DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u> </u>
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			COMF	E SURVEY PLETED
		345531	B. WING				C / 27/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	21/2010
NC STATE	E VETERANS HOME - SA	LISBURY			01 BRENNER AVE, BUILDNG #10		
_	1			SA	LISBURY, NC 28145		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
	conducted on 06/24/2 The facility was found requirement CFR483 Preparedness. Even						
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-	(3)(8)	F 5	61			7/19/19
	promote and facilitate through support of re-	right to and the facility must resident self-determination sident choice, including but ts specified in paragraphs (f)					
	activities, schedules (waking times), health						
		ident has a right to make s of his or her life in the cant to the resident.					
	with members of the	ident has a right to interact community and participate in poth inside and outside the					
	religious, and commu interfere with the right facility.	ident has a right to stivities, including social, inity activities that do not ts of other residents in the is not met as evidenced					
LABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	 E		TITLE		(X6) DATE
	cally Signed						07/22/2019

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.

		ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 07/29/2019 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345531	B. WING			C)6/27/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				1601 BRENNER AVE, BUILDNG #10)	
NC STATE	VETERANS HOME - SA	LISBURY		SALISBURY, NC 28145		
(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	TION SHOULD BE	(X5) COMPLETION DATE
F 561	Continued From page	e 1	F 5	61		
	interviews and record honor the beverage p (Resident #12) review The findings included Resident #12 was ad 09/26/2017 with diag limited to Type 2 Dial complications. Review of the Minimu was a Significant Cha revealed Resident #1 cognition. The MDS supervision with set of meals. An observation was of service on 06/24/19 a #12. The meal tray of instructions, Lactaid I written underneath it. with Fat Free Milk on was observed to be set An observation was of service on 06/25/19 a #12. The meal tray of instructions, Lactaid I observed with Fat Free Lactaid Milk was obs resident. An interview was con	I: mitted to the facility on noses that included but not betes Mellitus without um Data Set (MDS) which ange dated 03/28/2019 2 had moderate impaired further revealed he required up help only for eating his conducted of the lunch meal at 12:51 PM for Resident eard read under special Milk and the word "out" was Resident was observed his tray and no Lactaid Milk served to resident. conducted on the lunch meal at 12:47 PM for Resident eard read under special Milk. Resident was ee Milk on his tray and no		This Plan of correction co written allegation of comp Preparation and submissic correction does not constit admission or agreement b the truths of the conclusion the corrections of the comp forth on the statement of of plan of correction is prepa- submitted solely because under state and federal la The facility failed to meet (1)-(8) self-determination provide the beverage pref Resident #12. The corrective action for F was accomplished by the and the dietary manager of Milk from Sysco foods on Process that lead to defici The Dietary Manager faile Lactaid Milk. The Dietary Manager faile the Registered Dietician to Fat free milk was a suitab Lactaid Milk. The process for implement acceptable Plan of Correct specific deficiency are as 100% Audit of Resident P completed and verified on The dietary manager will of Lactaid milk per order. The dietary manager will of orders to verify receipt of	liance. on of the plan of itute an oy the provider of ons alleged or clusions set deficiencies. The ared and of requirements w. CFR 483.10(f) by failing to ference of Resident #12 administrator obtaining Lactaid 6/26/2019. iency. ed to order ed to consult with o determine if le substitute for natation of the ction for the follows. Preferences of 7/19/18. order 4 cases of	
		s to have Lactaid Milk at		items.		

