon available, stored Ativa Nurse # 1 on 7/31/15 Ativan pills left on the and this matched the Substance Inventory indicate that the " Co Inventory Sheet, " wa resident ' s " Controll Sheet " could not be on the resident ' s M/ had administered the dates and the " Cont Sheet " contained no nurses had removed cart: the 8 AM dose of 7/27/15; the 8 PM do dose for 7/30/15. The inability to recome | iven (the circled initials that the medication was not nd the reason documented AR). No reason was ealed Resident # 2 was y on 5/29/12. The resident es which included but were wing: Dementia, ssion, Severe Degenerative istory of Left Hip Fracture. an orders revealed the to receive Ativan 0.5 mg day on a regularly origin of the order was 2 2 's July MAR on 7/31/15 nurses had initialed they had dent 's Ativan twice per day th. All of the resident 's an pills were observed with at 9:15 AM. There were 24 c current Ativan card in use resident 's "Controlled Sheet, " which would | F | 514 | | | |

If continuation sheet Page 19 of 23

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|--|---|---------------------|-----|---|-----------|----------------------------|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | CONSTRUCTION | (X3) DATE | |
| | | 345492 | B. WING _ | | | | C 31/2015 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | ST | IREET ADDRESS, CITY, STATE, ZIP CODE | | |
| NC STATE | VETERANS NURSING H | IOME | | | 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 | K | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETION DATE |
| F 514 F 520 | 7/31/15 at 9:20 AM ar look into it. The DON at 11 AM and 12:50 P nurses had been door were giving the Ativar really had not adminis | tention of the DON on nd she stated she would was interviewed at 7/31/15 PM and verified that the umenting on the MAR they n on days on which they | F 5 | | | | 9/1/15 |
| SS=D | 483.75(0)(1) QAA COMMITTEE-MEMBI QUARTERLY/PLANS | | | 520 | | | 9/1/15 |
| | assurance committee nursing services; a ph | in a quality assessment and consisting of the director of hysician designated by the other members of the | | | | | |
| | issues with respect to and assurance activit develops and implem | ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of ified quality deficiencies. | | | | | |
| | | rds of such committee h disclosure is related to the ommittee with the | | | | | |
| | | y the committee to identify ficiencies will not be used as | | | | | |
| | This REQUIREMENT | is not met as evidenced | | | | | |

If continuation sheet Page 20 of 23

| | S FOR MEDICARE & | | | | | 8-039 | |
|--------------------------|-------------------------------|---|---------------------|---|---|------------------------|--|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | PLE CONSTRUCTION | (X3) DATE SURVE COMPLETED | | |
| | | | A. DOILDING | | C | с | |
| | | 345492 | B. WING | | 07/31/20 | 15 | |
| NAME OF PF | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | | | |
| | VETERANS NURSING | HOME | | 214 COCHRAN AVENUE | | | |
| NC STATE | VETERANS NORSING | HOME | | FAYETTEVILLE, NC 28301 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE COME THE APPROPRIATE D | (X5) PLETIO DATE | |
| F 520 | Continued From page | <u>-</u> 20 | F 52 | 20 | | | |
| 1 020 | | ons, record reviews and staff | F J2 | GOOD FAITH ATTEMPT | STATEMENT | | |
| | | 's Quality Assessment and | | This time line investigatio | - | | |
| | Assurance Committe | - | | correction constitutes a w | - | | |
| | | ures and monitor these | | of substantial compliance | | | |
| | | committee put into place in | | and Medicaid requiremen | | | |
| | June 2015. This was | s for two recited deficiencies | | and/or execution of this c | orrection do not | | |
| | which were originally | cited on a complaint | | constitute admission or ag | greement by the | | |
| | | ed on 6/23/15 and were | | provider of the truth of ite | • | | |
| | - | ompleted on 7/31/15. The | | conclusions set forth for t | - | | |
| | | he areas of medication | | deficiencies. The plan of | | | |
| | | bring and maintenance of | | prepared and/or executed | | | |
| | - | te medical records. The ne facility during two federal | | it is required by the provis and federal law in order to | | | |
| | | by a pattern of the facilities | | substantial noncomplianc | | | |
| | | effective Quality Assurance | | demonstrates our good fa | | | |
| | Program. | | | continue to improve the q | | | |
| | | | | and services to our reside | - | | |
| | Findings included: | | | | | | |
| | | | | IMMEDIATE ACTION | | | |
| | This tag is cross refe | rred to: | | Medication administration | | | |
| | | | | reconciled with the narcot | | | |
| | | observation, record review | | validate that all residents | | | |
| | | views the facility failed to | | their medications appropr | lately. | | |
| | | istration monitoring to | | METHOD TO IDENTIFY | | | |
| | | re necessary and correctly (Resident # 1 and Resident | | The Clinical management | | | |
| | # 2) of two sampled | • | | conducted an audit of all | | | |
| | medications were rev | | | admissions/readmissions | | | |
| | | | | 30 days to ensure all med | | | |
| | The facility was recite | ed for F 329 for failing to | | transcribed correctly was | | | |
| | - | ation monitoring for Resident | | 8/14/2015. | | | |
| | | d in the June 23, 2015 | | 100% medication adminis | stration record | | |
| | complaint investigation | | | audit was completed on | | | |
| | | g in relation to his Dilantin. | | 8/5/2015.Identified issues | | | |
| | | llow up survey the facility | | with the facility physician. | | | |
| | | an medication administration | | | | | |
| | monitoring for Reside | | 1 | | | | |
| | 5 | | | SYSTEMIC CHANGES | | | |

