STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345531	A. BUILDING ______ B. WING ______	C 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS HOME - SALISBURY	1601 BRENNER AVE, BUILDNG #10 SALISBURY, NC 28145

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The survey team entered the facility on 8/5/24 to conduct a Recertification and Complaint Investigation survey. The survey team was onsite 8/5/24 through 8/7/24. Additional information was obtained offsite on 8/8/24. Therefore, the exit date was 8/8/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# LG1K11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 8/5/24 to conduct a Recertification and Complaint Investigation survey and was unable to return to the facility on 8/8/24 due to adverse weather of a tropical storm and unsafe travel conditions. Additional information was obtained offsite on 8/8/24. Therefore, the exit date was 8/8/24. Event ID# LG1K11. The following intakes were investigated NC00219587, NC00219336, NC00217100, NC00212017, NC00207083, and NC00206538. 1 of the 5 complaint allegations resulted in deficiency.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and	F 561		8/30/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/23/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 561	Continued From page 1 waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and resident interviews, the facility failed to honor residents' preference for eating in the dining room in the evenings for 1 of 1 resident reviewed for choices (Residents #58). Findings included: Resident # 58 was admitted to the facility on 05/18/22 with diagnoses which included hypertension and muscle weakness. Review of the Resident #58's significant change Minimum Dat Set (MDS) dated 05/24/22 revealed the resident was alert and oriented. The MDS further revealed Resident #58 was independent and required setup for eating. The MDS further revealed resident #58 was coded for wheelchair	F 561	What corrective action will be accomplished for the resident found to have been affected by the deficient practice: "On 08/08/2024, the Director of Health Services /Assistant Director of Health Services completed a Dining Preference form for resident #58. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: "All residents have the potential to be affected.	

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F 561

Continued From page 2
use.

An interview conducted with Resident #58 on 08/05/24 at 2:40 PM revealed he enjoyed eating dinner meals in the 200-hall dining room with friends but was told by staff on multiple dates that he could not eat in the dining room due to shortage of staff. Resident #58 indicated this often occurred on weekends and sometimes throughout the week.

An interview conducted with Nurse Aide (NA) #4 on 08/06/24 at 2:55 PM revealed Resident #58 wanted to eat in the dining room in the evening. NA #4 further revealed on weekends and sometimes during the week residents were not able to eat in the dining room for supper due to staff calling out of work and staff being too busy to assist residents with setting up for dinner. NA #4 stated Resident #58 had complained to staff multiple times that he wanted to eat dinner with the dining room with other residents.

An interview conducted with Nurse Aide (NA) #5 on 08/06/24 at 4:15 PM revealed it was common for residents to not use the dining room on the 200-hall due to staff calling out and staff having to assist residents that required help. NA #4 indicated Resident #58 often complained that he didn ' t want to eat in his room and requested to eat in the dining room.

An interview conducted with Nurse #3 on 08/07/24 at 10:05 AM revealed Resident #58 had complained during the second shift that he was unable to use the dining room for supper. Nurse #4 further revealed staff would call out and staff would assist residents who required assistance with feeding and would run out of time to assist

F 561

"On 8/23/2024 the Director of Health Services and Assistant Director of Health Services educated licensed nurses and CNAs on ensuring the dining rooms are open and staffed for meal services.

"On 8/23/2024 the Recreation Services Director posted at each dining room the dining room hours and included a printout in Activity□s Newsletter which is sent out to all residents families.

Measures to be put in place or systemic changes made to ensure practice will not re-occur:

"On 8/8/2024 All staff including maintenance, admin, housekeeping, licensed nurses, CNAs will be educated on use of the dining rooms for dinner during the week and on weekends. If staff are on PTO, FMLA, or out sick they will be educated upon return. Education will be added to orientation as well.

"On 8/23/2024 the Recreation Services Director posted the dining room hours outside of each dining room and included a printout in Activity□s Newsletter which is sent out to all residents families.

