DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OM	B NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONST			DATE SURVEY COMPLETED
AND I LAN OI	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	IG			
		345560	B. WING				C 01/12/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		01/13/2025
					LL ROAD		
NC STATE	VETERANS HOME-KIN	STON		KINSTO	N, NC 28504		
(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 SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	00			
	from 1/07/25 through information obtained 1/10/25. Onsite valid jeopardy removal pla	ation was conducted onsite 1/08/25 with additional remotely on 1/09/25 through ation of the immediate ns was conducted on ne exit date was 1/13/25.					
	The following intake v NC00225640.	was investigated:					
	Intake NC00225640 ı jeopardy.	resulted in immediate					
	1 of the 1 complaint a deficiency.	allegation resulted in					
	Immediate Jeopardy	was identified at:					
		580 at a scope and severity J 584 at a scope and severity J					
	The tag F684 constitu Care.	uted Substandard Quality of					
F 580	removed on 1/11/25. was conducted.	began on 11/23/24 and was A partial extended survey jury/Decline/Room, etc.)	F 5	80			1/31/25
SS=J				-			
	consult with the resid consistent with his or representative(s) whe	ediately inform the resident; ent's physician; and notify, her authority, the resident					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		1	TITLE		(X6) DATE
Electroni	cally Signed						01/27/2025

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.

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COMP		
		345560	B. WING			01/13/2025		
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE			
NC STATE	EVETERANS HOME-KINS	STON			2150 HULL ROAD KINSTON, NC 28504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 580	physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-thr clinical complications (C) A need to alter tree a need to discontinue treatment due to adve commence a new form (D) A decision to trans resident from the facil §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent information is available and provid physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a compo- that is a composite di §483.5) must disclose its physical configurat	as the potential for requiring ; ge in the resident's physical, ial status (that is, a , mental, or psychosocial eatening conditions or); atment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the ity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment 0(e)(6); or ent rights under Federal or ns as specified in paragraph ecord and periodically nailing and email) and	F	580				

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		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	IPLE CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. BUILDII			С
		345560	B. WING		0-	/13/2025
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP		
				2150 HULL ROAD		
NCSIAIE	EVETERANS HOME-KIN	ISTON		KINSTON, NC 28504		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 580	Continued From nos			-00		
F 360			F 5	080		
		fy the policies that apply to				
		een its different locations				
	under §483.15(c)(9).					
		T is not met as evidenced				
	by:					
		views and interviews with		Address how corrective a		
		in's office staff, Nurse		accomplished for those re		
		d Medical Director, the facility		have been affected by the	deficient	
		nysician or nurse practitioner		practice.		
		an unwitnessed fall with				
	head injury for a resi			Resident #1 passed away	on 11/30/2024.	
		thinner) in order for the				
		ne the necessary treatment		Address how the facility w		
	plan. The resident fe	ll on Saturday 11/23/24 and		residents having the poter	ntial to be	
	the physician was no	ot notified until Monday		affected by the same defic	cient practice.	
	11/25/24. Resident #	1 continued to receive his				
	anticoagulant medic	ation. On 11/27/24, Resident		The Director of Nursing co	ompleted an	
	#1 had an acute cha	nge in condition and was		audit of all falls from 11/1/	25 to 11/30/25	
	sent to the hospital.	Resident #1's Glasgow		with head injury to include	falls with head	
	Coma Scale (used to	o objectively describe the		injury and prescribed an a	inticoagulant.	
	extent of impaired co	onsciousness in all types of		The audit also included tir	nely notification	
	acute medical and tr	auma patients) in the hospital		of responsible representat	tive and	
	indicated he sustaine	ed a severe traumatic brain		physician and physician e	xtender. The	
	injury. He received t	treatment to reverse the		audit was completed 12/3	/24 by the	
	effects of Eliquis (a b	blood thinner) and attempt to		Director of Nursing.		
		le was placed on a ventilator				
	-	at helps people breathe by		Address what measures v	vill be put into	
		out of their lungs) and was		place or systemic changes		
	-	rent hospital for a higher level		ensure that the deficient p		
	of care. A computer	ized tomography (CT) scan		recur.		
	revealed multiple ab	normalities including a large				
	subdural hematoma	(brain bleed) measuring 3.7		The Director of Health Sei	rvices or Clinical	
		h a 9 millimeter (mm) midline		Competency Coordinator	will educate all	
	shift (displacement c	of brain tissue across the		licensed nursing staff to in	nmediately notify	
		in) and a small subfalcine		the physician or physician		
		(types of brain herniations		person or by phone of a fa		
	that are life threaten			injury for a resident on an		
		nside the skull causes brain		for the physician or physic	-	
		gh openings in the brain). The		make an informed decisio		

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/04/2025 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345560	B. WING				C / 13/2025
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		2701		2	150 HULL ROAD		
NC STATE	VETERANS HOME-KIN	STON		ĸ	KINSTON, NC 28504		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	vertebrae (a broken f spine). He died on 11 certificate indicated th was complications fro hematoma with midlin cause was listed as b brain. This deficient p residents reviewed for (Resident #1). Immediate jeopardy b Resident #1, who was anticoagulant, had a head injury and the p Immediate jeopardy w when the facility imple credible allegation of removal. The facility was	the had a fracture of the L1 irst lumbar bone in the /30/24 and the death the immediate cause of death orm a right side subdural the shift. The underlying oburt force injury of head and oractice was for 1 of 4 or notification of the physician began on 11/23/24 when s prescribed an fall with obvious signs of hysician was not notified. was removed on 1/11/25 emented an acceptable immediate jeopardy will remain out of compliance severity of D to ensure ed and monitoring systems	F	580	continued use anticoagulant or need transfer the resident to an acute care facility. The physician or physician extender should be notified immediate person or by phone if any significant change in condition, to include falls whead injury, for residents prescribed a anticoagulant. Licensed nurses will be educated regarding health risk for residents on anticoagulants and the importance of notification of physiciar physician extender in person or by phose staff education will be completed on 1/10/25 or prior to the staff working the next scheduled shift. The education will be added to the licensed nurse writter orientation program.	ely in ith an e n or ione. vill n	
	The findings included Resident #1 was adm 10/21/24 with diagnos (irregular heart beat), cognitive communica (high blood pressure) Resident #1's medica document that summ information in a patie indicated his code sta full medical interventi	i: hitted to the facility on ses including atrial fibrillation congestive heart failure, tion deficit, and hypertension h. al record face sheet (a arizes a patient's important			Beginning 1/10/25, the Director of He Services, Performance Improvement Nurse or the Nurse Supervisor will us Fall/Anticoagulant/Discharge Audit To review of all fall events during the mo clinical meeting to verify licensed nurs staff immediately notified the physicia physician extender in person or by ph of a fall with head injury for a resident an anticoagulant for the physician or physician extender to make an inform decision regarding continued use anticoagulant or need to transfer the resident to an acute care facility. The Director of Health Services,	e the iol for rning sing n or ione t on	
		4 indicated he had severe			Performance Improvement Nurse or t	he	