Facility ID: 970225

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| | OF DEFICIENCIES | MEDICAID SERVICES | (X2) MULTI | PLE (| CONSTRUCTION | T | <u>10. 0938-039</u> TE SURVEY |
|--------------------------|---|---|---------------------|-------|---|-----------------|----------------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | , , | | | 1 Y Z | MPLETED |
| | | | B. WING | | | C 07/31/2015 | |
| | | 345492 | | | | | |
| NAME OF PI | ROVIDER OR SUPPLIER | • | | | | | |
| | VETERANS NURSING | HOME | | 21 | 4 COCHRAN AVENUE | | |
| NC STATE | VETERANS NORSING | HOME | | FA | AYETTEVILLE, NC 28301 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETIOI DATE |
| F 520 | Continued From pag | e 21 | F 52 | 20 | | | |
| | and staff interviews t | observation, record review, he facility failed to assure nd Resident # 2) of four | | | DHS and/or the clinical nurse management team for all Licensed Nurses on medication administration. | | |
| | | medical records were | | | 2.Education will be conducted by the | | |
| | accurate and comple | | | | Southeastern Regional Area Health | | |
| | medications. | | | | Education Center as to medication | | |
| | | | | | administration and ethics on 8/31/201 | ••• | |
| | | ed for F 514 for failing to d complete medical records. | | | Education on medication administra with emphasis on documentation of | ation | |
| | | ivestigation of June 23, 2015 | | | medication in the Medication Record | and | |
| | ÷ . | for F 514 for failing to assure | | | Narcotic sheets will be conducted by | | |
| | medical records were complete regarding | | | | United Pharmacy Services on 8/25/20 | 15. | |
| | | edication administration. | | | 4. Clinical Management team will revie | | |
| | During the complaint | | | | the Medication Administration Record | | |
| | | failed to assure Resident # 1 's MAR were accurate and | | | and Narcotic count sheets for accurat and complete documentation weekly | | |
| | complete. | S MAR were accurate and | | | weeks then monthly thereafter. | Κ4 | |
| | | | | | MONITORING PROCESS | | |
| | | | | | Narcotic sheets are reconciled with | | |
| | | interviewed on 7/31/15 at | | | Medication Administration Records to | | |
| | | oned about the facility ' s forts to correct the deficient | | | ensure medications are accuratley documented on the Medication | | |
| | | g the facility 's complaint | | | Administration Record. Medication | | |
| | | 15. The DON stated that | | | Administration Records are reviewed | with | |
| | | facility only for the past two | | | the Narcotic sheets to ensure accurat | е | |
| | | acility had implemented the | | | and complete documentation on the | | |
| | | t she had discovered that | | | Narcotic sheets. DHS and Quality | a a | |
| | | lved than just in servicing the oblem and doing quality | | | Assurance nurse will review the findin from the Medication Administration | ys | |
| | | he DON stated since she | | | Record audit. Findings from the audit | will | |
| | | ling she had been busy | | | be presented by the Quality Assurance | | |
| | | to take more of the work | | | nurse to the monthly QAPI committee | | |
| | | irses so that they could have | | | | | |
| | | ntive to their medication | | | | | |
| | | ocumentation. The DON | | | | | |
| | | in services on a regular basis ed that time was a factor in | | | | | |
| | the facility 's failure t | | | | | | |

If continuation sheet Page 22 of 23

| | OMB NO. 0938-0391 TIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED |
|--|---|
| A. BUI | |
| 345492 B. WIN | C 07/31/2015 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
| NC STATE VETERANS NURSING HOME | |
| | FAYETTEVILLE, NC 28301 |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR TAG REGULATORY OR LSC IDENTIFYING INFORMATION) T | FIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION |
| F 520 Continued From page 22 practice. The DON stated that although routines had been developed to decrease the medication nurses' workload and the staff had been in serviced, she perceived they needed someone to actually follow along with them on a daily basis and stand by them as they learned to correct some of the deficient practice observed. | 520 |

Facility ID: 970225

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