STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIAD CARE AND REHABILITATION CENTER	707 NORTH ELM STREET HIGH POINT, NC 27262

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F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews and record reviews, the facility failed to provide 2 of 3 sampled residents with full oxygen tanks (Resident #1 and Resident #4). The findings included. Resident #1 was admitted to the facility on 1/17/13. The diagnoses included chronic airway obstructive pulmonary disease, coronary artery disease, dementia, psychoses, chronic respiratory failure, congestive heart failure and esophageal reflux. The quarterly Minimum Data Set(MDS dated 4/23/13, indicated that Resident #1 cognition and decision making skills was impaired and required extensive assistance with activities of daily living. The MDS also indicated that Resident #1 was dependent on continuous oxygen therapy. Review of the physician order dated 3/12/13, revealed that Resident #1 wears 2l (liters) of	F 328	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Genesis Triad Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for deficiency."	

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

Alyce Hopping Adm. 7-25-13

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 328	Continued From page 1 oxygen continuously everyday/every shift. The oxygen tubing to be changed weekly every shift Review of the care plan dated 4/23/13, identified the problem as altered respiratory status; shortness of breath/difficulty breathing related to COPD(chronic obstructive pulmonary disease), respiratory failure. The goal would be to maintain adequate oxygen saturation level. The approaches included observe resident alterations in respiratory status including shortness of breath, pain/discomfort with breathing, abnormal lung sounds and report abnormalities, provide oxygen as ordered. During an observation on 7/2/13 at 10:04AM, Resident #1 was seated in a wheelchair with oxyen via nasal cannula in place. The protable tank on back read(empty) it was in the red zone. Resident #1 was sleeping in the chair unaware the tank was empty. During an observation on 7/2/13 at 10:12AM, the DON checked and confirmed the portable oxygen tank for Resident #1 was in the red zone indicating it was empty. During an interview on 7/2/13 at 10:12AM, the Director of Nursing(DON) indicated that all staff were responsible for checking the tanks each shift to ensure that they were full. She added that once the resident morning grooming/hygeine was complete and resident was ready for daily routine. Staff should checked the tank to ensure there was enough oxygen available in tank. She added that there was no system in place to check the fullness of the tank since the oxygen was delivered from an outside company, nor was there a monitoring system to ensure that staff were checking the tanks consistently. During an observation of the oxygen storage	F 328	F328 Resident #1 and Resident #4's oxygen e-tanks were exchanged for full tanks on 7/2/2013. New oxygen regulators where purchased on 7/2/2013 and Resident #1 and Resident #4's oxygen regulators were replaced on 7/2/2013. Resident #1 and Resident #4's oxygen saturation rates were taken and were greater than 90% which revealed resident had no distress.	

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F 328	Continued From page 2 room and each hall crash cart on 7/2/13 at 10:16AM, 16 oxygen tanks were full available on the 2nd floor in the oxygen room. Hospice also has tanks available in the room for the identified residents(names were located on the tanks.). The crash carts all had full tanks. During an interview on 7/2/13 at 10:25AM, Nurse#1 indicated that she changed the cannula tubing for Resident #1 and the oxygen was flowing from what could be heard. Nurse#1 indicated that she did not check the tank to see if the tank was full. She added that she should have check the tank when the tubing was changed. During an interview on 7/2/13 at 10:43AM, Nurse #2 indicated that it was nursing staff responsibility for checking the portable oyxgen tanks for the residents. Nurse#2 indicated she was told by the DON to check the tanks and change Resident #1. During an observation on 7/2/13 at 12:00PM, Resident #1 was taken to the dining room by NA#1 with protable oxgen tank on the back of the chair. The NA did not check the tank, tank was in the red zone again reading empty. During a follow-up observation on 7/2/13 at 12:37PM, Resident #1 remained in the dining room eat meal, oxygen tank read 400. During an observation on 7/2/13 at 12:58PM, Nurse#2 and NA#1 standing in hall at oxygen room door on 2nd floor with Resident#1. Nurse#2 indicated that she had checked the tank earlier and it was not empty, could not remember the exact time she checked the tank. She indicated that she was changing the tank out now because it was now at 600, she added that Resident#1 should have 3Liters of oxygen on daily basis.	F 328	All other Residents in the facility using e-tanks had their oxygen levels checked on 7/2/2013 and if the oxygen level was at 500 psi (pounds per square inch) or less the e-tanks were replaced with full oxygen tanks. Residents on e-tanks had their oxygen saturation levels checked on 7/2/2013 and all saturation rates were in acceptable range. All residents on e-tanks had their oxygen saturation levels checked every hour for 24 hours while receiving oxygen via an e-tank. All resident's levels were in acceptable range.	

