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	345526	A. BUILDING _____ B. WING _____	08/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF BURKE	3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility staff failed to provide oxygen to a resident according to physician's orders in one (1) of four (4) sampled residents observed with oxygen. (Resident # 6) The findings are: A review of a facility policy dated 11/17/08 titled "Respiratory/Oxygen Equipment" stated Licensed nurses will administer and maintain respiratory equipment, oxygen administration, and oxygen equipment per physician's order and in accordance with standards of practice." Resident # 6 was admitted to the facility on 04/22/11 with diagnoses including chronic obstructive pulmonary disease, hypoxia, pneumonia and Alzheimer's disease. A review of the quarterly Minimum Data Set (MDS) dated 07/20/11 revealed the resident had short and long term memory problems, and was severely impaired in daily decision making. A review of the monthly physician order's dated	F 309	**Carolina Rehab Center of Burke acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually accurate and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The plan of corrections is submitted as a written statement of compliance.** **Carolina Rehab Center of Burke's response to this statement of deficiencies does not indicate agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Additionally, Carolina Rehab Center of Burke reserves the right to refute any of the deficiencies on this statement of deficiencies through informal dispute resolution, formal appeal procedure, and/or any other administrative or legal proceeding.** **F 309** **How corrective action will be accomplished for the resident affected.** On 8-4-2011 the physician's order for O2 for patient #6 was changed to 2 LPM continuously, based on the assessment that this patient's condition had improved, O2 saturation was > 90 % and patient was tolerating 2 LPM well.	9/1/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Sharon C. Whitlock — Administrator — August 18, 2011

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 309	Continued From page 1 08/01/11 until 08/31/11 stated oxygen 2.5 liters per minute by nasal cannula. A review of the monthly medication administration record dated 08/01/11 through 08/31/11 stated oxygen at 2.5 liters per minute by nasal cannula continuous. A review of Resident # 6's plan of care dated 07/27/11 for activity intolerance stated resident had decreased participation in activities due to required oxygen continuously. On 08/02/11 at 12:20 p.m. Resident # 6 was observed sitting in her wheelchair next to her bed with an oxygen concentrator behind her chair, a nasal cannula in her nose and oxygen on at two (2) liters per minute. On 08/02/11 at 12:53 p.m. Resident # 6 was observed sitting in her wheelchair next to her bed and coughing. She had a nasal cannula in her nose with oxygen on at (2) liters per minute. On 08/02/11 at 3:14 p.m. Resident # 6 was observed lying in bed with a nasal cannula in her nose and her oxygen on at (2) liters per minute. On 08/03/11 at 8:12 a.m. Resident # 6 was observed sitting in her wheelchair next to her bed eating breakfast. An oxygen concentrator was parked beside her bed. She had a nasal cannula in her nose and oxygen was on at (2) liters per minute. On 08/03/11 at 10:25 a.m. Resident # 6 was observed sitting next to her bed in her wheelchair with a nasal cannula in her nose and oxygen on	F 309	**F 309 Continued** **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** The Unit Managers, Staff Development Coordinator, and Director of Nursing conducted in-services for licensed nurses. Topics included: 1. Nurses must verify O2 is administered per physician's order. This will be accomplished by checking the O2 order on the medication administration record and then observing the O2 setting on the concentrator or E tank in use by the patient. The administration of O2, including flow rate, will be documented on the MAR each shift. 2. It is the responsibility of the nurse on duty to ensure O2 is administered at the prescribed rate. A list of patients with O2 orders was obtained from Omnicare Pharmacy on 8-4-2011. An audit was conducted and proper flow rate of O2 was verified for each patient at this time. **Measures in place to ensure practice will not occur.** Each charge nurse will monitor during med pass that O2 is administered at the prescribed flow rate as written on the medication administration record. An audit tool was implemented to assist unit managers in identifying areas of noncompliance during routine rounds.	9/1/11 9/1/11

