STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345558	A. BUILDING ______ B. WING ______	C **02/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS HOME-BLACK MOUNTAIN	**62 LAKE EDEN ROAD** **BLACK MOUNTAIN, NC 28711**

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F 000	INITIAL COMMENTS The survey team entered the facility on 02/18/25 to conduct an unannounced complaint investigation. The survey team was onsite 02/18/25. Additional information was obtained offsite on 02/19/25. Therefore, the exit date was 02/19/25. Event ID #NQLB11. The following intakes were investigated: NC00226112, NC00227083, NC00227129, NC00227512, and NC00227700. Seven (7) of the seven (7) complaint allegations did not result in deficiency.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)	F 607		3/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE — 03/10/2025

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.

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F 607	Continued From page 1 (3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure staff implemented their abuse policy and procedure in the area of reporting when nursing staff did not immediately inform the Administrator that a Nurse Aide had reported an alleged use of a physical restraint for a resident with no medical symptoms. This failure resulted in a delay in the facility investigating the allegation and reporting the allegation to the State Agency for 1 of 3 residents reviewed for restraints (Resident #1). Findings included: The facility's policy titled "Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property" last reviewed on 01/11/24 revealed in part, the facility would actively preserve each resident's right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, exploitation, mistreatment, and misappropriation of patient property and assure that staff was provided information on how and to who they reported concerns. The facility would also assure residents were free from physical or chemical restraints imposed for purposes of discipline or convenience and that were not required to treat medical symptoms. The facility's policy titled "Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and	F 607	Element #1 The facility failed to ensure staff implemented the abuse policy and procedure for Resident #1. Resident #1 is unable to be interviewed. Skin audit and Psychology Evaluation closest to the time of deficient practice reviewed by the Director of Health Services (DHS) without any changes from Resident #1 baseline noted. Element #2 All residents are at risk for this deficient practice. Thirty-five (35) residents with a Brief Interview for Menal Status score of 8 or higher will be interviewed by Social Services Assistant; Unit Coordinator; Unit Manager; Director of Health Services or Administrator regarding use of restraints/restrictive materials/equipment that do not have a physician□s order/care planned by 03/13/2025. residents who are unable to be interviewed have skin assessments from time closest to the time frame of the deficient practice will be reviewed by the Director of Health Services (DHS) by 03/13/2025 for indication for restraint. Element #3	

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F 607	Continued From page 2 Misappropriation of Property" last reviewed on 11/15/24, revealed any allegation, suspicion or identified occurrence identified involving resident abuse, neglect, exploitation, mistreatment, and misappropriation of property should be immediately reported to the Administrator. During a phone interview on 02/18/25 at 4:20 PM, Nurse Aide (NA) #1 revealed she worked during the hours of 6:00 PM to 6:00 AM and could not recall the exact date but stated it was toward the end of December 2024 when she had observed a bed sheet wrapped around Resident #1's feet and wheelchair. NA #1 recalled Resident #1 was sitting out in the common area in his wheelchair with his lap and legs covered with a blanket and she had taken Resident #1 back to his room to assist him to bed for the night. NA #1 stated when she removed the blanket off Resident #1, she observed a thin bed sheet had been wrapped around his feet and tucked up tightly underneath the foot rest of the wheelchair preventing Resident #1 from moving his feet. NA #1 stated it caught her off guard but she went ahead removed the sheet from Resident #1's feet, assisted him into bed and then informed the nurse. NA #1 stated there was no other staff member present in the room with her and Resident #1 at the time she assisted him to bed and she didn't think to call other staff into the room to observe what she had seen before removing the sheet from Resident #1's feet. She stated Nurse #1 and Nurse #2 were both working that evening but she could not recall for certain which one she informed. During a phone interview on 02/19/25, Nurse #1 stated he had never observed a bed sheet wrapped around Resident #1's feet but did recall	F 607	100% staff education which includes Administrative; Licensed Nurses and Certified Nursing Assistants; Maintenance; Dietary; Housekeeping; Therapy Departments; agency personnel are not utilized, initiated on 02/19/2025 about Identifying and Reporting of Abuse and will be completed by the Clinical Competency Coordinator (CCC), Director of Health Services (DHS) or Administrator by 02/28/2025. Any staff on FAMILY MEDICAL LEAVE ACT or paid time off will be educated prior to returning to work. Identifying and Reporting of Abuse will be conducted during new employee orientation by the Clinical Competency Coordinator, Director of Health Services or Administrator during employee orientation. Element #4 Five (5) residents will be reviewed daily for restraints/restrictive materials five (5) x per week for four (4) weeks; then three (3) residents will be reviewed three (3) times per week x four (4) weeks; then one (1) resident will be reviewed weekly x four (4) weeks by Social Services Director (SSD)/Admission Director (AD); Social Services Assistant; Unit Manager; Unit Coordinator; Infection Preventionist (IP), Clinical Competency Coordinator (CCC); Activity Director; Case Mix Director (CMD); Case Mix Coordinator (CMC); Nurse Navigator; Director of Health Services (DHS) or Administrator to ensure that no restraints/restrictive	

