PRINTED: 09/30/2021 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---------------------|---|-------------------------------|-----------------|----------------------------|
| | | 345558 | B. WING _ | B. WING | | C 09/13/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD | E | 1 03/ | 10/2021 |
| NC STATE | VETERANS HOME-BLA | CK MOUNTAIN | | 62 LAKE EDEN ROAD | | | |
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| F 000 | INITIAL COMMENTS | | F | 000 | | | |
| F 551 SS=J | was conducted on 07 information was obtain surveyor team returned and 09/13/21 to validate compliance. Therefor changed to 09/13/21, investigated and two substantiated. Event substantiated. Event substantiated substantiated. Event substantiated substantiated substantiated. Event substantiated su | ned through 08/09/21. The ed to the facility on 08/20/21 ate the credible allegation of e, the exit date was There were six allegations allegatiosn were ID# OGV711. (IJ) was identified at: 551 at a scope and severity (IJ) began on 07/02/2021 08/14/21. ed on 09/03/21 of additional identified after CMS quality (IJ) was identified at: 624 at a scope and severity (IJ) began on 07/16/2021 09/08/21. Representative | F | 551 | | | 9/7/21 |
| 55=J | §483.10(b)(3) In the count been adjudged incourt, the resident har epresentative, in account legal surrogate so the resident's rights to | case of a resident who has competent by the state is the right to designate a cordance with State law and o designated may exercise of the extent provided by sex spouse of a resident | | | | | |
| ADODATODY | DIDECTORIC OR PROVINCEN | SLIPPLIER REPRESENTATIVE'S SIGNATLIRE | | TITLE | | | (X6) DATE |

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

Electronically Signed

09/02/2021

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | ROVIDER OR SUPPLIER | LACK MOUNTAIN | | STREET ADDRESS, CITY, STATE, Z 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 287 | ZIP CODE | 03/10/2021 |
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| F 551 | to an opposite-sext valid in the jurisdict (i) The resident represents are delegated rights are delegated (ii) The resident retarights not delegated including the right to except as limited by §483.10(b)(4) The form of a resident representation of a resident representation on behalf extent required by the resident, in accordation of a resident representation of a resident representation of a resident representation of a resident, in accordation of a resident, the factorism of a resident, the factorism of a resident representation of a resident representation of a resident representation of a resident representation of competent under of competent jurisd devolve to and are representative appronthe resident representation of the residen | eatment equal to that afforded spouse if the marriage was ion in which it was celebrated. resentative has the right to nt's rights to the extent those if to the representative. It is to a resident representative, to revoke a delegation of rights, | F | 551 | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ` ′ | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| F 551 | law. (i) In the case of a redecision-making author court appointment to make those decisi representative's auth (ii) The resident's wis be considered in the representative. (iii) To the extent praprovided with opporticate planning process. This REQUIREMEN' by: Based on record restaff, the legal guard Social Services (DSS the facility failed to o LG for Resident #1 to discharge out of the advice (AMA). Resid occasions without melle was evaluated at intoxication the first the second time Resident evaluated at the hose and chest pain and a to the hospital by his alcohol consumption hygiene. This occurresidents reviewed for resident's rights. Immediate jeopardy Resident #1 exited the authorization from the jeopardy was removed. | sident representative whose nority is limited by State law, the resident retains the right ons outside the ority. These and preferences must exercise of rights by the exercise of rights by the exercise to participate in the second se | F 55 | This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Late. The corrective action for resident #1: Resident #1 left center against medical advice (AMA) on 7/16/21 and will not be returning to the facility. The medical director for the facility entered a note to resident #1 is no longer appropriate to at the facility. Other residents with potential to be affected: The Assistant Director of Health Servi (ADHS), Nurse Navigator and RN Supervisor completed a review of all | on nat ws. Il pe hat be |

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| NC STATE | VETERANS HOME-BLA | ACK MOUNTAIN | | | 2 LAKE EDEN ROAD | | |
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| F 551 | Continued From page | e 3 | F: | 551 | | | |
| | removal. The facility a lower scope and se actual harm with pote harm that is not Immeducation and ensure place are effective reprevent accidents. The findings included Resident #1 was adn 10/26/20 with diagno mellitus (DM), high b depression, chronic odisease (COPD), supchronic pain, gout, ar Review of the court of indicated the court factors. | nitted to the facility on ses including diabetes lood pressure, anxiety, obstructive pulmonary oraventricular tachycardia, | | | resident charts to determine a list of residents that were deemed a ward of State with guardians. This was comple on Aug 9, 2021. The facility identified for other residents that have the potential be affected by the same deficient pract No other residents were found to be affected by the facility selficient practice. Social Services Director (SSD) will be notified by Admission solirector (AD) when there is a new resident with a guardianship. SSD will update any resident with a guardian in the leave of absence books located at each nurse station as applicable. SSD will also indicate on the resident sace sheet, resident with a guardian. Measures put into place to ensure that deficient practice will not occur: | eted our to cice. | |
| | The quarterly Minimu 04/19/21 assessed R impairment in cogniticassistance in bed motoileting, personal hybathing. Resident #1 required a wheelchair A progress note charrow (SW) on 07/02/21 revequested to leave the couple of hours for the When he was leaving going to spend the ni | Im Data Set (MDS) dated tesident #1 with moderate on. He required extensive obility, transfer, dressing, giene, and total dependent in was non-ambulatory and he ras mobility device. Ited by the Social Worker wealed Resident #1 had be facility with a friend for a herapeutic leave initially. Ig, he told the SW that he was ght and return on 07/03/21. | | | Policy and Procedure Review of AMA a LOA process will be provided to all applicable staff (nurses, social services partners, receptionist□s partners, administrator, nurse navigator and admission director). The AMA/LOA education was completed on August 13 2021. Any new applicable staff will be made aware of residents who have a Guardian and what Guardianship meal In addition, verbal education will be provided to all applicable staff on where find the LOA books that include a list or residents with Legal Guardians. This education will be provided by Clinical Competency Coordinator or designee. | s, 3, ns. e to | |

