STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345560	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC State Veterans Home-Kinston	2150 Hull Road Kinston, NC 28504

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)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff, Responsible Party, Manager at the facility's contracted x-ray company, and Physician the facility failed to ensure nursing staff reported a fall with injury to a physician/medical provider resulting in the physician/medical provider not having all relevant information as a treatment plan was developed and implemented. On [DATE] Resident # 1 sustained a fall while Nurse Aide # 1 and Nurse Aide # 2 were caring for him. The resident was crying in pain while on the floor and had obvious injury to his left knee. The on-call provider was erroneously informed that the resident had pain, warmth, and swelling to the left knee for no known reason. The provider's treatment plan included a STAT (right away) x-ray of the left knee but no orders for stabilization of the resident's leg. The knee was not stabilized, and nursing staff members continued to turn, reposition, and transfer the resident in and out of bed with a mechanical lift for more than 48 hours following the fall. The order for the x-ray of the left knee was not received by the x-ray services provider on [DATE] and this was not discovered by facility staff until [DATE] which further delayed medical treatment and interventions. A medical provider was not notified the STAT x-ray had not been completed on [DATE]. Following [DATE] at 12:45 PM there was no further documentation in the medical record that the physician or on-call provider were notified on [DATE] or [DATE] about further issues with the resident's leg for a further treatment plan. The x-ray was completed on [DATE] and revealed a femur fracture. On [DATE] Resident # 1 was sent to the hospital for an evaluation and the hospital x-ray showed a comminuted fracture (broken in three or more pieces) of the femur (thigh bone) as a result of the fall. A diagnostic test showed the fractured bones were in close proximity to the resident's leg arteries. The resident underwent surgery for stabilization purposes, was placed on hospice care, and expired on [DATE]. The facility also failed to notify Resident # 1's Responsible Party regarding the resident's fall and subsequent pain, warmth, and swelling which occurred on [DATE]. This was for one of three sampled residents reviewed for supervision to prevent falls (Resident #1). Example 1.b. is being cited at a scope and severity level of D. The findings included:1.a. Record review revealed Resident # 1 was admitted to the facility on [DATE]. Resident # 1's diagnoses included a history of stroke with left hemiplegia (paralysis) and hemiparesis (weakness), Parkinson's disease, chronic obstructive pulmonary disease, and muscle weakness.Review of nursing notes revealed no nursing narrative notes for the shift which began on [DATE] at 11:00 PM and ended at 7:00 AM.Nurse Aide (NA) # 1) was interviewed on [DATE] at 4:21 PM and again on [DATE] at 8:31 AM and reported the following information about the events of the shift which began on [DATE] at 11:00 PM and ended at 7:00 AM on [DATE]. She had not been working at the facility very long and had recently completed orientation as a new facility Nurse Aide. She had been working as a team with NA # 2 on the shift which began on [DATE] at 11:00 PM and ended at 7:00 AM on [DATE]. It was her first night working with Resident # 1. She and NA # 2 had entered the room around 6 something in the morning to get Resident # 1 out of the bed. They were preparing to transfer Resident # 1 with the sit-to-stand lift. They had placed the sling on the resident, and he was sitting on the side of the bed. Before they started to mechanically lift Resident # 1 up in the sling, he slid from the side of the bed onto the floor and landed on his knees. While on the floor Resident # 1 was crying and she could tell there was something wrong, and he had hurt his knee. She and NA # 2 manually lifted Resident # 1 back into the bed and NA # 2 called Nurse # 1 into the room. Nurse # 1 came into the room and said it looked like his knee was dislocated. When interviewed about whether Nurse # 1 knew that Resident # 1 had fallen, NA # 1 reported he knew. When asked if they had told Nurse # 1 the resident had fallen, NA # 1 reported she could not recall if verbally she told him but that he knew something had happened and reiterated without further explanation that Nurse # 1 knew Resident # 1 had fallen. After Nurse # 1 checked Resident # 1, Nurse # 1 helped her (NA #1) and NA # 2 transfer Resident # 1 from the bed to the chair using the sit-to-stand lift. After Resident # 1 was in the wheelchair, the Night Shift Supervisor (Nurse # 2) came to also check Resident # 1's leg. While in the wheelchair, Resident # 1 was still having some pain, but he was no longer crying. According to NA # 1, Nurse # 1 and NA # 2 wanted her (NA # 1) to not disclose that Resident # 1 had actually fallen. NA # 1 reported she had told the truth when she was further questioned about the incident by administrative staff members several days after the fall. NA # 2 was interviewed on [DATE] at 2:05 PM. According to NA # 2, Resident # 1 did not fall. NA # 2 reported the following information about caring for Resident # 1 on the shift which began at 11:00 PM on [DATE] and ended on [DATE] at 7:00 AM. Near the end of the shift she and NA # 1 were bathing Resident #