Facility ID: 090963

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/04/2025 / APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345560	B. WING _				C 13/2025
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	VETERANS HOME-KIN	STON	2150 HULL ROAD				
				KI	INSTON, NC 28504		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Continued From page	<u>م</u>	F 5	80			
	cognitive impairment anticoagulant medica	and was taking an tion. an orders dated 11/8/24			Nurse Supervisor will use the Fall/Anticoagulant/Discharge Audit To weekly x eight weeks. The results of weekly audits will be presented to the Quality Assurance team weekly x 4	the	
	anticoagulant) 2.5 mi	lligrams (mg) twice a day.			weeks, then no less than monthly unt compliance is achieved	l	
	dated 11/23/24 indica unwitnessed fall in his was found by staff on assessment, it was for an abrasion to top lef indentation. His vital was able to move his placed back into his w he was alert and orien needed or wanted to stated he did not. He was given Tylenol per noted his neurological limits.	bund he hit his head and had t side of his head with an signs were stable and he arms and legs. He was wheelchair. Nurse #1 noted nted. Nurse #1 asked if he go to the hospital and he stated his head hurt and he r his request. Nurse #1 al checks were within normal			Compliance will be achieved by 1/31/	25.	
	11/23/24 at 2:00 PM Nurse #3 was alerted that Resident #1 was #3 entered his room, floor near the televisio of having a headache was given and no oth #3 noted the physicia updated on 11/23/24. The Facility/Provider documented an entry which noted Residen						

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			A. BUILDI	NG _			C
		345560	B. WING			01/	13/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE	VETERANS HOME-KINS	STON			150 HULL ROAD KINSTON, NC 28504		
0(0)15		ATEMENT OF DEFICIENCIES		n	PROVIDER'S PLAN OF CORRECTION		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	95	F	580			
		/25 at 11:08 AM, Nurse #3					
		o the room by NA #1. When n, Resident #1 was on the					
		evision cabinet and the wall.					
		sessed him and NA #1					
		ring him into his wheelchair. had a small indentation that					
		neone would press down					
		approximately the size of a ere it had hit something.					
		esident #1 was taking a					
		me of the fall. Nurse #3 said					
	-	normally called the physician incident but that she wrote					
	about the fall in the pl	nysician communication					
	book kept at the nurse	es' station.					
	A nursing progress no	ote dated 11/23/24 at 2:04					
	•	#1 indicated Resident #1					
		all and hit his head. She d an abrasion to the top left					
		a visible indentation. His					
	-	e and he was able to move					
	back in his wheelchai	Resident #1 was placed r and was alert and					
		lled the Director of Nursing					
	. ,	#1 was asked if he needed hospital and Resident #1					
	•	1 stated his head hurt but					
		im some Tylenol and he					
		#1 documented Tylenol was ogical checks were within					
	normal limits.	ารูเอลา อาเออกจ พอเฮ พแแแก					
		/25 at 4:04 PM, Nurse #1					
		by Nurse #3 that Resident					
		floor in his room. Nurse #1, ipervisor that day, went to					