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| NAME OF D | DOV/IDED OD OUDDUIED | 343336 | D. WING | | TREET ADDRESS SITV STATE ZID SODE | 09/ | 13/2021 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| NC STATE | VETERANS HOME-BLA | ACK MOUNTAIN | | | 2 LAKE EDEN ROAD | | | |
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| F 551 | Continued From page | e 4 | F: | 551 | | | | |
| F 551 | revealed Resident #1 Emergency Medical S glucose (BG) of 170 of deciliter) and blood a (value of 80 mg/dL or alcohol intoxication). and stated he felt fine just drunk as he had the 07/03/21 morning out any neurological of Basic labs did not sho findings. After about 3 room (ER), Resident significantly. The phy safe to discharge Resident. A nurse's note charter revealed Resident #1 around 1:00 PM with #1 stated he did not he leaving the facility on not show any signs oo His vital signs were wexcept having pulse of blood pressure (BP) of normal range. Reside assessed on return to A nurse's note charter revealed Resident #1 out of facility over the the hospital via EMS and released several fell and laid in the floot to assist him up. Resident #1 out of sasist him up. Resident #1 out of sasist him up. Resident #1 out of facility over the the hospital via EMS and released several fell and laid in the floot to assist him up. Resident #1 out of sasist him up. Resident #1 out of sasist him up. Resident #1 out of facility over the the sasist him up. Resident #1 out of sasist him up. Re | arrived at hospital via Services (EMS) with blood mg/dL (milligrams per Icohol level of 231 mg/dL above is indicative of He was awake on arrival at Resident #1 added he was been drinking alcohol since at Physical examination ruled deficits and signs of trauma. Ow any new concerning a hours in the emergency #1's condition improved sician determined it was sident #1 home with his and by Nurse #1 on 07/05/21 returned to the facility out shoes or socks. Resident have any medications since 07/02/21. Resident #1 did f distress when he returned. Within the normal limits of 102 beats per minute. His of 121/72 was within the ent #1's BG was not to the facility. In the day Nurse #1 on 07/07/21 told her that while he was a weekend, he was taken to due to unresponsiveness hours later. He added he or before his friends arrived ident #1 stated while he was incohold the stated while he was in | F | 551 | New Nurses and any Agency Nurses we be educated on the AMA and LOA policy upon hire with coordination from our Clinical Competency Coordinator (CCC or her designee. Monitoring of POC: SSD will monitor LOA books and applicable face sheets weekly related for any LOA/AMA discharges. The IDT text will monitor these discharges on a week basis to ensure that our policy and procedures on LOA and AMA are followed. This monitoring will occur for the next 12 weeks. In-service sheets from the CCC or designee will be given to the Administration when orientation is conducted or when new Agency Nurses are contracted. The IDT team will monitor the LOA/AM discharges each month during our QAF meetings. The Administrator or his designee will ensure that the reviews a comprehensive and adhere to LOA/AM policies and procedures. Correction Action Completed: 9/7/2021 | cies c) for am kly ator | | |
| | to the trailer and atter | er park staff hooked a tractor mpted to pull the trailer off le of the trailer out and | | | | | | |

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| F 551 | #1 indicated that he the trailer. Upon the arrival, he initially rethey would have to the court declared in explained to Reside the ER. Review of Brief Interest (BIMS) dated 07/18 scored 15 in the assecond to the explained to Reside the ER. Review of Brief Interest (BIMS) dated 07/18 scored 15 in the assecond to the Medit (MARs) revealed Refollowing medication 07/16/21: "Levemir 15 undaily at bedtime for "Novolog 4 unit meals for DM. "Metformin 1,00 mouth two times daily for DM. "Metformin 1,00 mouth two times daily for light blood "Ventolin, inhale 6 hours as needed "Ativan 0.5 mg," | valls fell toward him. Resident edid not eat while he was in e EMS and the police officer efused to transfer, stating that arrest him first. After reviewing incompetency papers, officer ent #1 that he did have to go to erview for Mental Status 5/21 revealed Resident #1 had sessment, indicating he was cation Administration Records esident #1 was receiving the ns prior to discharge on this subcutaneously (SQ) once DM. s SQ three times daily before 00 milligrams (mg), 1 tablet by aily for DM. mg, one-half tablets by mouth high blood pressure. 1. 1 tablet by mouth two times pressure. 2. 2 puffs by mouth once every | F 5 | 551 | | |
| | for depression. | g, 1 caplet by mouth once daily records dated 07/16/21 and Resident #1 signed the 1/21 at 3:30 PM. | | | | |

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| F 551 | revealed Resident #7 the facility AMA at 4: the AMA document we that he was going ag was not a safe dischabis life, health, and sethat there were court had an appointed guarant was made aware AMA the facility would The SW called the Lounessage. Review of an emerge 07/17/21 revealed Real ER before midnight of and chest pain. He did with productive coug deep breath. Resider requesting food. Chebilateral lung passag replaced with fluids, and chronic changes community acquired oral antibiotics. He had blood cell count of 5. within normal limits. If the ER and was discontended to the serior of the serior worsening occurred. | ted by the SW on 07/16/21 I had checked himself out of 15 PM. Resident #1 signed vith the full understanding ainst medical advice and it arge. It could pose a threat to afety. The SW reminded him documents indicating he ardian of person. Resident if he chose to discharge d not take him back in future. G at 4:25 PM and left a ency department report dated esident #1 presented to the flue to complaint of cough id report shortness of breath that became worsen with a nut #1 was hungry as he kept est X-ray showed portion of eway and lower lobes likely a combination of acute. He was diagnosed with pneumonia and started on ad BG of 83 mg/dL, white 8, and his vital signs were Resident #1 spent a night in harged on 07/18/21 morning. Friend were instructed by the othe hospital if any symptom | F 5 | | | |
| | revealed Resident #1 of facility for a few ho 07/02/21. When Res | V on 07/20/21 at 10:46 AM I initially requested to go out ours around noon on ident #1's friend arrived late SW before leaving that he | | | | |

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| F 551 | had left the facility, herepeatedly. Residen facility on 07/05/21. 07/02/21 through 07 on 07/06/21, she no about the incident at fault for failure to no #1 left the facility on conversation on 07/0 that Resident #1 was facility without his penotified the LG after facility AMA on 07/10 told her on 07/13/21 Resident #1 insisted stated the facility con Resident #1 from least Resident #1 voiced from the facility on 0 she explained to Redeclared deemed in had to remain in the The SW educated Repotential harm without care, and he would infacility in future. He agreed he would not Resident #1 stated he decision and he was facility. Resident #1 medications but not medications as he semedications from the (VA) hospital. The Sthe LG before Resident R | in his friend's house. After he he called for extension that finally returned to the The SW was on a break from 1/06/21. When she returned tified the LG immediately and indicated that it was her tify the LG before Resident 1/07/02/21. During the phone 1/06/21, the LG stated clearly is not allowed to leave the ermission. The SW stated she Resident #1 had left the 1/06/21. She recalled the LG had that she could call police if 1/10 leave the facility. The SW all don't physically restrict awing the facility. When this intention to discharge 1/16/21 around 10:00 AM, sident #1 that he had been competent by the court, he facility as directed by the LG. the sident #1 that he could face but medications and medical mot be allowed to return to the expressed understanding and the return to the facility in future. The did not believe that court is determined to get out of the was given a list of his the prescription or the tated he would obtain the experience of the would obtain the experience of the world in the experience of the world in the experience of the world obtain the experience of the w | F | 551 | | | |