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews with staff, Responsible Party, a Manager at the facility's contracted x-ray company, and Physician the facility failed to protect a severely cognitively impaired resident's right to be free of neglect after he sustained a fall with obvious injury on [DATE] between 6:00 AM and 7:00 AM. Nurse Aide # 1 and Nurse Aide # 2 were preparing to use a sit-to stand lift to transfer Resident # 1, who was totally dependent on staff for sitting balance and required a total mechanical lift for transfers, from the bed to the chair when the resident slid off the side of the bed and landed on his knees. The resident was crying while on the floor and Nurse Aide # 1 reported she could tell something was wrong. Resident # 1 was lifted to the bed without a nursing assessment. Once in bed, the resident was transferred by Nurse Aide # 1, Nurse Aide # 2, and Nurse # 1 to the wheelchair with the sit-to-stand lift. The fall was not disclosed to further staff members who were assigned to care for the resident or to the medical provider while the resident resided at the facility. Following the fall, Resident # 1 experienced swelling of his knee, pain, and warmth. Following the fall, due to a lack of communication and follow -up, the resident did not receive comprehensive assessment, treatment, and an x-ray was not completed on [DATE] as ordered. On [DATE] Resident # 1 was hospitalized and identified to have a comminuted fracture (broken in three or more pieces) of the femur as a result of the fall. A diagnostic test showed the fractured bones were in close proximity to the resident's leg arteries. The resident underwent surgery for stabilization purposes, was placed on hospice care, and expired on [DATE]. Resident # 1's physician reported that prior to Resident # 1's fall and fracture, his death was not expected to be imminent. Following the identification of the fracture on [DATE], Nurse Aide # 1, Nurse Aide # 2, and Nurse # 1 still did not come forward and disclose the fall. While investigating the fracture of unknown origin, the Administrator interviewed multiple staff members. Multiple days after the resident had been discharged , on [DATE] Nurse Aide # 1 reported to the Administrator the resident had fallen and there had been a plan to not disclose the fall although Nurse # 1, NA #2, and she knew the resident had been hurt. Nurse #1's, NA #1's, and NA #2's choice to deliberately withhold the fact that the resident fell despite Resident # 1 experiencing pain, warmth, and swelling following the fall was a complete disregard for the resident's needs, had a high likelihood of resulting in further injury, and constituted neglect. This was for one of one sampled resident reviewed for injuries which were initially reported to the state agency as being from an unknown cause (Resident # 1). The findings included: This tag is cross referenced to: F 580: Based on record review, and interviews with staff, Responsible Party, Manager at the facility's contracted x-ray company, and Physician the facility failed to ensure nursing staff reported a fall with injury to a physician/medical provider resulting in the physician/medical provider not having all relevant information as a treatment plan was developed and implemented. On [DATE] Resident # 1 sustained a fall while Nurse Aide # 1 and Nurse Aide # 2 were caring for him. The resident was crying in pain while on the floor and had obvious injury to his left knee. The on-call provider was erroneously informed that the resident had pain, warmth, and swelling to the left knee for no known reason. The provider's treatment plan included a STAT (right away) x-ray of the left knee but no orders for stabilization of the resident's leg. The knee was not stabilized, and nursing staff members continued to turn, reposition, and transfer the resident in and out of bed with a mechanical lift for more than 48 hours following the fall. The order for the x-ray of the left knee was not received by the x-ray services provider on [DATE] and this was not discovered by facility staff until [DATE] which further delayed medical treatment and interventions. A medical provider was not notified the STAT x-ray had not been completed on [DATE]. Following [DATE] at 12:45 PM there was no further documentation in the medical record that the physician or on-call provider were notified on [DATE] or [DATE] about further issues with the resident's leg for a further treatment plan. The x-ray was completed on [DATE] and revealed a femur fracture. On [DATE] Resident # 1 was sent to the hospital for an evaluation and the hospital x-ray showed a comminuted fracture (broken in three or more pieces) of the femur (thigh bone) as a result of the fall. A diagnostic test showed the fractured bones were in close proximity to the resident's leg arteries. The resident underwent surgery for stabilization purposes, was placed on hospice care, and expired on [DATE]. The facility also failed to notify Resident # 1's Responsible Party regarding the resident's fall and subsequent pain, warmth, and swelling which occurred on [DATE]. This was for one of three sampled residents reviewed for supervision to prevent falls (Resident #1). Example 1.b. is being cited at a scope and severity level of D F 684: Based on record review, and interviews with staff, the facility's contracted x-ray