Facility ID: 000488

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
					С	
		345531			06/27/2019	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATI	E VETERANS HOME - SA	LISBURY		1601 BRENNER AVE, BUILDNG #10 SALISBURY, NC 28145		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO	
F 561	every meal related to #12 further stated that milk at every meal and because he could not when he drank regulat loose bowel moveme Resident #12 stated to but preferred Lactaid During an interview w 12:47 PM, she reveal preferred Lactaid Milk not available to be set free milk was given a During an interview w 08:01 AM, she reveal choice was to drink L facility was out of it, s in its place. Interview with Registe 06/26/19 at 04:24 PM not an appropriate su RD said he was awar preference for Lactaid During an interview w on 06/27/19 at 01:20 out of Lactaid Milk ov forgot to order it. An interview was con Nursing (DON) and th at 04:25 PM. During stated it was disappo	his preference. Resident the was getting Fat Free d he had to "turn it away" t drink it. He expressed that ar milk it caused him to have nts. Furthermore, that he loved to drink milk Milk. with NA #1 on 06/25/19 at led that Resident #12 c and that Lactaid Milk was rived to the resident and fat s alternative. with NA #2 on 06/26/19 at led that Residents #12's actaid Milk and that the to he was given fat free milk ered Dietician (RD) on I revealed fat free milk was ibstitution for Lactaid Milk. e of Resident #12's d Milk. with Dietary Manager (DM) PM, DM stated that they ran er the weekend and he ducted with the Director or he Administrator on 06/27/19 this interview the DON inting that the Lactaid Milk be served to Resident #12 in	F 561	The dietary manager will monitor tra 4 days a week to ensure that trays accurate. All dietary staff completed 100% education on 6/28/2019 to read and every tray, ensuring accuracy to ea Veterans likes and dislikes, and spe requests and to inform the Dietary Manager when running low on said The title of the person responsible f implementing the acceptable Plan of Correction. The Administrator/Dieta Manager/designee. is responsible for implementing the acceptable Plan of Correction	i initial ch ecial items. or of ry or	

Facility ID: 000488

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	ECONSTRUCTION		TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED
						С
		345531	B. WING		06/27/2019	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
NC STATE	VETERANS HOME - SA	LISBURY		1601 BRENNER AVE, BUILDNG #10 SALISBURY, NC 28145		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 656	Continued From page	23	F 656			
F 656 SS=D		Comprehensive Care Plan	F 656			7/19/19
	implement a compret care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The con describe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483. provided due to the re under §483.10, include treatment under §483. (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside (iv)In consultation wit resident's representa (A) The resident's good desired outcomes.	cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's I mental and psychosocial ied in the comprehensive mprehensive care plan must Q - are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized a the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)-				
	whether the resident's community was asse	ilities must document s desire to return to the ssed and any referrals to s and/or other appropriate				

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		ID HUMAN SERVICES MEDICAID SERVICES					1 APPROVE 0. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				LETED
		345531	B. WING				C 27/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE	VETERANS HOME - SA	LISBURY			01 BRENNER AVE, BUILDNG #10 ALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 656	entities, for this purper (C) Discharge plans i plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on observatio interview, the facility f plans for 4 of 17 sam #57, Resident #44, R #64) reviewed for car The Findings Includer 1. Record review ret admitted on 5/30/17 v diabetes, hypertensiv failure, and chronic d failure Review of the most ret (MDS) dated 5/21/19 needed extensive ass transfers and toileting eating. Review of the care pl Resident #57 reveale nutrition and significa intake with meals. Ap diet as ordered and p and calorie packed ic On 6/27/19 at 8:15 ar #57's breakfast meal not receive magic cup	 by Se. In the comprehensive care in accordance with the in paragraph (c) of this is not met as evidenced In, record review and staff failed to implement care pled residents (Resident esident #11 and Resident e plans. d: vealed Resident #57 was with diagnosis that included the heart disease with bed mobility, and was independent with an updated 5/21/19 for the apotential for alteration in in tweight loss with poor opproaches included, serve rovide magic cup (a protein e cream) at all meals. n observation of Resident did 	F	656	The title of the person responsible for implementing the acceptable Plan of Correction. The Administrator/Dietary Manager/designee. is responsible for implementing the acceptable Plan of Correction. The facility failed to develop/implemer comprehensive care plan CFR483.210 by failing to provide magic cups for resident #57. The corrective action for resident #57 accomplished by the administrator and dietary manager obtaining Magic Cup from Sysco Foods 6/28/2019. The process for implementation the acceptable Plan of Correction for the specific deficiency was accomplished the Administrator/Director of Health Services/Dietary manager on 7/19/19 as follows. 100% audit of veteran □s supplements was completed on 6/28/2019. On 7/19/2019 a monitoring tool was created and utilized by the Administrat /designee to collect data weekly on all veterans with supplements and discus with the Interdisciplinary Team. On 6/28/2019 a supplement monitorin tool was created and utilized by the dietary manager/designee to ensure s	nt (b)1 was d s by was s tor ssed g	