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| F 551 | Resident #1 arrived after claiming he haw with a hammer by a examination revealed face. Head compute no evidence of acute skull fracture. He ham g/dL, BG of 102 m within normal limits. evaluated with ches complete blood cour metabolic panel (CN unremarkable. He would but had to remain in placement. During a phone interesident #1's friend 07/16/21 stated that 07/16/21 before lund from the facility. The Resident #1 back to facility. He brought for dropped him at his form that unless Resident #1 a with his friend on 07 him that unless Resident geally a could endanger him do anything legally a ruled Resident #1 derived Re | rtment report revealed at ER on 07/20/21 afternoon d been assaulted in the head woman. Physical d atraumatic for head and d tomography (CT) revealed be bleeding inside the skull or d blood alcohol level of 63 g/dL, and his vital signs were Resident #1 was also t X-ray and labs included at (CBC) and comprehensive MP). All the findings were as ready to be discharged the hospital awaiting rview on 07/20/21 at 2:16 PM, who picked him up on the SW called him on the topick Resident #1 up as SW told him not to bring the facility after leaving the Resident #1 to Hickory and riend's house. on 07/20/21 at 4:03 PM the the facility had called police tempted to leave the facility /13/21. The police officer told ident #1 tried to leave the neelchair on the street that self and others, he could not | F 55 | 51 | | | |

| AND DI AN OF CORRECTION IDENTIFICATION NUMBER | | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
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| F 551 | o7/21/21 at 2:30 PM facility on 07/16/21, medications but not medications. The SN him a form to sign at to leave the facility. after leaving the faciany medication in the prescriptions. He collocal pharmacy as honly medication he tracility on July 4th wany court ruling relatithe guardianship. Interview with Nurse revealed Resident # unable to care for hileave the facility with caregiver as he had insulin dependent. During a phone interest 12:45 PM, he state obtain his permission leave the facility on respectively. He had Administrator repeat allowed to leave the unless it was for me Resident #1 was hos intoxication. On 07/17 Resident #1 had left Resident #1 had no | | F 55 | 51 | |

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| NAME OF PROVIDER OR SUPPLIER NC STATE VETERANS HOME-BLACK MOUN | ITAIN | | 62 LA | ET ADDRESS, CITY, STATE, ZIP CODE AKE EDEN ROAD CK MOUNTAIN, NC 28711 | , | | |
| (X4) ID SUMMARY STATEMENT O PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTIF | PRECEDED BY FULL | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 551 Continued From page 10 him that the SW called him to a facility to pick Resident #1 up. the facility without medications hospitalized on 07/17/21 due to found Resident #1 on 07/19/21 trailer. Resident #1 was without including insulin, but he appead However, when he visited him Resident #1 was sitting in a requrine and feces and had been called EMS to transport him to During a phone interview with Director (MD) on 07/21/21 at 1 Resident #1 lacked legal capar form as he was declared inconcourt. The only person authorist Resident #1's behalf was the LDuring a subsequent phone into n 07/22/21 at 2:33 PM, he state concern for Resident #1 was he insulin as he was insulin dependent as he was insulin dependent provided the follow immediate jeopardy removal procorrection date of 08/14/21. Identify those recipients who he are likely to suffer, a serious at a result of the noncompliance: Four current residents at the fata appointed guardians and are a outcome as a result of noncome. | As Resident #1 left is, he was o chest pain. He I in his friend's it any medication red to be okay. again on 7/20/21, cliner in his own drinking. The LG the hospital. the Medical :48 PM, he stated city to sign the AMA inpetent by the zed to act on .G. terview with the MD ated his biggest is DM without indent. d of immediate PM. ing acceptable lan with the ave suffered, or dverse outcome as acility have court it risk for adverse | F | 551 | | | | |