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	
			A. BUILDI	ING			C
		345560	B. WING				/13/2025
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE	E VETERANS HOME-KINS	STON			2150 HULL ROAD KINSTON, NC 28504		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 580	the unit and found Rewheelchair. Nurse #1 neurologically and ph assessments were wis said she called the Di who told her to ask R go to the hospital and to no hospital." Nurse on blood thinners and on blood thinners could bleeding and a brain f physician or NP was through the medical p program. She said she telemedicine program notification was done In a phone interview of Medical Records Coop practice said when she records, there was no notifying the medical 11/23/24. Resident #1's Novem Administration Records to receive Eliquis twice Resident #1's Nurse I note dated 11/25/24 if the past week with the Resident #1 complain said he did not hit his The NP noted that star requests at the time of In a phone interview of said she came to the	esident #1 was up in his assessed Resident #1 ysically and all of his thin normal limits. Nurse #1 rector of Nurses (DON), esident #1 if he would like to the said no, he "ain't going #1 stated she knew he was that hitting his head while ld lead to uncontrolled bleed. She stated the usually notified of falls oractice telemedicine e did not notify the a about the fall and that by Nurse #3. on 1/8/25 at 2:42 PM, the ordinator at the medical he reviewed the notification o record of the facility practice regarding the fall on ber 2024 Medication d documented he continued are a day. Practitioner (NP) progress indicated he had two falls in e last one on 11/23/24. hed of pain from the fall but head and was doing well. aff had no acute concerns or	F	580			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345560	B. WING				C 13/2025
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE	EVETERANS HOME-KINS	STON			150 HULL ROAD INSTON, NC 28504		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	were to call the medic service with any incid condition. She remen cognitively impaired a historian. She said we on 11/25/24, she learn on 11/23/24. She said did not hit his head ar normally and at basel out later that visit (uni small abrasion on the she did not recall if sh abrasion that day. Sh the fall on 11/23/24 ur reviewed the physicia During the interview, telemedicine notificati said the practice had from the facility about 11/24/25. She said if st 11/23/24 and that Res she would have revie assessments and we of hospitalization or w prevent bleeding. Resident #1's nursing 11/27/24 at 11:15 AM documented she notifi Nurse #1, and inform not opening his eyes Resident #1 responde mumble but he would In her interview on 1/8 said that after the fall was acting normally.	cal practice telemedicine ents or changes of abered that Resident #1 was and was not a reliable hen she came into the facility hed about Resident #1's fall d Resident #1 reported he and appeared to be acting ine. The NP said she found recalled when) that he had a top of his head. She said he had assessed the e said she was not aware of ntil 11/25/24 when she in communication log. she reviewed the ion log on her phone and not received a notification c Resident #1 on 11/23/24 or she had known of the fall on sident #1 had a head injury, wed the nursing ighed the risks and benefits rithholding his Eliquis to progress notes dated written by Nurse #3 fied the nurse supervisor, ed her that Resident #1 was and waking up. She noted ed to touch and would not open his eyes. B/25 at 11:08 AM, Nurse #3 on 11/23/24, Resident #1 On the morning of 11/27/24,	F	580			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 02/04/2025 1 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	LETED
		345560	B. WING		_		_ 13/2025
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
NC STATE	EVETERANS HOME-KINS	STON		150 HULL ROAD KINSTON, NC 28504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Resident #1 and she several times through take all of his medicat NA #1 that Resident # morning, which was n liked working with NA her at approximately morning saying Resid She went to Resident significantly less resp she called his name. moan but did not ope was when she first no condition. She called nurse supervisor that concerns. Nurse #3 s Resident #1's room to vitals. Nurse #1 came brought Nurse #2 with stayed in the room for Nurse #1 and Nurse # they said he needed to the room to get the ho done. Resident #1's nursing 11/27/24 at 12 noon v she went to assess R call from Nurse #3 tha Nurse #1 noted she p Resident #1 had a ter Fahrenheit (F). Nurse with her findings. The bed and his blood pre 153/67. Resident #1 v responded to pain. No	that was not unusual for frequently had to attempt out the morning for him to tions. She had been told by #1 had yelled at her that not normal since he usually #1. NA #1 also came to get 10:30-11:30 AM that lent #1 wouldn't wake up. #1's room and saw he was onsive than normal when He would move a little and in his eyes. She said this ticed a change in his for Nurse #1, who was the day, and told her of her aid she went back into in her. Nurse #3 said she r a few minutes during #2's assessments, but when to go to the hospital, she left ospital transfer paperwork	F 580				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVE COMPLETED		
		345560	B. WING				C 13/2025	
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
					2150 HULL ROAD			
NC STATE	VETERANS HOME-KINS	STON		1	KINSTON, NC 28504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 580	and fever. In her interview by ph Nurse #1 said she wa see Resident #1 beca on 11/27/24 at approx she arrived on the uni #1 would respond onl she performed a sterr moan and move his a respond or open his e NP directly on the NP the resident was resp him to be sent to the I Resident #1's Emerge (EMS) Call Detail Rep they received a call for at 11:35 AM due to co status and that Reside Resident #1's hospita 11/27/24 noted he had days prior and hit his (bruise) in the occipita The ER note docume was woken up at app "cussing out" the staff sleep. He was later for unresponsive. The EF unresponsive with set where he would sque given painful stimulus words but was in gen physician noted Resid	R) for altered mental status one on 1/7/25 at 3:25 PM, is called by Nurse #3 to go buse he was not waking up dimately 11:00 AM. When it with Nurse #2, Resident y to painful stimuli. She said hal rub, which caused him to rms a little, but not verbally eyes. She said she called the 's cell phone, described how onding, and the NP ordered ER. ency Medical Services bort dated 11/27/24 noted or services for Resident #1 omplaint of altered mental ent #1 was unconscious. I #1's ER report dated d fallen approximately four head. He had a contusion al area (back) of his head. inted that morning when he roximately 7:30 AM and f and wanted to go back to bund at approximately noon R noted he was mi-purposeful movements eze the hand. If he was the would say nonsensible eral not responding. The dent #1 was given the two	F	580				
	to reverse the effects	and Tranexamic acid (TXA) of Eliquis. He was intubated ring 3-8 on the Glasgow						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345560	B. WING				C 13/2025
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	2150 HULL ROAD		
NC STATE	VETERANS HOME-KINS	STON		I	KINSTON, NC 28504		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	He was placed on a w breathing and was tra- hospital for a higher le Resident #1's hospital included results from multiple abnormalities hematoma measuring midline shift and a sm herniation. The CT sc acute fracture of the L noted he was evaluat determined he was no neurosurgery due to r meaningful recovery. comfort care and expi Resident #1's death of indicated Resident #1 noted the immediate of complications from rig with midline shift. The was listed as blunt for In an interview on 1/8 Medical Director, who physician, said Reside preventable if the reside hospital, but the facilitie even if he didn't unde benefits due to his co the industry practice of fall, even if the reside decision would depending mediately send a reside	adicated he was comatose. rentilator to assist with his insferred to a different evel of care. Il #2's report dated 11/30/24 a CT scan which revealed is including a large subdural g 3.7 cm with a 9 mm hall subfalcine and uncal can also found he had an 1 vertebrae. The report ed by neurology and it was but a candidate for no expectation of a Resident #1 was placed on ired on 11/30/24. Exertificate dated 12/4/24 expired on 11/30/24 and cause of death was due to ght side subdural hematoma e underlying cause of death rce injury of head and brain. /25 at 11:55 AM, the was also Resident #1's ent #1's death was ident had gone to the ty couldn't force him to go, rstand the risks versus gnitive impairment. She said	F	580			
	resident, and the sub						

Facility ID: 090963

If continuation sheet Page 11 of 32

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED
		345560	B. WING				C / 13/2025
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NC STATE	EVETERANS HOME-KINS	STON			2150 HULL ROAD KINSTON, NC 28504		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 580	stopped the Eliquis if report on 11/23/24. Sl as a stroke prevention him, she said he was stroke if the Eliquis was the neurological chece appropriately, and the medically until 11/27/2 anything other than to time. She said she re- communication log ar by the NP, and the far practice or providers of She said Resident #1 shown symptoms unti- enough to affect him was at baseline until 11/27 In an interview on 1/8 said Nurse #3 update communication log af said any nurse, inclue the physician either th communication log or telemedicine notificati a fall. She said the nu- method to use to com- physician, depending change of condition. S remained at his basel why Nurse #3 used the log to notify the provide facility Monday throug did not regularly work medical practice had weekends. When the should have notification telemedicine notification	she had received the fall he said because the Eliquis in medication was new for at an increased risk of as held. She said because ks had been done ere was no change in him 24, she would not have done o monitor him during that viewed the physician the documentation written cility did not notify the on 11/23/24 or 11/24/24. 's brain bleed wouldn't have il days later when it grew big which was why he appeared 7/24. /25 at 5:55 PM, the DON d the physician ter the fall on 11/23/24. She ding Nurse #3, should notify prough the physician through the practice ion system when there was ursing staff determine which municate with the on if the resident had a She said Resident #1 ine after the fall, which was he physician communication der. The NP came to the gh Friday and the physician to nthe weekends. The on-call physicians for the DON was asked if staff	F	580			