Event ID: X1LB11

Facility ID: 000488

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/29/2019 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	COM	E SURVEY PLETED
		345531	B. WING			C 06/27/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	E VETERANS HOME - SA			16	601 BRENNER AVE, BUILDNG #10		
No olivite				S	ALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From page	e 5	F	656			
	supplement. On 06/27/19 01:14 Pl Resident #57's lunch did not receive magic is typed on the meal of beside it. 2. A record review of resident was admitted that included diagnost following cerebral infa hemiplegia following and atrial fabulation. Review of the most re (MDS) dated 5/13/19 cognitively impaired. total assistance with l and bladder. It also s	M an observation of meal tray showed resident cup on his tray. Magic Cup card and "OUT" was written Resident #44 revealed d on 3/7/19 with diagnosis sis that included hemiplegia arct affecting left side, infarct affecting right side ecent Minimum Data Set revealed resident was It showed resident needed bed mobility, bathing, bowel showed that resident was on	Quality Assurance Performance Improvement meeting weekly a reported to the administrator ar designee weekly for 3 months to monthly ongoing.The title of the person responsi implementing the acceptable P Correction. The Administrator/ID Manager/designee. is responsi implementing the acceptable P Correction.The facility failed to develop/im comprehensive care plan CFR4 by failing to provide magic cups resident #44.The corrective action for reside accomplished by the administrator		The title of the person responsible for implementing the acceptable Plan of Correction. The Administrator/Dietary Manager/designee. is responsible for implementing the acceptable Plan of Correction. The facility failed to develop/impleme comprehensive care plan CFR483.21 by failing to provide magic cups for resident #44. The corrective action for resident #44 accomplished by the administrator an	nt (b)1 was d	
	alteration in nutrition Vascular Accident. A included dietary supp An observation of Re on 6/27/19 at 1:15pm tray. Resident's lunch resident was to receive supplement. Magic C card and "OUT" was During an interview w 1:20pm on 6/27/19, h of Magic Cups over th	included potential for related to recent Cerebral pproaches to the care plan elements as ordered. sident #44's lunch meal tray a showed no magic cup on h meal card revealed that we a magic cup as a Cup is typed on the meal			dietary manager obtaining Magic Cup from Sysco Foods 6/28/2019. The process for implementation the acceptable Plan of Correction for the specific deficiency was accomplished the Administrator/Director of Health Services/Dietary manager on 7/19/19 as follows. 100% audit of veteran s supplement was completed on 6/28/2019. On 7/19/2019 a monitoring tool was created and utilized by the Administra /designee to collect data weekly on al veterans with supplements and discus with the Interdisciplinary Team. On 6/28/2019 a supplement monitorir tool was created and utilized by the dietary manager/designee to ensure s supplement is on tray. The results fro	by was s tor I ssed ng said	