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| | ROVIDER OR SUPPLIER | LACK MOUNTAIN | | STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711 | 1 03/10/2021 | | |
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| F 551 | not return to Facility facility entered a not longer appropriate. Resident #1 admitt. His diagnoses includepression, COPD supraventricular tack 4 pressure ulcer at osteoarthritis. Revidated 02/17/21 indi Resident #1 deemed guardianship was goden by the company of A On 7/2/21 resident leave the facility for leave with a friend. facility, he stated the night and return on to facility on 7/5/21 had any medication 7/2/21. Facility was resident would return to Center via EMS durecords from this via resident arrived at I fine but was just driedtermined to be a facility, resident not facility facility and facility facility. | whiter (AMA) on 7/16/21 and will by. The Medical Director for the ote that the resident was no to be at the facility. Bed to the facility on 10/26/20. Indeed diabetes mellitus, anxiety, hypertension, chycardia, chronic pain, stage left hip, gout, and liew of the court document facted the court had declared and incompetent and granted to Catawba County Allegation: #1 stated that he was going to be a few hours for a therapeutic fact he was going to spend the saturday. Resident returned and stated that he had not has since leaving facility on a funder impression that the fact while on LOA resident catawba Valley Medical for the total cate of the total cate of the felt wink. Blood alcohol level was tified staff that he had allegedly life in the staff that he had allegedly stified staff that he had allegedly | F 55 | , | | | |
| | determined to be a facility, resident not fallen while on leav the floor for a day u him. Hospital recor skin tears, abrasion | t 231. After returning to | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDII | IPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|-----------------------|--|-----------|----------------------------|
| | | 345558 | B. WING _ | | | C 09/13/2021 |
| | ROVIDER OR SUPPLIER | ACK MOUNTAIN | | STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711 | | 3071072021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFII TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDEDICION OF THE ADD | SHOULD BE | (X5) COMPLETION DATE |
| F 551 | Continued From pa | ge 12 | F t | 551 | | |
| | to go home. Adminicounseled resident Resident #1 was disadvice (AMA) from 3:30pm on 7/16/21 form was signed by clear in understand decisions and voice home without clears 4:15pm resident #1 Resident was notifice readmit him if he chest was then notified allombudsman, reside Buncombe County DSS and lewas then notified via messag from guardian at who fisituation and that readmitted to facility. Per survey findings presented to ER with cough, chest pain, and Chest x-ray reveale passageway and low #1 diagnosed with concept presented at ER class and the presented at ER clas | I antibiotics initiated. Resident ning of 7/18/21 with his friend. on 7/20/21 resident #1 niming he had been assaulted ruck him in the head with a exam and CT scan were | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ' ' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|---------------------|---|---------|----------------------------|
| | | 345558 | B. WING | | | C 9/13/2021 |
| | ROVIDER OR SUPPLIER | 1 | | STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711 | 1 0 | 9/13/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEI | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 551 | #1 participated in b assessments. He s indicating that he w on his PHQ-9 confi The Facility has ide that have a Guardia However, to date, r by any of the four rewithout Guardian's Specify the action t process or system adverse outcome free when the action will Policy and Procedu process was provided (nurses, social service) and process was provided by Augu have been made and Guardian and what addition, verbal edu LOA books that incured Load social services and services was initiated on Augu have been made and Guardian and what addition, verbal edu LOA books that incured the provided all educations was provided all educations. | ess notes dated 7/15/21, Res oth his BIMS and PHQ-9 cored a 15 on his BIMS ras cognitively intact and 0/27 rming he was not depressed. entified four other residents an and could be at risk. To attempts have been made residents to leave facility permission. The entity will take to alter the failure to prevent a serious from occurring or recurring and I be completed: The Review of AMA and LOA red to all applicable staff rices partners, receptionist's reator, nurse navigator and the AMA/LOA education gust 9, 2021 and will be st 13, 2021. All applicable staff ware of residents who have a Guardianship means. In ucation on where to find the lude a list of all residents with as provided. The staff that ion from 8/9/2021 - 8/13/2021 | F 55 | | | |
| | Navigator, the Clini and the QAPI nurse (SSD) was notified responsibility on Au and any Agency Nu | DON, Nurse Supervisor, Nurse cal Competency Coordinator, e. Social Services Director of her LOA book updating ligust 9, 2021. New Nurses urses will be educated on the cies upon hire with coordination | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | l ` ′ | TIPLE CONS | STRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|--------------------|-----------|---|------|----------------------------|
| | | 345558 | B. WING | | | | C /13/2021 |
| | ROVIDER OR SUPPLIER E VETERANS HOME-BI | ACK MOUNTAIN | • | 62 LAKI | ADDRESS, CITY, STATE, ZIP CODE E EDEN ROAD (MOUNTAIN, NC 28711 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 551 | and her trained designed and her trained designed and her trained designed (ADHS), Nurse Navicompleted a review determine a list of reward of the State word of the State word of the State word of the State word on help and Solver education on below education from 8/9/0 of the ADON, Nurse the Clinical Compet QAPI nurse. The Stand SSD were educised is noted on each reguardians can make will be notified by Athere is a new reside Administrator was receive a change in guardianship. The responsibility to not made by resident to worker is not availad guardian and docur Administrator and Stame verbal education verbalized understate commenced on August 13, 2021. Nurses will be educe policies upon hire were supplied to the same verbal in the same verbal education of the | tor of Health Services rigator and RN Supervisor of all resident charts to esidents that were deemed a ith guardians. This was 0, 2021. were provided verbal : the staff that provided all 2021 - 8/13/2021 comprised e Supervisor, Nurse Navigator, ency Coordinator, and the staff including the Administrator cated that the guardian status sident's face sheet and only de decisions for resident. SSD dmission's Director (AD) when ent with a guardianship. The notified of his responsibility to y current residents that status related to any new SSD is aware of her ify guardian of any request to leave the facility. If Social ble, RN/LPN will notify | F | 551 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--------------------|---|---|-------------------------------|----------------------------|
| | | 345558 | B. WING | | | | C 13/2021 |
| | ROVIDER OR SUPPLIER | ACK MOUNTAIN | | 6 | TREET ADDRESS, CITY, STATE, ZIP CODE 2 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711 | | 10,202 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 551 | Assistant Director of designees for all nursed staff Notification of responsive absence Documentation of when they when ret Documentation of a medications/supplier esident and individual facility. Any staff not receiving scheduled time office their next social absoluted time office before their next social absolute additional to the forward basis. Education began or by the Assistant Direction of the sequence | n 8/9/21 conducted by the f Health Services and rsing staff including Licensed f to include but not limited to: insible party/Guardian before who is taking resident from the where the resident is going and turn any s/education provided to the party and the party and taking resident from the where the resident is going and turn any s/education provided to the party and taking resident from the whole party and taking resident from the party before leave who is taking resident from the party before leave who is taking resident from the party before to the party before the party be | F | 551 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---------------------|---|-------------------------------|----------------------------|
| | | 345558 | B. WING _ | | | C 9/13/2021 |
| | ROVIDER OR SUPPLIER | LACK MOUNTAIN | | STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711 | | 3/13/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 551 | also be added to no forward basis. CC0 | ge 16 heduled shift. Education will ew partner orientation on a go C and the ADON will tracking were initially notified of this on | F 5 | 51 | | |
| | Improvement meeti conducted by the A Quality Assurance I Work Director and I | surance Performance ng was held on 8/9/2021, dministrator, Assistant DHS, Nurse, Nurse Navigator, Social RN Supervisor to discuss the te interventions as indicated August 14, 2021. | | | | |
| | The facility's credib jeopardy removal p 08/14/21 was valida and procedure of A (LOA), and the LOA residents with legal no concerns identification records conducted 08/13/21 revealed a departments including receptionist, admissional had completed the the in-services were LOA process, provinguardian status from resident's face sheet guardian could make In-service began on the Assistant Direction 18/14/21 revealed a departments including receptionist, admissional to the in-services were LOA process, provinguardian status from resident's face sheet guardian could make In-service began or the Assistant Direction. | immediate jeopardy removal 4/21. Ile allegation of immediate allegation of attention date of attention | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|---|-------------------------------|----------------------------|
| | | 345558 | B. WING _ | | | C 09/13/2021 |
| | ROVIDER OR SUPPLIER | LACK MOUNTAIN | | STREET ADDRESS, CITY, STATE, ZIP COD 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711 | • | 3071072021 |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 551 | before the leave of "Documentation resident from the fate of the leave of pocumentation going and when he Documentation medications/supplied resident and the incomposition of the facility. Any staff not received scheduled time off the Act (FMLA) would be scheduled shift. Edute to new partner oried the ADON would the ADON would the ADON would the LOA book and request made by the LOA book and r | itied to: responsible party/Guardian absence n of who was taking the icility n of where the resident was /she would return n of any es/education provided to the dividual taking the resident ing in-service due to or Family and Medical Leave be educated before their next ucation would also be added intation on a go forward basis. etency Coordinator (CCC) and ack the in-services to ensure e SW was assigned to update into the services to ensure e SW was assigned to update into the services to ensure and the guardian of any is resident to leave the facility. Invailable, the hall nurse would and document the Admission Director was the SW when admitting a new redianship and the esponsible to notify the SW of ts that received a change in | F | 551 | | |

| ` , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---|-----|--|-------------------------------|----------------------------|
| | | 345558 | B. WING | | | | C 13/2021 |
| | ROVIDER OR SUPPLIER VETERANS HOME-BLA | CK MOUNTAIN | | 62 | TREET ADDRESS, CITY, STATE, ZIP CODE 2 LAKE EDEN ROAD LACK MOUNTAIN, NC 28711 | 1 00/ | 10/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX (EACH CORRECTIVE ACTION SHOULD | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 624 SS=J | book and notify the grequested to leave the verbalized understand guardian and docume SW was not available was aware of her resewhen admitting a new guardianship. The Adunderstanding to notificate had a change in status Preparation for Safe/CCFR(s): 483.15(c)(7) §483.15(c)(7) Oriental discharge. A facility must provide preparation and orients afe and orderly transfacility. This orientation form and manner that understand. This REQUIREMENT by: Based on record revelophysician and Legal of facility failed to make needs for a safe dischim with prescriptions accessibility or safety determine if he would running water, refer her or contact the Veteral day after Resident #1 Medical Advice (AMA) | sibility to update the LOA uardian if any resident e facility. The hall nurses ding of their role to notify the ent the conversation if the e. The Admission Director ponsibility to notify the SW versident with a liministrator verbalized fy the SW when residents is in guardianship. Orderly Transfer/Dschrg ation for transfer or e and document sufficient entation to residents to ensure enter or discharge from the for must be provided in a tather than the tather than the services of the provisions for Resident #1's the provisions #1's the provisions for Resident #1's the provisions for Resident #1's the provisions for Resident #1's the provisions #1's the provisions for Resident #1's t | | 624 | The corrective action for resident #1: Resident #1 is no longer at the facility. has been placed in another Skilled Nursing Facility (SNF). Other residents with potential to be affected: The Assistant Director on Nursing (ADON), Nurse Navigator (NN) and RN Supervisor completed a review of all resident charts to determine a list of residents that were indicating an intent | I | 9/24/21 |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL ⁻ A. BUILDI | | CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
|--------------------------|--|---|------------------------------------|---|--|-------------------|----------------------------|
| | | 345558 | B. WING | | | | C 43/2024 |
| NAME OF D | ROVIDER OR SUPPLIER | 0.1000 | | 6. | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 09/ | 13/2021 |
| NAME OF FI | NOVIDER OR SUFFLIER | | | | | | |
| NC STATE | VETERANS HOME-BLA | CK MOUNTAIN | | | 2 LAKE EDEN ROAD | | |
| | | | | В | BLACK MOUNTAIN, NC 28711 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | 1 | ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APF DEFICIENCY) | | | (X5) COMPLETION DATE |
| F 624 | Continued From page | : 19 | F | 624 | | | |
| | occurred for 1 of 3 sa for safe and orderly d | - | | | discharge. This occurred on August 9, 2021. There were and are no current residents that are actively seeking discharge at this time. | | |
| | Resident #1 was disc authorization from his | ~ | | | Social Service Director (SSD) will notify the Interdisciplinary Team (IDT) that a discharge is pending. The particular | y | |
| | facility provided and in | d on 09/08/21 when the mplemented an acceptable | | | partners of the IDT team that need to b notified are the NN, Director of Nursing | | |
| | _ | Immediately Jeopardy emains out of compliance at | | | (DON), the charge nurse caring for respective resident/s and the Medical | | |
| | a lower scope and severity of D (isolated with no actual harm with potential for more than minimal | | | | Director (MD) or Nurse Practitioner (NF | ⁹). | |
| | education and ensure | ediate Jeopardy) to complete monitoring systems put into ated to safe and orderly | | | Measures put in place to ensure that the deficient practice will not occur: | ie | |
| | discharge. | , | | | Policy and Procedure (P and P) for Discharge Planning was provided by the | ne | |
| | The findings included | : | | | Nurse Consultant on 9/3/21 who assist the ADON and the NHA with the trainin | | |
| | Resident #1 was adm | | | | for in-servicing that was given to the | | |
| | 10/26/20 with diagnos | | | | Clinical Care Coordinator (CCC), NN, a | and | |
| | • | nellitus (DM), high blood pression, chronic obstructive | | | the DON. The CC, NN and DON in-serviced all applicable staff (nurses, | | |
| | | COPD), supraventricular | | | social service partners, NHA, ADON ar | | |
| | | pain, gout, and osteoarthritis. | | | Admission⊡s Coordinator (AC). This | iu | |
| | Review of the court do | ocument dated 02/17/21 | | | education was completed on Sept 7, 2021. All education included notification | on | |
| | | d declared Resident #1 | | | of and permission from guardian (if | " | |
| | | and guardianship was | | | applicable), Responsible Party (RP) pri | ior | |
| | granted to DSS. | | | | to any discharge/leave of absence (LO safe discharge/Against Medical | | |
| | 04/19/21 assessed Reimpairment in cognition | m Data Set (MDS) dated esident #1 with moderate on. He required extensive bility, transfer, dressing, | | | Advice(AMA) practices up to and include medications/medical supplies that are to sent with all discharges if those medications are available at the facility | be | |
| | | giene, and total dependent in | | | prescriptions obtained and sent home | | |
| | | was non-ambulatory, and he as mobility device. He had | | | resident; home health set up when indicated; medication and discharge | | |