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURV COMPLETER	
345560 B. WING 01/13/20	3/2025
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
NC STATE VETERANS HOME-KINSTON 2150 HULL ROAD KINSTON, NC 28504	
	(X5) COMPLETION DATE
F 580 Continued From page 12 using the communication log that would be viewed on Monday, she indicated the communication log notification was appropriate. F 580 The Administrator was notified of Immediate Jeopardy on 1/8/24 at 6:06 PM. The facility provided the following credible allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome The facility failed to notify the physician immediately of a fall with head injury for a resident on an anticoagulant for the physician to determine the necessary treatment plan. The resident fell on 11/23/24. Failure to notify the physician of the resident's fall with head injury while taking anticoagulant resulted in the resident being discharged to an acute care facility on 11/27/24 with a severe traumatic brain injury. Licensed nurses failed to understand the risk related to a resident having the potential for a severe injury while taking anticoagulants. Licensed nurses failed to understand the risk related to a resident having anticoagulants. Licensed nurses failed to understand the risk related to a resident having anticoagulants. Licensed nurses failed to understand the risk related to a resident having anticoagulants. Licensed anticoaguiant result ob be notified when a resident has had at all with a head injury and is being administered anticoagulants. Resident #1 passed away on 11/30/24. All residents receiving anticoagulants are at risk of suffering a serious outcome.	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345560	B. WING				/13/2025
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE	VETERANS HOME-KINS	STON			2150 HULL ROAD KINSTON, NC 28504		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	process or system fai adverse outcome from when the action will b Beginning 1/10/25, th Services or the Nurse events during the more verify the physician of been notified of chang falls with head injury fanticoagulants. The Director of Health Competency Coordina nursing staff to immed physician extender in with head injury for a for the physician or pl an informed decision anticoagulant or need an acute care facility. extender should be no or by phone if any sig to include falls with he prescribed an anticoa be educated regardin anticoagulants and th of physician or physic phone. Staff educatio 1/10/25 or prior to the scheduled shift. The et the licensed nurse wr The immediate jeopar 1/11/25.	e entity will take to alter the lure to prevent a serious in occurring or recurring, and e complete. e Director of Health a Supervisor will review all ming clinical meeting to r the physician extender has ges in condition to include for residents on a Services or Clinical ator will educate all licensed diately notify the physician or person or by phone of a fall resident on an anticoagulant hysician extender to make regarding continued use to transfer the resident to The physician or physician otified immediately in person nificant change in condition, ead injury, for residents gulant. Licensed nurses will g health risk for residents on e importance of notification tian extender in person or by n will be completed on a staff working their next education will be added to itten orientation program. rdy was removed on	F	580			

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C
		345560	B. WING		01/13/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
NC STATE	EVETERANS HOME-KINS	STON		2150 HULL ROAD KINSTON, NC 28504	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 580	Continued From page	9 14	F 58	30	
F 684 SS=J	licensed nurses were notify the physician or person or by phone or resident on an anticoa physician or physician decision regarding co or the need to transfe care facility. Education residents on anticoag of notification of the p person or by phone. The immediate jeopan was validated. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fun applies to all treatment facility residents. Base assessment of a resident that residents receive accordance with profe practice, the comprehe care plan, and the resident this REQUIREMENT by: Based on record revit Responsible Party (R (NP), and Medical Dir explain to the resident threatening consequent hospital evaluation white impaired resident who	ndamental principle that and care provided to ed on the comprehensive lent, the facility must ensure treatment and care in essional standards of ensive person-centered sidents' choices. It is not met as evidenced ews and interviews with the P), staff, Nurse Practitioner ector, the facility failed to: t and RP the risk of life ences and the importance of nen a severely cognitively	F 68	Address how corrective action will be accomplished for those residents found have been affected by the deficient practice. Resident #1 passed away on 11/30/202 All residents on anticoagulants are at serious risk of suffering a serious	

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345560	B. WING				C 1 3/2025	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		13/2025	
	NOVIDER ON OUT FIELD				50 HULL ROAD			
NC STATE	VETERANS HOME-KIN	STON			NSTON, NC 28504			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From pag	o 15		684				
1 004			FC	004				
	hospital evaluation; a	-			outcome.			
	seriousness of a cha				Address how the facility will identify oth	ner		
	-	nergent medical care. On			residents having the potential to be			
		had an unwitnessed fall and			affected by the same deficient practice			
		ving an abrasion with a small			The Divertee of Newsian economicated and			
		p of his head described by			The Director of Nursing completed an audit of all falls from 11/1/25 to 11/30/2			
		someone would press down The resident stated he "ain't			with head injury to include falls with he	-		
		The RP was notified of the			injury and prescribed an anticoagulant			
		did not mention that the			The audit also included timely notificat			
		hospital or explain the			of responsible representative and			
		ces of a serious head injury.			physician and physician extender. The	9		
		lid not understand the			audit was completed 12/3/24 by the			
	-	jury. Resident #1 continued			Director of Nursing.			
		agulant medication. On						
	11/27/24, Resident #	1 was noted with a change in			Address what measures will be put inte	C		
	behaviors at approxi	mately 8:00 AM and between			place or systemic changes made to			
		AM and 10:15 AM Nurse			ensure that the deficient practice will n	ot		
		wake the resident but he			recur.			
		es and his only response was						
	grunting and mumblin	•			Education began 1/9/24 by the Directo	r of		
		assessed by a nurse until			Health Services to all licensed staff on			
		AM. Nurse #1 performed a			identification of change in condition an			
	, .	stimulus used to assess a			what constitutes a change in condition The education will include the use of the			
		l status and responsiveness) was only responsive to			Interact Change in condition tool. Nurs			
		NP was contacted at 11:20			will be educated regarding notification			
	AM to report the chai				physician when a change in resident			
	-	Services (EMS) were			condition occurs. The education will b	е		
		M. Resident #1's Glasgow			added to the licensed nurse orientation			
		objectively describe the						
		nsciousness in all types of			Licensed staff will be educated regardi	ng		
		auma patients) in the hospital			a resident with any cognition level that	-		
		ed a severe traumatic brain			refuses hospital transport once a			
	injury. He received t	reatment to reverse the			physician and/or physician extender or	der		
		icoagulant) and attempt to			has been received, that the physician			
		e was placed on a ventilator			and/or physician extender and residen	t		
	(a medical device tha	at helps people breathe by			representative must be notified of the			