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F 328	Continued From page 3 Nurse#2 indicated she was uncertain if there was a system in place to check the tanks routinely or when staff should be checking the tanks to ensure that residents were not running out. During an interview on 7/2/13 at 1:05PM, the Nurse consultant indicated that there was no system in place to ensure that the oxygen tanks were being checked routinely. She indicated that she was uncertain whether the tanks were being completely filled by the contracting company when delivered or whether there was problem with the tank regulator. During a follow-up interview on 7/2/13 at 2:36PM, the DON, indicated that there was no current system in place to check the oxygen tanks and she was uncertain how long the tanks for the resident have been reading empty in the red zone, since the tanks were not being routinely checked and the contracting company only visited once a month to change out what has been used. During a family interview on 7/3/13 at 11:13AM, the family member indicated that Resident #1 was on 2 milliliters of continuous oxygen so that his overall health could be maintained at a comfortable level. The main concern was that the oyxgen tanks should be full so that Resident #1could breathe at a comfortable level. She added that she had spoken with several of the nursing staff and the DON about making sure that the tanks were checked routinely throughout the day, but staff didn ' t seem to think it was a problem. In addition, no-one could tell her how long the tanks were empty. During several visits when she arrived at different times the tank was in the red zone which means there empty. She	F 328	All oxygen regulators were replaced with new oxygen regulators on 7/2/2013. Nursing staff was in-serviced on how to read the oxygen level in the e-tanks and instructed to notify the resident's nurse when the level is at or below 500 psi. Completed 7/4/2013 Nursing staff will complete a 24 hour e-tank oxygen check-off log once a week for the next 4 weeks, then 2 times a month for 1 month to ensure the e-tanks continue to function properly. Findings will be submitted to the Performance Improvement Committee by the Director of Nursing monthly x2 months with follow up as needed. Completed 7-25-13	

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F 328	Continued From page 4 indicated that she was upset that staff were not making sure the tanks were being kept full to meet the required oxygen need of Resident#1. During an interview on 7/3/13 at 11:30AM, the administrator indicated the expectation would be that the staff check all the residents using portable oxygen tanks to ensure they were completely full, the regulators were on properly and staff were checking them several times throughout the day during each shift. Administrator indicated there was no current system in place to ensure the tanks were delivered full or that staff were routinely checking the tanks to ensure the residents were no going long periods without oxygen. She added that a new system would be immplemented immediately. 2. Residnet #4 was admitted to the facility on 12/8/10. The diagnoses included chronic kidney disease, diabetes, dementia, and short of breath. The quarterly Minimum Data Set(MDS) dated 6/7/2013, indicated that Resident#4 had cognitive and decision making impairments. Resident#4 required extensive/total care for all activities of daily and dependent upon oxygen therapy. Review of the physician ' s orders dated 8/9/12, revealed that Resident #4 required continuous 2militers of oxygen per minute daily via nasal cannula. Review of the nursing assessemnt dated 6/6/13, under the respirtatory section indicated the reason for oxygen was shortness of breath when exertion. Review of the care plan dated 6/27/13, identified	F 328		

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F 328	Continued From page 5	F 328		

the problemas altered respiratory status; shortness of breath/ difficulty breathing related to anemia, kidney disease. Resident is oxygen dependent. The goal was that Resident would be maintain on adequate oxygen saturation levels. The approaches included keeping head of bed elevated as resident would allow, observe for alterations in respiratory status including shortness of breath, pain/discomfort with breathing, abnormal lung sounds and report abnormalities to physician, obtain oxygen saturaton levels per physician order and notify physician of satsless than 90%.

During an observation on 7/2/13 at 9:39AM, Resident#4 was sitting in room with door closed and the portable oxygen tank located on the back of chair was in the red zone reading empty. During an interview on 7/2/13 at 10:12AM, the Director of Nursing(DON) indicated that all staff were responsible for checking the tanks each shift to ensure that they were full. She added that once the resident morning grooming/hygeine was complete and resident was ready for daily routine. Staff should checked the tank to ensure there was enough oxygen available in tank. She added that there was no system in place to check the fullness of the tank since the oxygen was delivered from an outside company, nor was there a monitoring system to ensure that staff were checking the tanks consistently.

During an observation on 7/2/13 at 10:16AM, 16 oxygen tanks were full available on the 2nd floor in the oxygen room. Hospice also has tanks available in the room for the identified residents(names were located on the tanks.). Resident #4 was on the hospice list for oxygen

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F 328	Continued From page 7 administrator indicated the expectation would be that the staff check all the residents using portable oxygen tanks to ensure they were completely full, the regulators were on properly and staff were checking them several times throughout the day during each shift. Administrator indicated there was no current system in place to ensure the tanks were delivered full or that staff were routinely checking the tanks to ensure the residents were no going long periods without oxygen. She added that a new system would be immplemented immediately.	F 328		