Facility ID: 000488

If continuation sheet Page 6 of 16

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/29/2019 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		PLETED
		345531	B. WING			C 06/27/2019	
NAME OF P	ROVIDER OR SUPPLIER		-	ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE	E VETERANS HOME - SA	LISBURY			301 BRENNER AVE, BUILDNG #10 ALISBURY, NC 28145		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	were no substitutions contact the dietitian a Magic Cup. An interview was con Administrator on 6/27 stated that resident c 3. Resident #11 was 1/15/16 with a diagno Renal failure, Demen disturbance, Anxiety, Diabetes mellitus with Essential hypertension The quarterly Minimu assessment dated 3// #11 was cognitively in extensive assistance Resident #11's Care revealed he was at ris status. The interventi supplements as orde day and Register Die An observation on 06 Resident # 11 during observe a magic cup ticket indicated reside on the breakfast mea An observation on 06 no magic cup on mea meal ticket it stated o the side. Record review of Sig	 a offered and he did not about substitutions for the ducted with the 7/19 at 5:30pm and she are plans are to be followed. admitted to the facility on osis that including Chronic tia with behavioral Depression, Type 2 nout complication and on. m Data Set (MDS) 27/2019 indicated Resident mpaired and required the of 1 for eating. Plan dated 7/4/2018 sk for altered nutritional ons included dietary red, magic cup three times a titian consult as needed. 7/27/19 at 08:10 AM revealed breakfast meal. Did not on meal tray and meal tray ent was to have a magic cup I tray. i/27/19 at 1:15 PM revealed al tray and noted that on out of magic cup written to 	F6	556	the monitoring tool will be forwarded Quality Assurance Performance Improvement meeting weekly and reported to the administrator and or designee weekly for 3 months then monthly ongoing. The title of the person responsible for implementing the acceptable Plan of Correction. The Administrator/Dietary Manager/designee. is responsible for implementing the acceptable Plan of Correction. The facility failed to develop/impleme comprehensive care plan CFR483.21 by failing to provide magic cups for resident #11. The corrective action for resident #11 accomplished by the administrator and dietary manager obtaining Magic Cup from Sysco Foods 6/28/2019. The process for implementation the acceptable Plan of Correction for the specific deficiency was accomplished the Administrator/Director of Health Services/Dietary manager on 7/19/19 as follows. 100% audit of veteran supplement was completed on 7/19/2019. On 7/19/2019 a monitoring tool was created and utilized by the Administra /designee to collect data weekly on a veterans with supplements and discu with the Interdisciplinary Team. On 6/28/2019 a supplement monitor tool was created and utilized by the dietary manager/designee to ensure	nt (b)1 was id os by was s ator Il ssed ng said	
	meal ticket it stated o the side. Record review of Sig check list form dated	ut of magic cup written to nificant weight loss/gain			with the Interdisciplinary Team. On 6/28/2019 a supplement monitori tool was created and utilized by the	ng said m	

Facility ID: 000488

If continuation sheet Page 7 of 16

		MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-039
		IDENTIFICATION NUMBER:	`		. ,	IE SURVEY MPLETED
				·		С
		345531	B. WING		0	6/27/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		
				1601 BRENNER AVE, BUILDNG	#10	
NC STATE	VETERANS HOME - SA	ALISBURY		SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 656	Continued From pag	e 7	F 65			
1 000	all meals.	e /	F 00		ormanco	
	an medis.			Quality Assurance Performance Improvement meeting v		
	During an interview v	with the dietary manager at		reported to the administ	-	
		ne stated the facility ran out		designee weekly for 3 r		
		he weekend and he had		monthly ongoing.		
		ore. He further stated there				
		offered and he did not		T I 6 111 6 11 14 1		
		about substitutions for the		The facility failed to dev comprehensive care pla		
	Magic Cup.			by failing to provide ma		
	An interview was cor	nducted with the		resident #64.	gie cups for	
		rector of Nursing on 6/27/19		The corrective action fo	or resident #64 was	
	at 5:30pm and they s	stated the Care plan		accomplished by the ac	ministrator and	
	interventions were al	ways to be implemented.		dietary manager obtain		
				from Sysco Foods 6/28		
				The process for implem		
				acceptable Plan of Corr specific deficiency was		
				the Administrator/Direct		
				Services/Dietary manag		
	4. Resident #64 was	admitted to the facility on		as follows.		
	9/2/17 with diagnose	s that included middle		100% audit of veteran	s supplements	
		ovascular accident (CVA),		was completed on 7/19		
		eimer's, dementia, coronary		On 7/19/2019 a monitor	•	
) w/o angina, hemiplegia due		created and utilized by		
	vascular disease.	pertension, and peripheral		/designee to collect data veterans with suppleme		
		recent quarterly minimum		with the Interdisciplinary		
		d 5/28/2019 documented the		On 6/28/2019 a supple		
	· · ·	ely impaired. His MDS		tool was created and ut	•	
		eceived anticoagulation		dietary manager/design		
	therapy 7 out of 7 da	ys.		supplement is on tray.		
	Deview of the same a	lan data 5/20/2010 revealed		the monitoring tool will I		
	Review of the care p Resident #64 was at	lan date 5/30/2019 revealed		Quality Assurance Performance Improvement meeting v		
	excessive bruising di			reported to the administ	-	
		ipy related to his diagnosis of		designee weekly for 3 r		
	-	interventions included		monthly ongoing.		
		red and notify physician (MD)				