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· · /			IPLETED
				·		С
		345560	B. WING		0,	1/13/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		1/10/2020
				2150 HULL ROAD		
NC STATE	EVETERANS HOME-KIN	STON		KINSTON, NC 28504		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE / CROSS-REFERENCED	TO THE APPROPRIATE	COMPLETION
F 684	Continued From page	e 16	F 68	4		
	moving air into and o	ut of their lungs) and was		refusal. Staff education	will be complete	
		ent hospital for a higher level		by 1/10/25 or prior to the		
	of care. A computeriz	zed tomography (CT) scan		their next scheduled shi	-	
:		normalities including a large		will be added to the licer	nsed nurse	
		(brain bleed) measuring 3.7		orientation.		
		n a 9 millimeter (mm) midline				
		f brain tissue across the		Licensed staff will be ed		
		n) and a small subfalcine (types of brain herniations		responsibility to educate the resident representat		
	that are life threatening			refusal of follow-up at ar		
		nside the skull causes brain		facility to ensure the res		
		h openings in the brain). The		representative are making		
		he had a fracture of the L1		decision. The resident a	-	
	vertebrae (a broken f	irst lumbar bone in the		representative education	n will be	
	spine).He died on 11	/30/24 and the death		documented by the licer	nsed nurse in the	
		ne immediate cause of death		medical record. The Dir		
	-	om a right side subdural		Services and the Admin		
		ne shift. The underlying		notified when a resident		
		blunt force injury of head and		ordered transport to an a		
	residents reviewed for	practice was for 1 of 4		Staff education will be c 1/10/25 or prior to the st		
				next scheduled shift. Th	-	
	Immediate ieonardy h	began on 11/23/24 when		be added to the licensed		
		s severely cognitively		orientation.		
	impaired and prescrib					
	refused hospital evalu	-		Certified Nursing Assista	ants and the	
		obvious signs of head injury		Therapy Department sta	aff will be	
		to explain to the resident		educated by the Directo		
		tening consequences that		or the Clinical Competer		
		mportance of hospital		on reporting to the licen		
		te jeopardy was removed on		changes they notice in a	•	
	1/11/25 when the fac	ility implemented an illegation of immediate		are outside of the reside		
		le facility will remain out of		behavior, physical appe signs. Staff education w		
		r scope and severity of D to		by 1/10/25 or prior to the		
		completed and monitoring		their next scheduled shi		
	systems put in place			will be added to the cert		
	,				-	
				assistant and Therapy D	Department	

Facility ID: 090963

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 02/04/2025 RM APPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		345560	B. WING			0.	C I/13/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		STON		2	150 HULL ROAD		
NC STATE	E VETERANS HOME-KIN	STON		ĸ	(INSTON, NC 28504		
(X4) ID PREFIX TAG	(EACH DEFICIENC	H DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION) JLATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO TH			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From page	e 17	F	684			
	10/21/24 with diagnos (irregular heart beat), cognitive communica (high blood pressure) Resident #1's medical document that summ information in a patie indicated his code sta full medical interventi Resident #1's compre 10/21/24 revealed he risk for falls, and was medication. Intervent use was to educate th representative on risk anticoagulation use. Resident #1's admiss (MDS) dated 10/28/2 cognitive impairment, needed partial or mod for his activities of da indicated he had not admission and was ta medication. Resident #1's physici noted he was prescrit anticoagulant) 2.5 mi An event incident rep dated 11/23/24 indica	Resident #1's medical record face sheet (a document that summarizes a patient's important information in a patient's medical record) indicated his code status was full code requesting ull medical interventions in an emergency. Resident #1's comprehensive care plan dated 10/21/24 revealed he would refuse care, was at isk for falls, and was taking an anticoagulant nedication. Interventions for his anticoagulant use was to educate the resident and epresentative on risk and benefits of anticoagulation use. Resident #1's admission Minimum Data Set MDS) dated 10/28/24 indicated he had severe cognitive impairment, would refuse care, and needed partial or moderate assistance from staff or his activities of daily living (ADLs). The MDS indicated he had not had any falls since his admission and was taking an anticoagulant		PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/04/2025 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE S COMPLI	
		345560	B. WING				C / 13/2025
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
NC STATE	VETERANS HOME-KIN	STON			150 HULL ROAD		
				ĸ	KINSTON, NC 28504		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	F 684 Continued From page 18		F	684			
	Continued From page 18 an abrasion to top left side of his head with an indentation. His vital signs were stable and he was able to move his arms and legs. He was placed back into his wheelchair. Nurse #1 noted he was alert and oriented. Nurse #1 asked if he needed or wanted to go to the hospital and he stated he did not. He stated his head hurt and he was given Tylenol per his request. Nurse #1 noted his neurological checks were within normal limits. Nurse #1 noted she asked Resident #1 several times if he would like to go to the hospital and he continued to refuse. Resident #1's nursing progress notes dated 11/23/24 at 2:00 PM written by Nurse #3 indicated Nurse #3 was alerted by a Nursing Assistant (NA) that Resident #1 was on the floor. When Nurse #3 entered his room, he was in the corner on the floor near the television. Resident #1 complained of having a headache and Nurse #3 noted Tylenol was given and no other issues were noted. Nurse #3 noted the physician notification communication book was updated and she notified Resident #1's RP.				Compliance will be achieved by 1/31/	25.	
	PM written by Nurse fall huddle, a meeting the nurse supervisor the fall and any possi to Resident #1 being noted he had an unw head. She noted Res the top left side of his indentation. His vital was able to move all #1 was placed back i alert and oriented. Nu	ote dated 11/23/24 at 2:04 #1 indicated staff called for a g of all staff on the unit and to review a fall to discuss ble contributing factors, due found on the floor. Nurse #1 itnessed fall and hit his ident #1 had an abrasion to a head with a visible signs were stable and he of his extremities. Resident n his wheelchair and was urse #1 called the Director of Resident #1 was asked if he					