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F 309	Continued From page 2 at (2) liters per minute. A nursing assistant was observed walking in and out of her room assisting Resident # 6 and her roommate. On 08/03/11 at 11:23 a.m. Resident # 6 was observed sitting next to her bed in her wheelchair watching television. She had a nasal cannula in her nose and oxygen was on at (2) liters per minute. On 08/03/11 at 4:45 p.m. Resident # 6 was observed lying in bed with a nasal cannula in her nose and oxygen was on at (2) liters per minute. On 08/04/11 at 8:00 a.m. Resident # 6 was observed sitting in her wheelchair next to her bed eating breakfast. She had a nasal cannula in her nose and oxygen was on at (2) liters per minute. On 08/03/11 at 4:05 p.m. during an interview with NA # 3 she stated nursing assistants are supposed to look at oxygen when they go into a resident's room to make sure it is turned on. She further stated if a resident had a nasal cannula they were to make sure that it was in place in their nose. NA # 3 stated everyone tried to look at oxygen when they put the resident to bed or got them up to make sure it was on and everything was in place. On 08/03/11 at 4:12 p.m. during an interview with LN # 2 she stated nurses put oxygen on the residents and maintain the oxygen. She explained the nursing assistants don't do anything with the oxygen concentrators except to tell a nurse if they noticed the liter per minute setting was not set on what it normally was. LN # 2 stated the first shift nurses check vital signs	F 309	**F 309 Continued** O2 flow rates found out of compliance will be corrected immediately. Needed disciplinary action will be taken for the assigned nurse as areas are found out of compliance. **How the facility plans to monitor and ensure correction is achieved and sustained.** Information compiled from the O2 audit tool will be presented to the QA Committee monthly for 3 months or until compliance is achieved and sustained and then as directed by the QA Committee.	9/1/11

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F 309	Continued From page 3 including oxygen saturation percentages on all even numbered resident rooms and second shift nurses check vital signs including oxygen saturation percentages on all odd numbered resident rooms. She further stated if a resident was receiving oxygen, it was usually checked during the first round at the beginning of the shift and the medication nurses were supposed to look at the oxygen when they went into a resident's room to give medications. On 08/03/11 at 4:35 p.m. during an interview with NA # 4 she stated when the nursing assistants first arrive on their shift, they do a "walk through" with the nursing assistant going off duty to discuss each resident they are assigned and if there are any changes in their care. She stated if a resident has oxygen they check to make sure it is turned on. On 08/04/11 at 9:46 a.m. during an interview with LN # 3 he stated the medication nurses check the medication administration record to determine how many liters per minute of oxygen a resident should receive. He explained the nurses check the oxygen and liters per minute flow rates when they made their rounds and nursing assistants should check the oxygen when they went into the resident's room. LN # 3 verified that Resident # 6's oxygen was turned on at two (2) liters per minute but the medication administration record indicated Resident # 6 should have received 2.5 liters per minute of oxygen. On 08/04/11 at 9:50 a.m. during an interview with the Nurse Manager, she stated it was her expectation the nurses should check the oxygen settings when they go into the residents room and	F 309		

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F 309	Continued From page 4 compare it to the medication administration record or physicians orders to make sure it is on the correct setting. She verified Resident # 6 had a physician order for continuous oxygen at 2.5 liters per minute and her oxygen concentrator should have been set on 2.5 liters per minute. She further stated sometimes the flow rates on the oxygen concentrators will decrease over time and staff should check them when they went into a resident's room. On 08/04/11 at 1:30 p.m. during an interview with the Director of Nurses (DON) she stated it was her expectation oxygen should be administered to residents according to the physician's orders. She stated Resident # 6 should have had her oxygen set on 2.5 liters per minute instead of (2) liters per minute. She further stated it was her expectation that nurses and nursing assistants should check oxygen and set the liters per minute flow rate to the correct liters per minute when they went into the resident's room. On 08/04/11 at 1:45 p.m. during an interview with Resident # 6's Physician Assistant (PA) he stated Resident # 6 was admitted from a hospital with orders for oxygen at 2.5 liters per minute and these orders were continued. He stated it was his expectation nurses should follow what's written on the physician's order sheet. He explained the facility used a communication sheet that nurses filled out to send to the Physician or P.A. if they had any questions or concerns regarding a resident and they would go evaluate these concerns when they made their rounds in the facility. He further stated he was not aware of any concerns or current problems regarding Resident # 6.	F 309		

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F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	**F441** **How corrective action will be accomplished for the resident affected.** Individualized in-service education was provided for the staff member who failed to perform hand hygiene before and after dressing change and for the staff member who failed to perform hand hygiene after wiping a resident's nose. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** The Unit Managers, Staff Development Coordinator, and Director of Nursing conducted in-services for staff regarding policy 401, Handwashing Requirements. **Measures in place to ensure practice will not occur.** Unit managers, or designee, will monitor during routine rounds. Non-compliance with hand hygiene will be corrected immediately, and reported to the Staff Development Coordinator. Using an audit tool, audits will be performed during rounds by Staff Development Coordinator, or designee, observing for proper hand hygiene during meal time and before and after dressing changes. Any areas of non-compliance will be corrected immediately and education or appropriate disciplinary action will be provided.	9/1/11 9/1/11 9/1/11