| l ` ' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345558 | B. WING | | | 1 | C (42/2024 |
| NAME OF D | ROVIDER OR SUPPLIER | 0.0000 | 1 | 27 | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 09/ | /13/2021 |
| NAME OF T | NOVIDEN ON GOLT EIEN | | | | 2 LAKE EDEN ROAD | | |
| NC STATE | VETERANS HOME-E | BLACK MOUNTAIN | | | | | |
| | | | | В | LACK MOUNTAIN, NC 28711 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 624 | Continued From pa | age 20 | F | 524 | | | |
| | moderate difficulty | in hearing and impaired vision. | | | instructions given to the resident and/o | r | |
| | | d Resident#1 had impairment | | | responsible party; education provided | | |
| | for both sides of up | oper extremities. Further review | | | the nurse about medication and discha | - | |
| | | ed Resident #1 had received | | | instructions given to the Guardian (if | Ū | |
| | antidepressant dai | ly, antipsychotic 6 days, and | | | applicable), RP, and resident. Return | | |
| | opioid 1 day in the | 7-day look back period. | | | demonstration including but not limited | to | |
| | | • | | | safe administration of injectable | | |
| | Review of the Med | lication Administration Records | | | medications including insulin which is | | |
| (MARs) revealed Resident #1 was prescribed the | | | | demonstrated by discharging nurse. | | | |
| | following medication | ons in July 2021: | | | Education to Guardian/RP/resident | | |
| | | | | | includes signs and symptoms of | | |
| | | ubcutaneously (SQ) once daily | | | hyperglycemia if applicable. Education | | |
| | at bedtime for DM. | | | | includes possible adverse consequence | | |
| | | Q three times daily before | | | of AMA discharges and consequences | | |
| | meals for DM. | illianama (man) 4 tablat bu | | | discharges that do not involve guardia | | |
| | mouth two times d | nilligrams (mg), 1 tablet by | | | and families. Any staff not receiving the education due to time off or FMLA is | ilS | |
| | | one-half tablets by mouth two | | | educated at orientation or on or before | | |
| | times daily for high | | | | their next scheduled shift. The ADON | | |
| | | ablet by mouth two times daily | | | and the CCC were notified on 9/3/21 th | | |
| | for high blood pres | | | | they are responsible for tracking who h | | |
| | | ouffs by mouth once every 6 | | | and who has not received stated training | | |
| | hours as needed for | | | | The CCC, DON and NN were notified | • | |
| | Ativan 0.5 mg, 1 ta | ablet by mouth two times daily | | | 9/3/21 that hey would be responsible for | or | |
| | for anxiety. | | | | providing the education for staff that di | d | |
| | Lexapro 15 mg, 1 | caplet by mouth once daily for | | | not receive education on the AMA and | | |
| | depression. | | | | safe discharges upon hire, the setting | up | |
| | | | | | of home health, medications and any | | |
| | | narted by the Social Service | | | applicable durable medical equipment | | |
| | | 07/16/21 revealed Resident #1 | | | (DME) with coordination from our CCC | | |
| | | elf out of the facility AMA at | | | trained designees. The SSD was notifi | | |
| | | #1 signed the AMA document | | | on 9/3/21 of her responsibility to facility | | |
| | | standing that he was going | | | any use of DME needed for the reside | 10 10 | |
| | • | lvice and it was not a safe | | | safely discharge. | | |
| | _ | pose a threat to his life, health, | | | SSD and NN are accessing every | | |
| | | SD reminded him that there ents indicating he had an | | | SSD and NN are assessing every discharge for accessibility and safety of | √f | |
| | | n of person. The SSD called | | | discharge destination including access | | |
| | | and left a message. | | | food and running water, access to hom | | |
| | , | | 1 | - 1 | | | 1 |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | | | | | | С |
| | | 345558 | B. WING _ | | | 09 | /13/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 62 | LAKE EDEN ROAD | | |
| NC STATE | VETERANS HOME-E | BLACK MOUNTAIN | | Bl | LACK MOUNTAIN, NC 28711 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES CNCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 624 | Continued From p | age 21 SSD on 07/20/21 at 10:46 AM | F | 624 | health services (if applicable). In addi | | |
| | revealed the LG has phone conversation was not allowed to permission. The S | ad stated clearly during a n on 07/06/21 that Resident #1 leave the facility without his SD stated she notified the LG nad left the facility AMA on | | | current medications/medical supplies facility (if applicable) NN or designated nurse educates on medications, disch instructions prior to discharge. The SS and NN were notified of their responsi | in d arge SD | |
| | 07/13/21 that she insisted to leave the facility could not the facility could not woiced his intention on 07/16/21 aroun Administrator (NH, Nursing (ADON) a | alled the LG had told her on could call police if Resident #1 he facility. The SSD explained by physically restrict Resident e facility. When Resident #1 he to discharge from the facility d 10:00 AM, the Nursing Home A), Assistant Director of he the SSD explained to he had been declared deemed | | | on 9/3/21. The DON or designee reviews the discharges completed from the previo day to ensure that all components were completed per P and P. Any findings be brought up in the monthly Quality Assurance/Performance Improvement (QAPI) meeting. | us re will | |
| | facility as directed Resident #1 that h without medication #1 expressed under he was determined Resident #1 stated had provided the a all the phone num departure. Residen medications but no medications as he | be court, he had to remain in the by the LG. The SSD educated e could face potential harm as and medical care. Resident erstanding and indicated that do get out of the facility. If he had a home to go to and address to the SSD. She called person to verify before his and #1 was given a list of his of the prescription or the stated he would obtain the | | | If the resident has a legal guardian, the legal guardian is notified immediately any AMA wishes of the resident by SS NHA. If the facility feels that the discharge is unsafe due to the resident persistence, then the facility notifies Guardian (if applicable), RP, Powers of Attorney (if applicable), APS, VA, Med Director and Ombudsman. The SSD at the NHA were notified of their responsibility on 9/3/21. | amediately of dent by SSD or at the the resident⊡s y notifies P, Powers of S, VA, Medical The SSD and | |
| | Administrator (NH. explained the facil Resident #1 from I physically restrain Resident #1 had a ruling that declared | he VA hospital. w with the Nursing Home A) on 07/20/21 at 4:03 PM, he ity had no capacity to keep eaving as they could not him. The NHA was aware that guardianship and a court d his incompetency. The evealed the facility tried to give | | | ADHOC QAPI meeting was eld on 9/3 conducted by the NHA, ADON, CCC tin-service all applicable partners about plans and immediate interventions of and discharges as indicated. Date of POC completion: September 2 2021 | o t the AMA | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPI A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|--|-----------------|
| | | 345558 | B. WING | | 09/13/2021 |
| | ROVIDER OR SUPPLIER | ACK MOUNTAIN | | STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711 | 1 00/10/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COMPLETION |