Facility ID: 090963

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		ND HUMAN SERVICES MEDICAID SERVICES				F	TED: 02/04/2025 ORM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		CONSTRUCTION	(X3) I	DATE SURVEY COMPLETED
		345560	B. WING				C 01/13/2025
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	·	
NC STATE	VETERANS HOME-KIN	STON			50 HULL ROAD		
0(0)5	SHMMADY ST	ATEMENT OF DEFICIENCIES			NSTON, NC 28504 PROVIDER'S PLAN OF CORRI		(72)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 684	Resident #1 stated numerical head hurt but for Numerical head head head head head head head head	go to the hospital and o. Resident #1 stated his se #1 to give him some I be fine. Nurse #1 was administered. were within normal limits. d she asked him several to go to the hospital and he 7/25 at 4:04 PM, Nurse #1 by Nurse #3 that Resident floor in his room. Nurse #1, upervisor that day, went to esident #1 was up in his assessed Resident #1 hysically and all of his ithin normal limits. Nurse #1 irector of Nurses (DON), tesident #1 if he would like to d he said no, he "ain't going e #1 stated she knew he was d that hitting his head while uld lead to uncontrolled bleed. She stated she ut how the blood thinners he ct him by causing g, but he continued to say he	F	684			

Facility ID: 090963

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		345560	B. WING				C 13/2025
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	2150 HULL ROAD		
NCSIAIE	EVETERANS HOME-KINS	SION		ŀ	KINSTON, NC 28504		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	nickel in his head whe Nurse #3 said she cal staff did not identify a she was in the room w DON and heard Resid to go to the hospital. I headache and was gi brought Resident #1 o better monitor him an neurological checks. 3 #1 was taking a blood fall. Nurse #3 said she notify her of the fall an Nurse #3 said she did refused to go to the h complications he coul blood thinner. She sa she did not tell the RF In an interview on 1/8 when she found Resid hit his head on a shar cabinet. She said the After Nurse #3 assess move Resident #1 ba #1 said when she wou that shift, she told him and he should get it c he had hit his head ha fine. In a phone interview o Resident #1's RP said of the fall on 11/23/24 remembered Nurse # want to go to the hosp not understand the po and hitting his head w	ere it had hit something. Illed for a fall huddle and the ny concerns. Nurse #3 said when Nurse #1 called the dent #1 say he did not want He complained of having a ven Tylenol. She said she but to the common area to d to continue to perform She said she knew Resident d thinner at the time of the e called Resident #1's RP to nd that he hit his head. I not tell the RP that he had ospital or about the potential Id have due to being on a id she could not think why P. /25 at 11:22 AM, NA #1 said dent #1 on the floor, he had rp corner of his television re was a dent in his head. sed him, NA #1 helped her ck into his wheelchair. NA rked with him again later n he had a dent in his head hecked out. He told NA #1 arder than that and he was Dn 1/8/25 at 10:13 AM, d Nurse #3 had notified her	F	684			

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 02/04/2025 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				(X3) DATE COMP	SURVEY LETED
		345560	B. WING			_	(01/	C 13/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
NC STATE	VETERANS HOME-KINS	STON			150 HULL ROAD (INSTON, NC 28504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 684	risks were from the fa may have listened to if she (the RP) was cl of the situation. Resident #1's Novem Administration Record to receive Eliquis twice Resident #1's Nurse F note dated 11/25/24 in the past week with the Resident #1 complain said he did not hit his The NP noted that sta requests at the time of In a phone interview of remembered that Resi impaired and was not said he was able to m but needed assistance she came into the fac learned about Reside said Resident #1 repo and appeared to be a baseline. The NP said visit (unrecalled when abrasion on the top of not recall if she had a day. She said she had day. She said she had documentation of neu- results were normal. S of the fall on 11/23/24 head injury, she would assessments and wei	derstood how serious the II. She said Resident #1 her and gone to the hospital earer about the seriousness ber 2024 Medication d documented he continued e a day. Practitioner (NP) progress ndicated he had two falls in e last one on 11/23/24. red of pain from the fall but head and was doing well. aff had no acute concerns or f the visit. on 1/7/25 at 4:07 PM, the NP sident #1 was cognitively a reliable historian. She hake simple daily decisions e otherwise. She said when ility on 11/25/24, she nt #1's fall on 11/23/24. She orted he did not hit his head cting normally and at d she found out later that	F	684				

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 02/04/2025 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345560	B. WING			_		C 13/2025
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
NC STATE	VETERANS HOME-KINS	STON			150 HULL ROAD			
				ĸ	INSTON, NC 28504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	22	F	684				
	physical and speech t and neurological cheo limits. In her interview on 1/8 said when she came i went and checked on approximately 8:00 Al Resident #1 regularly with him. NA #1 said I mornings and liked to able to wake him in a him and he was alway morning, when she w attempted to wake hir immediately agitated he had never acted lik morning and it was a approximately 9:30-10 assistance. The RP to have had a hard night NA #1 said she went f wake him up. He had morning, which wasn' would sleep through b When she tried to wal eyes and would just g words, which was abr wake easily and talk t when woken up. She Nurse #3 that Resider and not responding at	vealed he participated in therapy and had vital signs cks that were within normal B/25 at 11:22 AM, NA #1 into work on 11/27/24, she Resident #1 at M. She said she worked with and had a good rapport he would be agitated in the sleep in. She said she was way that would not agitate ys nice to her. She said that ent to check on him, she						
	AM. In her phone interviev RP said she arrived a	v on 1/8/25 at 10:13 AM, the t the facility at						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	(X3) DATE	
		345560	B. WING				C 13/2025
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE	VETERANS HOME-KINS	STON			2150 HULL ROAD		
NO STATE					KINSTON, NC 28504		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	said Resident #1 was was told by staff (nam Resident #1 had "cus morning. The RP said members he was not have talked sharply to seemed the same sin she had not noticed a morning she thought normal. Resident #1's progres 10:03 AM documente (RD) noted she had a Resident #1 twice that sleeping. In an interview on 1/8 Resident #1 was slee to see him that morning the resident during that anything else about R Resident #1's nursing 11/27/24 at 11:15 AM documented she notif Nurse #1, and informant not opening his eyes Resident #1 responde mumble but he would In her interview on 1/8 said that after the fall was acting normally. She attempted to give medications and he would	30 AM on 11/27/24. She asleep in bed. She said she he not recalled) that sed" out one of the staff that there were some staff as patient with, so he may o them. She said he had ce his fall on 11/23/24 and ny changes in him. That he was more sleepy than as notes dated 11/27/24 at d the Registered Dietitian ttempted to visit with t morning but he had been /25 at 9:41 AM, the RD said ping deeply when she tried ng, but the RP came to visit at time. She could not recall tesident #1's condition. I progress notes dated written by Nurse #3 fied the nurse supervisor, ed her that Resident #1 was and waking up. She noted ed to touch and would not open his eyes. B/25 at 11:08 AM, Nurse #3 on 11/23/24, Resident #1 On the morning of 11/27/24,	F	684			
	bother him. She said						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 02/04/2025 APPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		345560	B. WING			_		C 13/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
NC STATE	VETERANS HOME-KINS	STON			150 HULL ROAD INSTON, NC 28504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page several times through	e 24 Hout the morning for him to	F	684				
		tions. She had been told by						
		1 had yelled at her that						
	•	not normal since he usually #1. NA #1 also came to get						
	her at approximately	-						
	morning saying Resid	lent #1 wouldn't wake up.						
		#1's room and saw he was						
		onsive than normal when He would move a little and						
		n his eyes. She said this						
	was when she first no							
		for Nurse #1, who was the						
	-	day, and told her of her						
		aid she went back into o monitor him and take his						
		to the unit immediately and						
		n her. Nurse #3 said she						
		r a few minutes during						
		#2's assessments, but when						
		to go to the hospital, she left ospital transfer paperwork						
	done.							
		progress notes dated						
		vritten by Nurse #1 noted esident #1 after receiving a						
		at he was unresponsive.						
		erformed a sternal rub and						
		oan. Nurse #1 also noted						
	Resident #1 had a ter	•						
		#1 noted she called the NP						
		nurses repositioned him in essure went up from 94/48 to						
		was still unresponsive but						
		urse #1 noted she received						
	an order from the NP	to send Resident #1 to the						
		R) for altered mental status						
	and fever.							

