

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345531	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER NC State Veterans Home - Salisbury		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 Brenner Ave, Buildng #10 Salisbury, NC 28145	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643</p> <p>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).</p> <p>Findings included:</p> <p>Resident # 58 was admitted to the facility on [DATE] with diagnoses which included hypertension and muscle weakness.</p> <p>Review of the Resident #58's significant change Minimum Dat Set (MDS) dated [DATE] 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 use.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 residents who wanted to set up in the dining room.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904</p> <p>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.</p> <p>Findings included:</p> <p>Resident #4 was admitted to the facility on [DATE] with diagnoses of stroke and hemiplegia.</p> <p>A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #4 was dependent on staff for showering and required moderate assistance with personal hygiene such as shaving.</p> <p>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.</p> <p>A Nurse's Progress Note by Nurse #1 written on 8/3/2024 at 12:03 pm indicated Resident #4 took his scheduled shower.</p> <p>Review of Resident #4's shower and personal hygiene documentation on 8/3/2024 at 6:47 pm indicated he was given a shower.</p> <p>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 1/2 inch long. Resident #4 stated he preferred to be shaved but staff did not have time to do it.</p> <p>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 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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43643</p> <p>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.</p> <p>Findings included:</p> <p>An observation and interview conducted with Dietary [NAME] #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 [NAME] #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 [NAME] #1 indicated it was nursing staffs' responsibility to label items that belong to residents and staff items were not allowed in the nourishment rooms.</p> <p>An observation and interview conducted with the Dietary [NAME] #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 [NAME] #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 belong to residents and that staff items were not allowed in the nourishment rooms.</p> <p>An interview conducted with the Dietary Manager (DM) was unable to be completed due to the DM being unavailable during the survey.</p> <p>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.</p> <p>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.</p>		