| F 624 | 7/16/21 before he let them from VA. During a phone inter at 12:45 PM, he star obtain his permission leave the facility on the SSD on 07/06/2 allowed to leave the unless it was for me the SSD called him facility AMA. As Reswithout medications 07/17/21 due to che on 07/19/21 in his fir without any medical appeared to be okan During a phone inter 07/21/21 at 2:30 PM facility on 07/16/21, medications but not | day supply of medications on eft, and he stated he could get erview with the LG on 07/22/21 ted the facility had failed to on before letting Resident #1 07/16/21. He had instructed 11 that Resident #1 was not efacility without his permission edical reason. On 07/16/21, after Resident #1 had left the sident #1 left the facility is, he was hospitalized on est pain. He found Resident #1 riend's trailer. Resident #1 was tion including insulin, but he y. Prview with Resident #1 on M, he stated when he left the the SSD gave him a list of the prescriptions nor | F 624 | | |
| | Administrator gave him that he was oka the medication list a was unable to obtai hospital without pre metformin in a local refills. He denied kn to his incompetency. An emergency deparevealed Resident # midnight due to con pain. He did report sproductive cough the | SD and the Nursing Home him a form to sign and told ay to leave the facility. He lost after leaving the facility and an any medication from the VA scriptions. He could only fill pharmacy as he still had allowing any court ruling related of and the guardianship. The presented to the ER before applaint of cough and chest schortness of breath with a tent #1 was hungry as he kept | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ' ' | PLE CONSTRUCTION B | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|--|----------------------------|----------------------------|
| | | 345558 | B. WING | | | C 09/13/2021 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711 | <u> </u> | 09/13/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 624 | requesting food. Ch bilateral lung passage replaced with fluids, and chronic change community acquired oral antibiotics. He had mydl, white blood signs were within no spent a night in the 07/18/21 morning. Fewere instructed by the hospital if any sympth orange or mythout insulin as he the diagnosis of CO revealed since Resideemed incompeter appointed legal gual him discharge AMA the facility that day, AMA papers. The Administrator we jeopardy on 09/03/22. The facility provided immediate jeopardy correction date of 05 lidentify those recipies are likely to suffer, as a result of the noncon Resident #1 is no loon The four residents the have any current plate. | est X-ray showed portion of geway and lower lobes likely a combination of acute so. He was diagnosed with a pneumonia and started on and blood glucose (BG) of 83 cell count of 5.8, and his vital ormal limits. Resident #1 ER and was discharged on Resident #1 and his friend the physician to return to the tom worsening occurred. Tryiew with the Medical (1/22/21 at 2:33 PM, he stated for Resident #1 was his DM awas insulin dependent and PD. The interview further dent #1 had been declared at by the court and had an ordian, it was not ideal to let at 1. The MD stated if he was in the would not have signed the last informed of immediate 1 at 8:39 AM. If the following acceptable removal plan with the 1/08/21. The serious adverse outcome as | F 62 | 2.4 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|--|-------------------------------|-------------------------------|--|
| | | 345558 | B. WING | | | C 0/43/2024 | |
| NAME OF PR | ROVIDER OR SUPPLIER | 040000 | | STREET ADDRESS, CITY, STATE, ZIP CO | | 9/13/2021 | |
| | | | | 62 LAKE EDEN ROAD | | | |
| NC STATE | VETERANS HOME-BL | ACK MOUNTAIN | | BLACK MOUNTAIN, NC 28711 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 624 | Continued From pag | ge 24 | F 6 | 24 | | | |
| | adverse outcomes. | fore are not at risk for serious charged from Center (AMA) | | | | | |
| | His diagnoses included depression, COPD, supraventricular tack 4 pressure ulcer at le osteoarthritis. Revied dated 02/17/21 indicated new months and the control of the con | nycardia, chronic pain, stage eft hip, gout, and ew of the court document eated the court had declared | | | | | |
| | to go home. Administ Director (SSD), and (ADON) counseled in Resident #1 was distributed advice (AMA) from the 3:30pm on 7/16/21 at form was signed by clear in understanding decisions and voiced home without clears at 15pm resident #1 4:25pm SSD attempt Catawba County DS Emergency Adult Protein the strength of the st | legation: #1 stated that he was going strator (NHA), Social Services Assistant Director of Nursing resident #1 prior to departure. charged against medical he facility on 7/16/21. At an against medical advice SSD and resident #1 was ng of ramifications of d clarity of his intent to go nce from guardian. At left facility with friend. At sted to notify guardian at 6S and left a message. Otective Services (APS) was with Buncombe County ent #1's financial guardian, attorney for resident #1 was as SSD received return call inch time she notified guardian discharge, resident was given as and offered one day of | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | (X3 | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---------------------|--|------------------------------|-------------------------------|--|--|
| | | 345558 | B. WING | | | C | | |
| NAME OF PROVIDER OR SUPPLIER NC STATE VETERANS HOME-BLACK MOUNTAIN | | | | STREET ADDRESS, CITY, STATE, ZIP CO 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711 | DE | 09/13/2021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | | |
| F 624 | medication. Safe tra personnel to the veh Per survey findings, presented to ER with cough, chest pain, a Chest x-ray revealed passageway and low #1 diagnosed with county pneumonia and oral discharged the morrow Specify the action the process or system for adverse outcome frowhen the action will Education and training for discharge planning Consultant on 09/03 and NHA with the tragiven to the Clinical (CCC), Nurse Navig Nursing (DON). The used to in-service all social services partna admission's directoried education will includ permission from guan otification to Respondischarge/leave of a discharge/AMA pracemedications/medical with all discharges if | nsfer was made by nursing icle of transport. on 7/17/21, resident #1 a complaint of productive and shortness of breath. It portion of bilateral lung over lobes with fluid. Resident community acquired antibiotics initiated. Resident sing of 7/18/21 with his friend. The entity will take to alter the ailure to prevent a serious of occurring or recurring and be completed: The gon policy and procedure and was provided by the Nurse and procedure and was provided by the Nurse and procedure and was provided by the Nurse and procedure are gone policy and procedure and was provided by the Nurse and procedure are gone policy and procedure and was provided by the Nurse and procedure are gone policy and procedure and the ADON and procedure are gone policy | Fé | 524 | | | | |
| | (CCC), Nurse Navig Nursing (DON). The used to in-service al social services partnadmission's director education is being in and will be complete education will includ permission from guanotification to Respondischarge/leave of a discharge/AMA pracmedications/medical with all discharges if available at the facili obtained and sent he | ator (NN) and Director of e CCC, NN and DON will be applicable staff (nurses, ers, NHA, ADON and b. The Discharge planning uitiated on September 3, 2021 d by September 7, 2021. All e notification of and ardian (if applicable) and unsible Party (RP) prior to any besence (LOA); safe tices up to and including a supplies that will be sent those medications are | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL | | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|--|--------------------------------|----------------------------|--|
| | | 345558 | B. WING _ | | , | C 09/13/2021 | |
| NAME OF PROVIDER OR SUPPLIER NC STATE VETERANS HOME-BLACK MOUNTAIN | | | | STREET ADDRESS, CITY, STATE, ZIP CO 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711 | | 00/10/2021 | |