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff, the facility's contracted x-ray company, Responsible Party, and Physician the facility failed to ensure nursing staff effectively communicated amongst themselves to ensure staff who cared for Resident #1 were aware of a fall with obvious injury that occurred and that Resident # 1 received comprehensive assessment and treatment. Resident # 1, who was severely cognitively impaired, sustained a fall on [DATE] between 6:00 AM and 7:00 AM. Night shift nursing staff members, who were assisting with Resident # 1 during the accident, were aware the resident was crying in pain as a result of the fall but did not disclose the fall. A comprehensive assessment was not completed prior to moving the resident after the fall. It was erroneously reported to the on-call medical provider and other nursing staff who cared for Resident # 1 in future shifts that the resident had pain and swelling to his left knee from no known cause. On [DATE] an x-ray was ordered when the provider was notified Resident # 1 had swelling, warmth, and pain to his left knee for no known reason. The x-ray was not completed until [DATE] which was over 48 hours after the fall and injury. The failure to communicate with other nursing staff and failure to obtain the x-ray as ordered resulted in a lack of ongoing assessment, monitoring, and treatment for over 48 hours. Nursing staff who were unaware of the fall continued to transfer, reposition, and provide care for the resident without professional stabilization of his leg despite indicators of problems with the resident's leg during this interim. On [DATE] Resident # 1 was hospitalized and identified to have a comminuted fracture (broken in three or more pieces) of the femur (thigh bone) as a result of the fall. A diagnostic test showed the fractured bones were in close proximity to the resident's leg arteries. The resident underwent surgery for stabilization purposes, was placed on hospice care, and expired on [DATE]. Resident # 1's physician reported that prior to Resident # 1's fall and fracture, his death was not expected to be imminent. This was for one of three residents reviewed for professional actions and care provided by nursing staff following falls (Resident #1). The findings included:Record review revealed Resident # 1 was admitted to the facility on [DATE]. Resident # 1's diagnoses included a history of stroke with left hemiplegia (paralysis) and hemiparesis (weakness), Parkinson's disease, chronic obstructive pulmonary disease, and muscle weakness. Resident # 1's quarterly Minimum Data Set Assessment, dated [DATE], coded Resident # 1 as severely cognitively impaired and as being totally dependent on staff for hygiene, bathing, dressing, turning in the bed, sitting up from a lying position, and transferring. He was not ambulatory and was assessed to be dependent on staff for wheelchair mobility. The resident was not coded as refusing care during the assessment period. A review of Resident # 1's care plan, last updated on [DATE], revealed Resident # 1 required a total mechanical lift for transfers. During an interview with the facility's Care Plan Nurse on [DATE] at 2:02 PM, the Care Plan nurse reported this information had been added to the care plan on [DATE]. The care plan also noted Resident # 1 was incontinent of both bowel and bladder which placed him at greater risk for pressure sores.Review of nursing notes revealed no nursing narrative notes for the shift which began on [DATE] at 11:00 PM and ended at 7:00 AM.Nurse Aide # 1 (NA # 1) was interviewed on [DATE] at 4:21 PM and again on [DATE] at 8:31 AM and reported the following information about the events of the shift which began on [DATE] at 11:00 PM and ended at 7:00 AM on [DATE]. She had not been working at the facility very long and had recently completed orientation as a new facility Nurse Aide. She had been working as a team with NA # 2 on the shift which began on [DATE] at 11:00 PM and ended at 7:00 AM on [DATE]. It was her first night working with Resident # 1. She and NA # 2 had entered the room around 6 something in the morning to get Resident # 1 out of the bed. They were preparing to transfer Resident # 1 with the sit-to-stand lift. She did not recall that it was her who had gotten the sit-to-stand lift. They had placed the sling on the resident, and he was sitting on the side of the bed. Before they started to mechanically lift Resident # 1 up in the sling, he slid from the side of the bed onto the floor and landed on his knees. While on the floor Resident # 1 was crying and she could tell there was something wrong, and he had hurt his knee. She and NA # 2 manually lifted Resident # 1 back into the bed and NA # 2 called Nurse # 1 into the room. Nurse # 1 came into the room and said it looked like his knee was dislocated. When interviewed about whether Nurse # 1 knew that Resident # 1 had fallen, NA # 1 reported he knew. When asked if they had told Nurse # 1 the resident had fallen, NA # 1 reported she could not recall if verbally she told him but that he knew something had happened and reiterated that Nurse # 1 knew Resident # 1 had fallen. According to NA # 1, Nurse # 1 and NA # 2 wanted her (NA # 1) to not disclose that Resident # 1 had actually fallen. After Nurse # 1 checked Resident # 1, Nurse # 1 helped her