Facility ID: 000488

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/29/2019 / APPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345531	B. WING				C 27/2019
NAME OF PR	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	-	
NC STATE	VETERANS HOME - SA	LISBURY			301 BRENNER AVE, BUILDNG #10 ALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page of any abnormal labs.		F	656			
	Resident #64 revealed stated hematocrit and	d a clarification order that I hemoglobin (H&H) every 2 019. Indication was listed as					
	Further record review been drawn on 6/11/2	revealed the labs had not 2019 or 6/25/2019.					
		PM administration stated the labs were immediately					
F 658 SS=D	Services Provided Me CFR(s): 483.21(b)(3)(eet Professional Standards (i)	F	658			7/19/19
	as outlined by the cor must- (i) Meet professional s	d or arranged by the facility, nprehensive care plan,					
	Based on observation observations and staft to provide a nutritional	f interview the facility failed Il supplement ordered by the sidents (Resident #57,			The facility failed to develop/implement comprehensive care plan CFR483.21(the by failing to provide magic cups for resident #57. The corrective action for resident #57 version and the provide action for resident #57 version and the provide the second se	o)1 vas	
	The findings included				accomplished by the administrator and dietary manager obtaining Magic Cups from Sysco Foods 6/28/2019.		
	admitted on 5/30/17 v diabetes, hypertensiv	vealed Resident #57 was vith diagnosis that included e heart disease with heart astolic (congestive) heart			The process for implementation the acceptable Plan of Correction for the specific deficiency was accomplished be the Administrator/Director of Health Services/Dietary manager on 7/19/19 was follows.	-	

Event ID: X1LB11

Facility ID: 000488

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			()(0) 1			<u>38-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURV COMPLETED	
			A. BOILDING		с	
		345531	B. WING		06/27/20)19
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				1601 BRENNER AVE, BUILDNG #10		
NC STATE	VETERANS HOME - SA	LISDURT		SALISBURY, NC 28145		
(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 SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE CON	(X5) IPLETIC DATE
F 658	Continued From page	e 9	F 65	8		
		ecent Minimum Data Set		100% audit of veteran⊡s supple	ments	
		showed Resident #57		was completed on 6/28/2019.		
		sistance with bed mobility,		On 7/19/2019 a monitoring tool v		
	-	g and was independent with		created and utilized by the Admi		
	eating.			/designee to collect data weekly		
	Poviow of the care pl	an updated 5/21/19 for		veterans with supplements and o with the Interdisciplinary Team.	discussed	
	-	ed a potential for alteration in		On 6/28/2019 a supplement mor	nitoring	
		nt weight loss with poor		tool was created and utilized by		
		oproaches included, serve		dietary manager/designee to ens		
		rovide magic cup (a protein		supplement is on tray. The resul		
	and calorie packed ic	e cream) at all meals.		the monitoring tool will be forwar	ded to the	
				Quality Assurance Performance		
		Order dated 5/21/19 ordered als for poor oral intake and		Improvement meeting weekly an reported to the administrator and		
	significant weight loss	-		designee weekly for 3 months th monthly ongoing.		
	On 6/27/19 at 8:15 ar	n observation of Resident		The title of the person responsib	le for	
		tray revealed resident did		implementing the acceptable Pla		
	not receive magic cu			Correction. The Administrator/Di	-	
		ent #57's meal card revealed		Manager/designee. is responsible		
		eceive a magic cup as a led observation of this meal		implementing the acceptable Pla Correction.		
		up was not present on the				
	resident's tray.			The facility failed to develop/imp	lement	
				comprehensive care plan CFR48		
	On 06/27/19 01:14 P			by failing to provide magic cups	for	
		meal tray showed resident		resident #44.		
		cup on his tray. Magic Cup card and "OUT" was written		The corrective action for residen accomplished by the administrat		
	beside it.	Gard and OOT was WILLEH		dietary manager obtaining Magic		
				from Sysco Foods 6/28/2019.		
	During an interview w	vith the dietary manager at		The process for implementation	the	
	1:20pm on 6/27/19, h	e stated the facility ran out		acceptable Plan of Correction fo		
	÷ .	he weekend and he had		specific deficiency was accompli	-	
	-	re. He further stated there		the Administrator/Director of Hea		
		offered and he did not		Services/Dietary manager on 7/	19/19 was	
	Magic Cup.	bout substitutions for the		as follows. 100% audit of veteran⊡s supple		