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F 441	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to wash hands before and after a dressing change for one (1) of eight (8) sampled residents observed during a dressing change (Resident #17) and failed to wash hands after wiping a resident's nose during one (1) of two (2) observed restorative dining meals. The findings are: 1. Review of the facility's hand washing requirement policy dated 12/18/09 revealed requirements of hand hygiene, which consisted of hand washing with soap and water or use of an alcohol based hand rub, before and after changing a dressing. Resident #17 was admitted to the facility on 08/01/11 with diagnoses which included Right Hip Hemiarthroplasty. Admission orders dated 08/01/11 included daily application of a dry sterile dressing to the right hip. Observation on 08/03/11 at 4:30 p.m. revealed Nursing Assistant (NA) #2 opened a dressing on the top of the treatment cart in the clean utility room. NA #2 did not wash hands, use hand sanitizer, or wear gloves. After she opened the dressing and sprayed several 4 by 4 gauze dressings with wound cleanser, NA #2 pushed the treatment cart to Resident # 17's doorway with the open dressings on the top of the cart. Continued observation revealed NA #2 did not wash hands or use hand sanitizer upon room	F 441	**F441 Continued** **How the facility plans to monitor and ensure correction is achieved and sustained.** Information compiled from the audit for hand hygiene will be presented to the QA Committee monthly for 3 months or until compliance is achieved and sustained and then as directed by the QA Committee.	9/1/11

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F 441	Continued From page 7 entry or donning gloves. NA #2 removed Resident #17's soiled dressing and discarded the gloves in a trash bag at the foot of the bed. Resident #17's surgical wound with staples had a small amount of serosanguinous drainage. There was no redness, swelling or foul odor. NA #2 donned gloves and cleansed the surgical wound. During the dressing change, Resident #17's family member requested "padding" under the top dressing. NA #2 discarded the gloves, drew back the privacy curtain, left the room and returned with gauze pads. NA #2 put on a new pair of gloves. She did not wash her hands or use hand sanitizer. NA #2 completed the dressing change and discarded the gloves in a trash bag at the foot of the bed. NA #2 drew back the privacy curtain and carried the trash bag to the treatment cart in the hallway where she discarded the trash. NA #2 used hand sanitizer after discarding the trash. Interview with NA #2 on 08/03/11 at 4:45 p.m. revealed she did not usually prepare the clean field for dressing changes in the clean utility room. NA #2 reported she did not wash her hands before the dressing change. NA #2 explained she did not think to wash hands before touching the privacy curtain. NA #2 reported she should have washed her hands before and after the dressing change. Interview with the Director of Nursing on 08/04/11 at 1:15 p.m. revealed staff should follow the facility's procedure of hand washing before and after dressing changes. 2. The facility's policy entitled Handwashing	F 441		

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F 441	Continued From page 8 Requirements, dated 12/18/09, was reviewed. Under the heading Hand Hygiene, the policy read in part: " The following is a list of some situations that require hand hygiene: Before and after assisting a resident with meals (hand washing with soap and water); after blowing or wiping nose. Resident #10 was admitted to the facility 05/23/09 with the diagnoses dementia, diabetes mellitus, and chronic obstructive pulmonary disease. A review of Resident #10's most recent Minimum Data Set (MDS) dated 07/13/11, revealed she had long and short term memory loss and was unable to make daily decisions. The MDS further assessed Resident #10 as needing extensive assistance with activities of daily living; she particularly needed extensive assistance with eating. An observation was made on 08/03/11 at 12:15 p.m. of Nursing Assistant (NA) #1 feeding Resident #10 and Resident #18 in the restorative dining room. NA #1 was sitting between the residents feeding one and then the other. NA #1 wiped Resident #10's nose which was visibly dripping. NA #1 then picked up Resident #18's utensil and proceeded to feed her. An interview was conducted on 08/03/11 at 1:10 p.m. with NA #1. NA #1 reported that she did not get any body fluid on her hand while wiping Resident #10's nose. She further reported had she gotten any body fluid on her hand she would have washed her hands. An interview was conducted on 08/04/11 at 2:00 p.m. with staff development coordinator. She	F 441		

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F 441	Continued From page 9 reported that when ever staff comes in contact with body fluids she would expect them to wash their hands. She further reported that she would expect staff to wash their hands after wiping a resident's nose before feeding another resident. An interview was conducted on 08/04/11 at 2:05 p.m. with the Director of Nursing (DON). The DON reported that she would expect staff to wash their hands prior to feeding a resident after wiping another resident's nose.	F 441		