How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:

"Director of Health Services or their designee will audit the use of resident dining rooms on 1st and 2nd floors four

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F 561	Continued From page 3 residents who wanted to set up in the dining room. An interview conducted with the Director of Nursing (DON) dated 08/07/24 at 9:10 AM revealed she recalled nursing staff had not allowed dining during dinner multiple days and had educated that if any resident wanted to have their evening meal in the dining room that it should be allowed. The DON further revealed she had not heard Resident #58 complain. The DON stated it was expected for residents to choose their preference of dining. An interview conducted with the Administrator on 08/07/24 at 8:20 AM revealed he was not aware Resident #58 had asked to eat in the dining room in the evenings and was unable too. The Administrator further revealed he expected residents to have a choice of dining and was not aware nursing staff was not following that.	F 561	days a week, three of the days during the week and one weekend day; three days a week for four weeks, two of the days being weekdays and one day on the weekend; then two days a week for four weeks, one day being a weekday and one day on the weekend. "Director of health services with take audit results to QAPI monthly until compliance is sustained. "Date of compliance 8/30/2024	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to provide shaving for 1 of 4 residents (Resident #4) reviewed for personal hygiene. Resident #4 was dependent on staff for personal hygiene. Findings included:	F 677	1.What corrective action will be accomplished for each resident found to have been affected by the deficient practice: "Resident #4 was shaven on 8/5. 2.How corrective action will be	8/30/24

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F 677 Continued From page 4

Resident #4 was admitted to the facility on 5/30/2019 with diagnoses of stroke and hemiplegia.

A quarterly Minimum Data Set assessment dated 6/4/2024 indicated Resident #4 was dependent on staff for showering and required moderate assistance with personal hygiene such as shaving.
Resident #4's Care Plan, which was updated on 6/10/2024, stated he was dependent for personal hygiene and bathing and staff would provide assistance as needed.

A Nurse's Progress Note by Nurse #1 written on 8/3/2024 at 12:03 pm indicated Resident #4 took his scheduled shower.

Review of Resident #4's shower and personal hygiene documentation on 8/3/2024 at 6:47 pm indicated he was given a shower.

During an observation and interview with Resident #4 on 8/5/2024 at 12:03 pm he was observed to have a full beard which was approximately ½ inch long. Resident #4 stated he preferred to be shaved but staff did not have time to do it.

During an interview by phone with Nurse Aide #2 on 8/8/2024 at 12:25 pm she stated she gave Resident #4 his shower on 8/3/2024. Nurse Aide #2 stated she did not shave Resident #4 and did not ask him if he wanted to be shaved. Nurse Aide #2 stated she was not able to provide Resident #4 with a shave because she had two other residents to give a shower because they had complained they had not received a shower on the 3:00 pm to 11:00 pm shift on their previous

F 677

accomplished for those residents having the potential to be affected by the same deficient practice:

"Full facility audit on facial hair will be completed by 8/23/2024 to ensure all residents who agree to be shaven are shaved this was completed by the assistant director of health services.

3. Measures to be put in place or systemic changes made to ensure practice will not re-occur:

"Starting 8/12/2024 Director of health services and Assistant director of health services re-educated all Licensed nurses and CNAs to follow company policy that residents are to be shaven on their shower days or as needed.

"100% education completed by 8/23/2024

"Anyone not trained by compliance date due to FMLA, PTO, or sick leave will be educated by next shift date.

"Education will be added to orientation as well.