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				LE CONSTRUCTION	OMB NO. 0938-03	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
					С	
		345531	B. WING		06/27/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE	VETERANS HOME - SA	ALISBURY		1601 BRENNER AVE, BUILDNG #10 SALISBURY, NC 28145		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO	
F 658	Continued From page	e 10	F 65	8		
				was completed on 6/28/2019.		
		of Resident #44 revealed		On 7/19/2019 a monitoring tool was		
		d on 3/7/19 with diagnosis		created and utilized by the Administ		
		sis that included hemiplegia arct affecting left side,		/designee to collect data weekly on veterans with supplements and disc		
	-	infarct affecting right side		with the Interdisciplinary Team.	1033EU	
	and atrial fabulation.	interfer and sting right slad		On 6/28/2019 a supplement monitor	ring	
				tool was created and utilized by the		
		ecent Minimum Data Set		dietary manager/designee to ensure		
		revealed resident was		supplement is on tray. The results fi		
		It showed resident needed		the monitoring tool will be forwarded	d to the	
		bed mobility, bathing, bowel showed that resident was on		Quality Assurance Performance Improvement meeting weekly and		
	a weight loss regime			reported to the administrator and or		
	therapeutic diet.			designee weekly for 3 months then monthly ongoing.		
		included potential for		The title of the person responsible f		
		related to recent Cerebral		implementing the acceptable Plan of		
		opproaches to the care plan		Correction. The Administrator/Dieta		
	included dietary supp	Diements as ordered.		Manager/designee. is responsible for implementing the acceptable Plan of implementing the acceptable Plan of implementi		
	A review of Physiciar	orders dated 6/3/19		Correction.		
		44 was to receive magic cup				
				The facility failed to develop/implem		
		nal assessment for Resident		comprehensive care plan CFR483.2	21(b)1	
		nowed that resident was to		by failing to provide magic cups for		
	receive magic cup 2	umes a day.		resident #11. The corrective action for resident #1	11 was	
	An observation of Re	sident #44's lunch meal tray		accomplished by the administrator a		
		n showed no magic cup on		dietary manager obtaining Magic Cu		
	•	h meal card revealed that		from Sysco Foods 6/28/2019.		
	resident was to recei			The process for implementation the		
	supplement. Magic C card and "OUT" was	Cup is typed on the meal		acceptable Plan of Correction for th		
				specific deficiency was accomplished the Administrator/Director of Health	-	
	During an interview w	vith the dietary manager at		Services/Dietary manager on 7/19/1		
	-	he stated the facility ran out		as follows.		
	of Magic Cups over t	•		100% audit of veteran □s supplement	nte	

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED
					С
		345531			06/27/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
NC STATE	E VETERANS HOME - SA	LISBURY		1601 BRENNER AVE, BUILDNG #10 SALISBURY, NC 28145	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO
F 658	Continued From page	e 11	F 658	3	
	were no substitutions contact the dietitian a Magic Cup. An interview was com Administrator on 6/27 stated the Magic Cup kept in stock and it to ordered by the physic 3. Resident #11 was 1/15/16 with a diagno Renal failure, Demen disturbance, Anxiety, Diabetes mellitus with Essential hypertensic Data Set (MDS) date resident was cognitiv extensive assistance Resident #11's June revealed a current on 08/1/17, for the reside of magic cup one ser breakfast, lunch, and Resident #11's Care revealed he was at ri- status. The interventi supplements as orde day and Register Die An observation on 06 Resident # 11 during	 7/19 at 5:30pm and she a was to be ordered and b be placed on meal trays as cian. admitted to the facility on poiss that including Chronic tria with behavioral Depression, Type 2 nout complication and on. The quarterly Minimum d for 3/27/19 revealed the ely impaired and required with activities of daily living. 2019 Physician's orders der, that was initiated on ent to receive a supplement ving three times a day at dinner. Plan dated 7/4/2018 sk for altered nutritional 		 was completed on 7/19/2019. On 7/19/2019 a monitoring tool was created and utilized by the Adminit /designee to collect data weekly of veterans with supplements and di with the Interdisciplinary Team. On 6/28/2019 a supplement monitool was created and utilized by the dietary manager/designee to ensus supplement is on tray. The results the monitoring tool will be forward Quality Assurance Performance Improvement meeting weekly and reported to the administrator and or designee weekly for 3 months the monthly ongoing. The title of the person responsible implementing the acceptable Plant Correction. The Administrator/Die Manager/designee is responsible implementing the acceptable Plant Correction. 	istrator in all scussed itoring ne ure said from ed to the or n e for of tary for