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	-	ID HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER					E CONSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER: A. E		ING _		COMPLETED		
		245500	B. WING				С	
345560			B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	01/	13/2025	
NAME OF P	ROVIDER OR SUPPLIER				2150 HULL ROAD			
NC STATE	EVETERANS HOME-KIN	STON			KINSTON, NC 28504			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTION(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD EREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRI DEFICIENCY)				(X5) COMPLETION DATE		
F 684	Continued From page	25	F	684				
	Nurse #1 said she wa see Resident #1 beca on 11/27/24 at approx she arrived on the un #1 would respond on the RP was in the roc how they thought he as had the RD and ot with Resident #1 that performed a sternal m moan and move his a respond or open his e NP, described how th and the NP ordered h In an interview on 1/8 said Nurse #1 asked with her due to a repo 11/27/24 at approxim said she asked the R she said she was hav Resident #1 up. Whe tried to wake him, he he had fallen a few da not recall when the far remember if Resident was mentioned at any In her phone interview NP said she received on 11/27/24 at 11:20 log) reporting that Re status. The NP said N assessed Resident #	Dentinued From page 25 her interview by phone on 1/7/25 at 3:25 PM, urse #1 said she was called by Nurse #3 to go e Resident #1 because he was not waking up 11/27/24 at approximately 11:00 AM. When e arrived on the unit with Nurse #2, Resident would respond only to painful stimuli. She said e RP was in the room and had commented on w they thought he was sleeping really deeply, had the RD and other staff who had worked th Resident #1 that day. She said she rformed a sternal rub, which caused him to ban and move his arms a little, but not verbally spond or open his eyes. She said she called the P, described how the resident was responding, d the NP ordered him to be sent to the ER. an interview on 1/8/25 at 11:49 AM, Nurse #2 id Nurse #1 asked her to go see Resident #1 th her due to a reported change of condition on /27/24 at approximately 11:00 AM. Nurse #2 id she asked the RP what was going on and e said she was having a hard time getting esident #1 up. When Nurse #1 and Nurse #2 ed to wake him, he would just moan. She knew thad fallen a few days prior to 11/27/24 but did the recall when the falls were. Nurse #2 did not member if Resident #1 taking blood thinners as mentioned at any time. her phone interview on 1/7/25 at 4:07 PM, the P said she received a phone call from Nurse #1 11/27/24 at 11:20 AM (time indicated in the call g) reporting that Resident #1 had a change in atus. The NP said Nurse #1 described how she sessed Resident #1 and the NP said she was ing to order a full clinical work-up including						

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	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345560					(X3) DATE SURVEY COMPLETED C 01/13/2025		
		B. WING					
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
NC STAT	E VETERANS HOME-KINS	STON			2150 HULL ROAD KINSTON, NC 28504		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			BE	(X5) COMPLETION DATE
F 684	said she then ordered out immediately to the Resident #1's Emerge (EMS) Call Detail Rep they received a call fo at 11:35 AM due to co status and that Resid Resident #1's hospita 11/27/24 noted he ha days prior and hit his (bruise) in the occipita The ER note docume was woken up at app "cussing out" the staff sleep. He was later fo unresponsive. The EF unresponsive with set where he would sque given painful stimulus words but was in gen physician noted Resid medications Andexxa to reverse the effects and assessed as scol Coma Scale, which in He was placed on a w breathing and was tra hospital for a higher lo Resident #1's hospital included results from multiple abnormalities hematoma measuring midline shift and a sm herniation. The CT scol	a that Resident #1 be sent e ER. ency Medical Services port dated 11/27/24 noted or services for Resident #1 omplaint of altered mental ent #1 was unconscious. If #1's ER report dated d fallen approximately four head. He had a contusion al area (back) of his head. nted that morning when he roximately 7:30 AM and f and wanted to go back to ound at approximately noon R noted he was mi-purposeful movements eze the hand. If he was a he would say nonsensible eral not responding. The dent #1 was given the two and Tranexamic acid (TXA) of Eliquis. He was intubated ring 3-8 on the Glasgow edicated he was comatose. rentilator to assist with his unsferred to a different evel of care.	F	684			

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		D HUMAN SERVICES				FORM): 02/04/2025 APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MI STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
345560		B. WING		_	(01/	C 13/2025		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	01/	10/2020	
				150 HULL ROAD				
NC STATE	VETERANS HOME-KINS	STON		(INSTON, NC 28504				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	Resident #1's death or indicated Resident #1 noted the immediate or complications from rig with midline shift. The was listed as blunt for In an interview on 1/8 Medical Director (MD) #1's physician, said R preventable if the resi hospital, but the facilitie even if he didn't under benefits due to his con the industry practice wi immediately send a ref fall, even if the reside decision would depen head injury, the medic resident, and the subs assessments. She sa stopped the Eliquis if report. She said beca prevention medication	227 bt a candidate for no expectation of a Resident #1 was placed on red on 11/30/24. ertificate dated 12/4/24 expired on 11/30/24 and cause of death was due to th side subdural hematoma underlying cause of death ce injury of head and brain. /25 at 11:55 AM, the b, who was also Resident esident #1's death was dent had gone to the y couldn't force him to go, rstand the risks versus gnitive impairment. She said was to no longer esident to the hospital after a nt hit their head, that the d on the severity of the cal history of that particular sequent clinical iid she would not have she had received the fall use the Eliquis as a stroke in was new for him, she said		CROSS-REFEREN D	ICED TO THE APPROPRIA		DATE	
	was held. She said be checks had been don was no change in him she would not have d monitor him during tha spoke with therapy, w worked with him on 1 baseline. She said Re	ed risk of stroke if the Eliquis ecause the neurological e appropriately, and there medically until 11/27/24, one anything other than to at time. The MD said she ho told her that they had 1/26/24 and he was at his esident #1's brain bleed symptoms until days later						