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews with staff, and physician the facility failed to provide the necessary supervision to prevent accidents and provide care in a safe manner for a severely cognitively impaired resident totally dependent on staff for care and required a total mechanical lift for transfers. On [DATE] between 6:00 AM and 7:00 AM Nurse Aide #1 and Nurse Aide #2 were preparing to use a sit-to stand mechanical lift to transfer Resident # 1 from the bed to the chair. On [DATE] while seated on the side of the bed, the resident slid to the floor on his knees and was crying on the floor. The resident was manually lifted from the floor to the bed following the fall. NA #1 reported Nurse #1, who was the supervising nurse for NA # 1 and NA # 2, then helped them transfer Resident # 1 from the bed to the wheelchair with the sit-to-stand lift. On [DATE] Resident # 1 was hospitalized and identified to have a comminuted fracture (broken in three or more pieces) of the femur (thigh bone). A diagnostic test showed the fractured bones in close proximity to the resident's leg arteries. The resident underwent surgery for stabilization purposes, was placed on hospice care, and expired on [DATE]. Resident # 1's physician reported that prior to Resident # 1's fall and fracture, his death was not expected to be imminent. This was for one of three sampled residents reviewed for falls (Resident #1). The findings included: Record review revealed Resident # 1 was admitted to the facility on [DATE]. Resident # 1's diagnoses included a history of stroke with left hemiplegia and hemiparesis, Parkinson's disease, chronic obstructive pulmonary disease, and muscle weakness.Review of an occupational therapy evaluation, dated [DATE], revealed the following information. The resident had balance problems and was assessed to need maximum assistance from staff to sit on the side of the bed. The resident was not assessed to have pain that interfered with his functional activity. He had impaired range of motion to his left shoulder, elbow/forearm, wrist, hand, thumb, and fingers. He also had impaired strength in his left shoulder, elbow/forearm, and wrist. He had problems with fine and gross motor coordination, strength, and attention.Resident # 1's quarterly Minimum Data Set Assessment, dated [DATE], coded Resident # 1 as severely cognitively impaired and as being totally dependent on staff for hygiene, bathing, dressing, turning in the bed, sitting up from a lying position, and transferring. He was not ambulatory and was assessed to be dependent on staff for wheelchair mobility.On [DATE] at 9:15 AM the Administrator provided a copy of Resident # 1's Nurse Aide care guide. According to the Administrator care guides were placed on the back of all residents' closet doors for the Nurse Aides to access. A review of Resident # 1's care guide revealed a notation it had been updated on [DATE] to reflect the resident was a total mechanical lift. The facility's Rehabilitation Director was interviewed on [DATE] at 3:50 PM and reported the following information regarding Resident # 1's physical capabilities and the types of lifts that the facility used. Resident # 1 had been experiencing a Parkinson's decline over the time he had resided at the facility. He had contracture of his hips, knees, ankles, and upper body and also suffered from tightness and rigidity from his Parkinson's disease. Resident # 1 would also hold his arms close into his body from the rigidity. He required a total mechanical lift for transfers. He could not bear weight. In order to utilize a sit- to- stand lift, an individual had to be able to bear a portion of their weight, and also be able to reach and hold onto the bars of the sit-to-stand mechanical lift. Also, with a sit-to-stand lift, a resident needed to be able to move smoothly up as the lift raised an individual from a seated position to a standing position prior to letting the individual down into a chair. Resident # 1's Parkinson's could cause sudden rigidity as the lift was moving him. A sit-to-stand lift was not an appropriate device for him.Review of physician orders revealed an order, dated [DATE], for 650 milligrams of acetaminophen every four hours as needed for pain.Review of nursing notes for Resident #1 revealed no nursing narrative notes for the shift which began on [DATE] at 11:00 PM and ended at 7:00 AM.Nurse Aide (NA) # 1 was interviewed on [DATE] at 4:21 PM and again on [DATE] at 8:31 AM and reported the following information about the events of the shift which began on [DATE] at 11:00 PM and ended at 7:00 AM on [DATE]. She had not been working at the facility very long and had recently completed orientation as a new facility Nurse Aide. She had been working as a team with NA # 2 on the shift which began on [DATE] at 11:00 PM and ended at 7:00 AM on [DATE]. It was her first night working with Resident # 1. She and NA # 2 had entered the room around 6 something in the morning to get Resident # 1 out of the bed. They were preparing to transfer Resident # 1 with the sit-to-stand lift. They had placed the sling on the resident, and he was sitting on the side of the bed. Before they started to mechanically lift Resident # 1 up in the sling, he slid from the side of the bed onto the floor and landed on his knees. While on the floor Resident