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F 607 Continued From page 3

being informed of such an incident. Nurse #1 revealed on 01/01/25 he had not known he was scheduled to work 6:00 PM to 6:00 AM and didn't arrive to the facility until approximately 9:00 PM. Nurse #1 stated when he took over the medication cart from Nurse #2, she informed him that a NA (did not recall who) had reported observing Resident #1's feet wrapped up in a bed sheet when the NA had assisted Resident #1 to bed. Nurse #1 stated he did not inform the Administrator or Director of Nursing (DON) what was reported to him by Nurse #2.

During a phone interview on 02/19/25 at 2:53 PM, Nurse #2 recalled on 01/01/25 she had covered the medication cart for Nurse #1 until he arrived at the facility and once Nurse #1 took over the medication cart, she went to work on another unit. Nurse #2 stated she could not recall the exact details but at one point during the shift, she was called back to the unit by Nurse #1 because a NA had reported they felt a bed sheet had been wrapped around Resident #1's legs too tight. When she arrived on the unit, NA #1 and another NA were talking with Nurse #1 at the medication cart. She recalled NA #1 stating the bed sheet was tucked in "snuggly" along Resident #1's legs and feet and NA #1 wanted to know if that was considered a restraint. Nurse #2 stated NA #1 had already placed Resident #1 in bed and she (Nurse #2) wasn't able to observe how the bed sheet was placed on Resident #1. Nurse #2 stated she did have a discussion with the staff about restraints, explaining it was never acceptable to use a bed sheet as a restraint and if they observed something like that being used, they needed to immediately inform her or the nurse so they could assess the resident before it was removed. Nurse #2 stated she was never

F 607

materials/equipment that do not have a physicians order/care planned are being used.

All staff education which includes Administrative; Licensed Nurses and Certified Nursing Assistants; Maintenance; Dietary; Housekeeping; Therapy Departments; agency personnel are not utilized, will verify in writing, daily, that they have not observed, been made aware of or heard rumor of, any type of abuse, if observed, have been made aware of, or heard rumor of, the abuse has been reported to the Administrator x 90 days. The Director of Health Services or Administrator will ensure compliance. The Quality Improvement Coordinator will track, trend and take to QAPI monthly x three (3) months or until compliance maintained.

Element #5
Date of compliance 03/17/2025

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F 607	Continued From page 4	F 607		

informed that the bed sheet was wrapped around Resident #1's feet and wheelchair, just that it was tucked in snuggly along Resident #1's legs. Nurse #2 stated she probably should have but didn't inform the DON or Administrator of NA #1's concerns.

During an interview on 02/18/25 at 3:55 PM with the Interim Administrator present, the DON revealed about a month ago she was informed by the Unit Coordinator that it had been brought to her attention that a NA had voiced concerns about a blanket being wrapped around Resident #1 too tightly but nothing that had restricted his movement. The DON stated no staff have reported any concerns of a bed sheet wrapped around Resident #1's legs and wheelchair as a restraint. She stated if they had, it would have warranted a reportable to the State Agency and immediate investigation.

During a follow-up phone interview on 02/19/25 at 4:21 PM, the DON stated an investigation was initiated following the conversation with the surveyor on 02/18/25. The DON explained that nursing staff were instructed to immediately report any concerns of abuse, even if they weren't sure it was abuse, to her or the Administrator so that it could be investigated.

During a follow-up phone interview on 02/19/25 at 4:34 PM, the Interim Administrator stated if nursing staff observed a bed sheet or throw wrapped around a resident as a restraint, they should have immediately informed her or the DON for an investigation to be initiated. The Interim Administrator stated she had informed staff they were to report anything concerning that turned out not to be reportable rather than not

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F 607	Continued From page 5 report something that should have been investigated.	F 607		