4.How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:

"The director of health services will audit 10 residents for four days a week for the first four weeks, 10 residents for three days a week for the second four weeks, and 10 residents for two days a week for

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F 677	Continued From page 5 shower days. She stated she did not know why the staff on previous 3:00 pm to 11:00 pm shift had not completed their showers. Nurse Aide #2 stated Resident #4 did not refuse a shower when she was assigned to him because she offered the shower when he does not have a smoking break. The Assistant Director of Nursing (ADON) was interviewed on 8/7/2024 at 9:12 am and she stated Resident #4 refused his shower if they offer his shower during the smoke breaks, so they attempted to offer his shower between smoke breaks. The ADON stated the Nurse Aide should provide a shave when they give a shower. On 8/7/2024 at 9:55 pm the Administrator was interviewed and stated Resident #4 does refuse to be shaved at times, but the staff would ask him to speak with him and he would allow them to shave him. The Administrator stated the staff should ensure he is shaved.	F 677	the third four weeks to ensure the deficient practice is corrected. "Results from audits will be taken to quality assurance and performance improvement monthly to ensure compliance is continued throughout auditing period. "Date of compliance 8/30/2024	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		8/30/24

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F 812	Continued From page 6 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to remove unlabeled items from 2 of 2 nourishment rooms. These practices had the potential to affect food served to residents. Findings included: An observation and interview conducted with Dietary Cook #1 on 08/05/24 at 11:10 AM revealed the nourishment room located on the second floor had a bottle of 12 fluid ounce (fl. oz) lactose free milk 20 fl. oz orange Gatorade, and an opened half full 20 fl oz. bottle of cherry coke located in the refrigerator that were unlabeled. Dietary Cook #1 further revealed they were not sure if the items belonged to a resident or nursing staff but should not have been located the refrigerator unlabeled. Dietary Cook #1 indicated it was nursing staffs' responsibility to label items that belong to residents and staff items were not allowed in the nourishment rooms. An observation and interview conducted with the Dietary Cook #1 and Nurse #2 on 08/05/24 at 11:20 AM revealed the nourishment room located on the first floor had two push-up ice cream cones and two 16 oz. containers of ice cream that were open and unlabeled. Dietary Cook #1 and Nurse #2 further revealed the items belonged to a resident but could not recall which specific resident. The DM and Nurse #2 indicated it was nursing staffs' responsibility to label items that	F 812	1.What corrective action will be accomplished for each resident found to have been affected by the deficient practice: "All unlabeled items that were noted were removed on 8/6/2024. 2.How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: "All residents have the potential to be affected "Administrator completed an audit on 8/6/2024 of both nourishment room refrigerators and two push pops were removed and disposed of. 3.Measures to be put in place or systemic changes made to ensure practice will not re-occur: "Educate maintenance, housekeeping, dietary, nursing, and admin on residents personal food storage policy and new labeling procedure which is there will be labels available in nourishment room with marker provided. Education started 8/8/2024.	

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F 812	Continued From page 7 belong to residents and that staff items were not allowed in the nourishment rooms. An interview conducted with the Dietary Manager (DM) was unable to be completed due to the DM being unavailable during the survey. An interview conducted with the Director of Nursing (DON) on 08/07/24 at 10:00 AM revealed nursing staff had been educated and notes were in the nourishment rooms to label resident items in the nourishment rooms. The DON indicated she expected nursing staff to follow this. An interview conducted with the Administrator on 08/07/24 at 8:05 AM revealed it was educated and expected for nursing staff to label residents' items when received and placed in the nourishment rooms. The Administrator further revealed when new staff were hired, they were taught that residents' items were to be labeled. The Administrator indicated dietary staff checked the nourishment rooms daily as well and were advised to look for items that were unlabeled.	F 812	" Educate current families via newsletter completed by director of activities on facility□s food storage policy and new labeling procedure mailed on 8/23/2024. "Any staff not available for education due to FMLA, PTO, or sick leave will be educated prior to returning to work. "Education will be added to orientation. 4.How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: "Administrator or his designee will audit nourishment room fridges starting 8/26/2024. The fridges in the resident nourishment rooms on 1st and 2nd floor will be audited three times a week for four weeks, two times a week for four weeks, then once a week for four weeks. " Results will be taken to quality assurance and performance improvement monthly until compliance Date of compliance is 8/30/2024	