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		345531	B. WING				27/2019
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE	VETERANS HOME - SA	LISBURY			601 BRENNER AVE, BUILDNG #10 ALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658 F 773 SS=D	An observation on 06 no magic cup on mea meal ticket it stated of the side. During an interview w 1:20pm on 6/27/19, h of Magic Cups over th forgotten to order more were no substitutions contact the dietitian a Magic Cup. An interview was com Administrator on 6/27 stated the Magic Cup in stock and it to be p ordered by the physic Lab Srvcs Physician 0 CFR(s): 483.50(a)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)	/27/19 at 1:15 PM revealed I tray and noted that on ut of magic cup written to ith the dietary manager at e stated the facility ran out he weekend and he had re. He further stated there offered and he did not bout substitutions for the ducted with the /19 at 5:30pm and she was to be ordered and kept laced on meal trays as ian. Order/Notify of Results (i)(ii) cility must- aboratory services only when n; physician assistant; nurse nurse specialist in e law, including scope of e ordering physician, urse practitioner, or clinical poratory results that fall pence ranges in accordance		558	The facility failed to meet CFR483.50(a)2)(i)(ii) for resident #64 b	Υ	7/19/19
	Based on record revi					у	

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						0.0938-039	
· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		/ULTIPLE CONSTRUCTION		SURVEY LETED	
						С	
345531		B. WING		06/27/2019			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
NC STATE	E VETERANS HOME - SA	LISBURY		1601 BRENNER AVE, BUILDNG #10 SALISBURY, NC 28145			
(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 773	Continued From page	e 13	F 77	73			
F ///3	obtain H&H (hemogle repeat complete bloo ordered by the physic residents (Resident # The findings included 1. Resident #64 was 9/2/17 with diagnoses cerebral artery cardic atrial fibrillation, Alzha artery disease (CAD) to CVA, essential hyp vascular disease. Resident #64's most data set (MDS) dated resident was cognitiv further revealed he re therapy 7 out of 7 day Review of the care pl Resident # 64's was excessive bruising du anticoagulation thera atrial fibrillation. The administer medication as ordered, monitor fibleeding, and notify p abnormal labs. Review of medication 2019 and June 2019 received Eliquis (apix daily. Review of Physician	bbin and hematocrit) and d count (CBC) results as cian for 2 of 6 sampled 4 64 and resident # 293). I: admitted to the facility on s that included middle ovascular accident (CVA), eimer's, dementia, coronary w/o angina, hemiplegia due pertension, and peripheral recent quarterly minimum d 5/28/2019 documented the ely impaired. His MDS accived anticoagulation ys. an date 5/30/2019 revealed at risk for bleeding or		 failing to obtain Hemoglobin and Hematocrit as ordered by physici The corrective action for resident accomplished by the Performanc Improvement RN notifying the PA labs were not drawn as ordered a obtained an order to draw the mis labs on 6/27/2019 with the results labs given to the PA after obtainin The process for implementation t acceptable Plan of Correction for specific deficiency was accomplis the Administrator/Director of Hea Services on 7/19/19 was as follow A 100% audit of all lab orders wd verified from chart to lab syst 7/19/2019. A new process of all lab orders wd verified and results of labs are ch daily by the Nursing Supervisor. 100% of nursing staff were educate the new process to verify and ensilabs ordered ore obtained. On 7/19/2019 a lab monitoring to created and utilized by the to ensilable orders will be forwarded to the Quality A Performance Improvement meeti weekly and reported to the admir and or designee weekly for 3 mor monthly ongoing. 	#64 was e that the and ssing s of the ng. he the shed by lth ws. cained tem on ill be ecked ated on sure all ol was ure ts are on oring tool ssurance ng nistrator nths then e for		
	stated hematocrit and	ed a clarification order that d hemoglobin (H&H) every 2 2019. Indication was listed as		Correction. The Administrator/Dir Health Services/designee is resp	ector of		