| (X4) ID PREFIX TAG | | | ID PREFII TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 624 | resident and/or resignovided by nurse a discharge instruction Responsible Party and demonstration inclusion administration of injure insulin will be demonstration to guard include signs and shyper/hypoglycemia also include possib AMA discharges and discharges that do families. Any staff in scheduled time office before their next so the CCC were notificed they were notified they were notifie | uctions are to be given to the consible party; education about medication and sins to guardian (if applicable), and Resident. Return ading but not limited to safe sectable medications including constrated to discharging nurse. If it is included and the consequences of a sequence of a sequence of a sequence of a consequence of a sequence of a consequence of a co | F | 524 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345558 | | ` ' | I ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|--------------------|---|---|-------------------------------|----------------------------|
| | | B. WING | | | C 09/13/2021 | | |
| | ROVIDER OR SUPPLIER | ACK MOUNTAIN | | 62 | REET ADDRESS, CITY, STATE, ZIP CODE LAKE EDEN ROAD ACK MOUNTAIN, NC 28711 | 1 00, | 10/2021 |
| (X4) ID PREFIX TAG | | | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 624 | be sent with the resimedications/medical applicable); NN or do not medications and discharge. The SSD on their responsibilit. The Director of Nursimeview the discharge previous day to ensure completed per policy to the monthly Quali Improvement (QAPI educated on her resident has a guardian will be notified wishes of the resident facility feels that the resident persists, the (if applicable), responsibility on 9/3, ADHOC Quality Ass Improvement meeting | prescriptions are obtained to dent as well as current supplies in facility (if esignated nurse will educate discharge instructions prior to and the NN were educated y on 9/3/2021. Ing (DON) or designee will es completed from the ure that all components were with the findings will be brought by Assurance/Performance of meeting. The DON was ponsibility on 9/3/2021. Ilegal guardian, the legal fied immediately of any AMA and by SSD or NHA. If the discharge is unsafe, but the en facility will notify Guardian ensible party, Power of the party, Power of the party, Power of the party of the party of the party of the party. APS, VA, Medical an and Facility Administration. HA were notified of their 1/2021. | F | 624 | DEFICIENCY) | | |
| | and Clinical Compet service all applicable and immediate inter- discharges as indica Immediate jeopardy 2021. | ency Coordinator (CCC) to in expartners about the plans ventions of AMA and ted above. Removal date: September 8, mmediate jeopardy removal | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|-------------------------|--|-------------------------------|----------------------------|--|
| | | 345558 | B. WING _ | | , | C 9/13/2021 | |
| NAME OF PROVIDER OR SUPPLIER NC STATE VETERANS HOME-BLACK MOUNTAIN | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711 | • | 3/13/2321 | |
| (X4) ID PREFIX TAG | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFI) TAG | PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 624 | Continued From pa | ge 28 | F 6 | 524 | | | |
| | immediate jeopardy was validated on 05 procedure titled "Di 06/30/21 and "Refu advice" revised on no concerns identification records conducted 09/06/21 revealed a included nursing, so DON, ADON, and to completed the in-set the in-service had reprocedure for disch training to conduct a lin-service that begat by the DON, CCC and deducation included -Notification of and applicable) and Resany discharge/leave -Safe discharge/leave -Safe discharge/Alvincluded sending m with all discharges available at the faci -Prescriptions were with Resident. -Set up home healt -The discharging no related to medication to the Resident and o Solicited return delimited to safe admit medications such a and/or RP/guardian | an on 09/03/21 was conducted and NN. The topic of the but not limited to: permission from guardian (if sponsible Party (RP) prior to e of absence (LOA). IA practices up to and edications/medical supplies if those medications were lity. to be obtained and sent home the when indicated. urse provided education ons and discharge instructions lor RP/guardian. emonstration including but not nistration of injectable insulin by the Resident | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345558 | | | (X2) MULT A. BUILDI | LTIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|------------------------|---------------------------------------|--|-------------------------------|----------------------------|
| | | 345558 | B. WING | | | 09/13/2021 | |
| NAME OF PROVIDER OR SUPPLIER NC STATE VETERANS HOME-BLACK MOUNTAIN | | | | 62 | REET ADDRESS, CITY, STATE, ZIP CODE LAKE EDEN ROAD LACK MOUNTAIN, NC 28711 | | |
| (X4) ID PREFIX TAG | | | ID PREFI TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD | | | (X5) COMPLETION DATE |
| F 624 | Continued From page | | F | 624 | | | |
| | applicable conditions hypoglycemia. o Counseled Resider possible adverse condischarges and dischardians and familie | arges that do not involve | | | | | |
| | Leave Act (FMLA) wo next scheduled shift. was responsible for to staffs to ensure the s The CCC, DON and providing the educati receive the in-service agency nurses and a educated on the AMA setting up of home he applicable durable m the coordination from | or Family and Medical ould be educated before their The ADON and the CCC racking all the applicable tated training was received. NN were responsible for on for staff who did not e on 09/03/21. New nurses, pplicable new hires would be a and safe discharges, ealth, medications, and edical equipment (DME) with CCC and her trained entation. The SSD was | | | | | |
| | responsible to facilitate discharging resident. responsible to review from the previous day were completed per prought to the month | te DME needs for the The DON or designee was the discharges completed to ensure all components policy. The findings would be | | | | | |
| | revealed all the applirequired to complete discharge planning h from 09/03/21 throug able to verbalize her | oplicable staffs on 09/13/21 cable staff who were the in-service related to ad completed the education th 09/06/21. The SSD was understanding to assess the ety of discharge destination | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345558 | | | | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--------------------|---|--|-------------------------------|--|
| | | B. WING | | | C 9/13/2021 | | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZI 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 2871 | P CODE | 9/13/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE | ACTION SHOULD BE TO THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 624 | water; refer to Homapplicable); ensure and to be sent with availability of medicular during discharge. At their responsibilitie instructions to Resmedications, safe amedications, identiof applicable condiconsequences of Ato discharge. The Oto provide education related to safe discated to safe discated. The ADON at an interview. The Noto notify the legal of | e; access to food and running the Health Services (if the prescriptions were obtained to the Resident and facilitate the cal supplies (if applicable) All the nurses were aware of the to provide discharge tident and/or RP/guardian on the administration of injectable fication of signs and symptoms tions, and possible adverse tions, and possible adverse tions, and possible adverse tions and tracking in-service tharge for all the applicable and DON were unavailable for the tide of the tide of the tide of the tide of tide of tide of tide tide of tide of tide of tide of tide of tide tide of tide tide of t | F | 524 | | | |