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		D HUMAN SERVICES				FORM	02/04/2025 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
	CONNECTION		A. BUILDI	ING .			C
		345560	B. WING			01/	13/2025
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE	VETERANS HOME-KINS	STON			2150 HULL ROAD KINSTON, NC 28504		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	why he appeared at b In an interview on 1/8 said Resident #1 did n his baseline after the 11/27/24. She said Re to the hospital after the him. In an interview on 1/8 Administrator said the Resident #1 and he h on 11/23/24. She said changes of condition the hospital immediat The Administrator was Jeopardy on 1/8/24 at The facility provided t allegation of immediat Identify those recipier are likely to suffer, a s The facility failed to ex the responsible party consequences that co importance of hospita cognitively impaired re thinner had an unwith signs of head injury a evaluation on 11/23/2 thinner continued to b Staff did not recognize	ugh to affect him which was baseline until 11/27/24. /25 at 5:55 PM, the DON not show any changes from fall on 11/23/24 until esident #1 had refused to go the fall when the nurse asked /25 at 6:00 PM, the e facility had monitored ad no changes after the fall d when the staff noticed the on 11/27/24, he was sent to ely. s notified of Immediate t 6:06 PM. the following credible te jeopardy removal: ths who have suffered, or serious adverse outcome explain to the resident and the life-threatening build occur and the I evaluation when a severely esident who was on a blood essed fall with obvious nd refused hospital 4. The resident's blood	F	684			
		condition and identify the cal attention when resident					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391	
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	PLE CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	<u> </u>	COMPLETED		
		345560 B. WING			C 13/2025			
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
NC STATE	VETERANS HOME-KIN	STON			2150 HULL ROAD			
	0.000				KINSTON, NC 28504		(X5)	
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 684	Continued From page	<u>20</u>	F	684	34			
1 001	was first identified wit	h a change in condition on		004	H+			
	11/27/24 at 8 AM.							
		on 11/30/2024. All residents						
	receiving anticoagula serious outcome.	nts are at risk of suffering a						
		entity will take to alter the						
		lure to prevent a serious n occurring or recurring, and						
	when the action will b	o						
	Services to all license change in condition a change in condition. the use of the Interac Nurses will be educat physician when a cha	The education will include t Change in condition tool. ed regarding notification of nge in resident condition n will be added to the						
	hospital transport onc physician extender or the physician and/or p resident representativ refusal. Staff educati 1/10/25 or prior to the	nition level that refuses e a physician and/or der has been received, that obysician extender and re must be notified of the on will be complete by staff working their next education will be added to						
	resident representativ follow-up at an acute resident and resident an informed decision.	educated in their ate the resident and the re regarding refusal of care facility to ensure the representative are making The resident and resident tion will be documented by						

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		ID HUMAN SERVICES				FORM	APPROVED	
			, í		LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C 01/13/2025		
		345560 B.V			3			
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	13/2025	
					2150 HULL ROAD			
NC STATE	VETERANS HOME-KINS	STON			KINSTON, NC 28504			
(X4) ID PREFIX TAG				IX S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Director of Health Ser will be notified when a ordered transport to a education will be com the staff working their education will be add orientation. Certified Nursing Assi Department staff will l of Health Service or th Coordinator on report any changes they not are outside of the resi physical appearance education will be com the staff working their education will be add assistant and Therapy The Supervisor and/o will review events dur ensure significant cha recognized by nursing medical attention is re and/or physician exte notified of change of o transfer. The immediate jeopar 1/11/2025. Onsite validation of th removal plan was cor	the medical record. The rvices and the Administrator a resident refuses an an acute care facility. Staff plete by 1/10/25 or prior to r next scheduled shift. The ed to the licensed nurse istants and the Therapy be educated by the Director he Clinical Competency ing to the licensed nurse, ice in a resident they feel ident's usual behavior, or vital signs. Staff pleted by 1/10/25 or prior to r next scheduled shift. The ed to the certified nursing y Department orientation. or Director of Health Services ing morning meetings to anges in condition are g staff, the need for urgent ecognized and physician nder and family were condition and/or refusal of rdy was removed on	F	684	4			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD	ING _					
		345560	B. WING			BE COMPLÉTIC			
NAME OF PROVIDER OR SUPPLIER				5	STREET ADDRESS, CITY, STATE, ZIP CODE	•			
NC STATE	E VETERANS HOME-KINS	STON			2150 HULL ROAD				
					KINSTON, NC 28504				
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	LD BE COMPLÉTIO			
F 684	change in condition. the facility's Interact C Licensed nursing staf notify a physician whe condition occurs. Add received regarding a level that refuses hos is received. The phy and resident represer the refusal. Licensed educated about their resident and the resid regarding the risk of r resident and resident an informed decision. nurses identified the I tool and its location. Interviews confirmed aides were educated nurse any changes th feel are outside of the physical appearance included the key point which included: sudde (like blood pressure, I status (confusion, lett unusual pain, change new or worsening skii weight loss, falls, cha included was the proc notification tool, Stop and nurse aides were the procedure to com	Education included use of Change in Condition tool. f were also educated to en a change in resident's ditional education was resident with any cognition pital transport once an order sician or physician extender tative must be notified of d nursing staff were also responsibility to educate the lent representative efusal to ensure the representative are making During interviews licensed nteract Change in Condition all therapy staff and nurse on reporting to a licensed ey notice in a resident they e resident's usual behavior, or vital signs. Education ts of a change of condition en changes in vital signs neart rate), altered mental hargy), difficulty breathing, s in appetite or fluid intake, n conditions, unexpected nges in bowel habits. Also cess for utilizing the facility's and Watch. Therapy staff a ble to locate the tool and	F	684					

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