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP		OMB NO. 0938-039 (X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETI			
				С	с	
345531		B. WING	······	06/27/2	2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
NO 0747				1601 BRENNER AVE, BUILDNG #	10	
NC STATE	EVETERANS HOME - SA	ALISBURT		SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE CO	(X5) DMPLETIO DATE
F 773	Continued From pag	e 14	F 77	73		
	long-term anticoagulation therapy.			for implementing the acc Correction.	eptable Plan of	
	Further record reviev	v revealed the labs had not				
	been drawn on 6/11/2					
	During and interview	with the Unit Manager on				
		I, she stated she would		The facility failed to mee		
		requisition for the 6/10/2019		(i)(ii) for resident #293 by		
	and 6/25/2019 lab re	sults.		CBC as ordered by phys The corrective action for		
	On 6/27/2019 at 3:37	7PM administration informed		was accomplished by the		
		not completed. She further		Improvement RN notifyin		
	stated the MD was n	-		labs were not drawn as o	•	
	immediately (STAT)	ordered.		obtained an order to drav	w the missing	
				labs on 6/27/2019 with th		
				labs given to the PA after	-	
				The process for impleme acceptable Plan of Corre		
	2 Resident #293 wa	s admitted to the facility on		specific deficiency was a		
		gnoses which included Major		the Administrator/Directo		
		Suicidal ideations, Pressure		Services on 7/19/19 was	as follows.	
	•	and Cerebral infarction		The process for impleme		
	without residual defic			acceptable Plan of Corre		
		MDS) quarterly assessment		specific deficiency was a		
	cognitively impaired.	ealed Resident #293 was		the Administrator/Director Services on 7/19/19 was		
				A 100% audit of all lab of		
	An order received da	ated 4/10/2019 revealed		and verified from chart to		
		o have a repeat CBC		7/19/2019.	-	
	(Complete Blood Co			A new process of all lab		
		tabolic Panel) performed in		verified, and results of la		
	one week.			daily by the Nursing Sup		
	Review of Resident f	#293 lab results of a CBC		100% of nursing staff we the new process to verify		
		Platelet dated 4/10/2019		labs ordered ore obtaine		
		BC and a Comprehensive		4 On 7/19/2019 a lab m	-	
		P was to be drawn in one		created and utilized by th	-	
	week.			ordered lab is obtained a		
		"		chart. The results from th	•	
	Review of Resident #	#293's medical record		will be forwarded to the 0	Juality Assurance	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345531		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL A. BUILDING	(X3) DATE COMF	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		B. WING			C /27/2019		
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	i		
NC STATE	VETERANS HOME - SA	LISBURY		1601 BRENNER AVE, BUILDNG #10 SALISBURY, NC 28145			
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 773	Continued From page		F 773				
	revealed no results of the repeat lab requested by the Physician assistant dated 4/10/19.			Performance Improvement mee weekly and reported to the adm and or designee weekly for 3 m	inistrator		
	06/27/2019 at 12:43 I	Unit Manager conducted on PM revealed she was unable		monthly ongoing.			
	to locate the CBC tha repeated on 4/17/201 the lab was missed.	at was ordered to be 9 and was unaware of why		The title of the person responsible implementing the acceptable Pla Correction. The Administrator/D Health Services/designee is res for implementing the acceptable	an of irector of ponsible		
	conducted with Nurse not recall this inciden	-		Correction.			
		ant on 06/27/2019 at 03:19 I requested a repeat lab for high WBC level.					
		vith the Director of Nursing 9 at 5:30 PM he revealed have been drawn per					

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