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 _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS HOME-KINSTON	2150 HULL ROAD KINSTON, NC 28504

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the Complaint Investigation of Event ID Q57N11 from 7/20/2018. NC00140979.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to provide respiratory care by not changing the oxygen tubing and humidification water bottle on an oxygen concentrator for 1 of 1 residents (Resident #36). Findings included: Record review revealed Resident #36 was admitted to the facility on 7/25/2017 with a recent hospitalization and readmission on 7/9/2018. The diagnoses from the readmission included Acute Respiratory Failure and shortness of breath. Record review of the Quarterly Minimum Data Set (MDS) dated 5/1/2018 revealed Resident #36 was severely cognitively impaired and required extensive to total assistance with all activities of daily living.	F 695	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. 1.Process that led to the deficiency Resident #36 did not have his respiratory care supplies changed weekly and as needed upon readmission to the facility on 7/9/18. This led to there being no dated label on the oxygen tubing and humidification bottle being used by the	8/17/18

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

Electronically Signed | 08/02/2018

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 695	Continued From page 1 Review of the hospital discharge Physician Orders dated 7/9/2018 for Resident #36 revealed an order for oxygen per nasal cannula at 3 liters and hour continually. The following observations were made of Resident #36: 7/17/2018 at 4:09 PM-Resident #36 was observed lying in bed with humidified oxygen at 3 liters per nasal cannula via oxygen concentrator. There was no date/label on the oxygen tubing or the humidification bottle. 7/18/2018 at 11:33 AM-Resident #36 was observed lying in bed with humidified oxygen at 3 liters per nasal cannula via oxygen concentrator. There was no date/label on the oxygen tubing or the humidification bottle. 7/19/2018 at 8:33 AM-Resident #36 was observed lying in bed with humidified oxygen at 3 liters per nasal cannula via oxygen concentrator. There was no date/label on the oxygen tubing or the humidification bottle. An interview was conducted with Nurse #2 on 7/19/2018 at 10:09 AM. Nurse #2 confirmed she was the nurse responsible for Resident #36. Nurse #2 stated the oxygen tubing and the humidification bottle was changed every week and as needed. Nurse #2 reported the weekly change was completed by the 11:00 PM-7:00 AM nurse and it was documented on the Medication Administration Record (MAR). Nurse #2 reviewed the MAR and stated there was no documentation on the MAR of the tubing change and it must have accidently been omitted when the resident returned for the hospital. An interview was conducted with the Director of Nursing (DON) on 7/19/2018 at 10:18 AM. The	F 695	resident. The admitting nurse and nurse verifying the orders to the POF did not write the order on the POF and transcribe it to the MAR on the resident□s readmission. 2.Process for implementing the acceptable plan of correction for specific deficiency On 7/19/2018, the Clinical Competency Coordinator initiated in-services for all licensed nurses on the following and completed 8/2/2018 on: (1) the oxygen tubing policy/procedures and facility expectation to date and change respiratory supplies weekly and record on the MAR upon admission into the facility; (2) assuring that any resident admitted/re-admitted to the facility requiring respiratory care has an order for respiratory supply change weekly, and PRN is written on the POF and transcribed to the MAR; (3) moreover, making sure that respiratory supply changes are completed weekly and PRN and documented on the MAR as ordered. On 7/19/2018, a 100% audit was completed by Director of Health Services, Quality Improvement Coordinator, and Unit Managers of all residents requiring respiratory care supplies to ensure that respiratory supplies were labeled with date of change, order to changes supplies weekly and PRN were transcribed to the MAR, and date of change was	

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F 695	Continued From page 2 DON stated the expectation was the tubing would be changed weekly and documented on the Medication Administration Record (MAR). The DON stated the expectation was the tubing and humidification bottled be dated.	F 695	documented on the MAR for each week. 3.Monitoring procedure to assure that the plan of correction is effective As of 7/19/2018, Unit Managers/Supervisors/or designee started respiratory care audit for all residents who require respiratory care daily for 4 weeks, then weekly for 6 weeks thereafter to ensure respiratory supply changes is documented on MAR and labeling of respiratory supplies with date of change; and also review completed admission/re-admission charts for residents requiring respiratory care to assure order has been written for respiratory supply changes weekly and PRN to the POF and transcribed to the MAR. DHS/Quality Improvement Coordinator will complete a log showing daily review and Administrator will initial daily showing review of compliance. QAPI team will review facility interventions monthly for a period of 3 months and as needed to discuss any issues with compliance and/or training. 4.Title of person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: August 17, 2018	
F 761	Label/Store Drugs and Biologicals	F 761		8/17/18

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F 761 SS=D	Continued From page 3 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to dispose of expired medication on one of two medication carts inspected for expired medications. Findings included: On 7/18/2018 at 4:00 PM, the medication cart for the Alpha Hall was inspected for expired medications. A container of Geri Lanta regular strength antacid antigas 12 fluid ounces was found to have an expiration date of 6/18.	F 761	PROCESS THAT LED TO THE DEFICIENCY The facility failed to discard expired medications due to the expired medication being missed on the nightly audit review. The expired medication was not removed from the medication cart on the Alpha unit because the 3rd shift nurses who were responsible for the nightly audit of	

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F 761	Continued From page 4 On 7/20/2018 at 8:30 AM, in an interview, the Director of Nursing stated her expectation was that all expired medications be disposed of.	F 761	medication storage, overlooked the medication and did not remove it from the cart. PROCESS FOR IMPLEMENTING THE ACCEPTABLE PLAN OF CORRECTION FOR SPECIFIC DEFICIENCY On 7/18/2018, a 100% audit of all medication carts and medication storage was completed to ensure there were no expired medication in storage and completed on 7/18/18, by the Director of Health Services, Quality Improvement Coordinator, and Unit Managers, Nurse Navigator, and MDS nurses. On 7/18/2018, the Clinical Competency Coordinator initiated in-services for all licensed nurses on the following and completed 8/2/2018 about: (1) Auditing medication cart to ensure no expired medications are on the cart daily by the licensed nurse working that shift and unit (2) auditing medication storage to ensure no expired medications weekly by 3rd shift licensed nurse working that unit MONITORING PROCEDURE TO ASSURE THAT THE PLAN OF CORRECTION IS EFFECTIVE As of 7/18/2018, Unit Managers/Supervisors/or designee are to complete weekly audits of medication cart and storage daily for 4 weeks, then weekly for 6 weeks thereafter to ensure there are no expired medications and that medications have open dates if	

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F 761	Continued From page 5	F 761	necessary. As of 7/18/2018, Quality Improvement Coordinator will do a random audit of medication cart and storage weekly for 4 weeks, then monthly for 3 months to ensure compliance. DHS will complete a log showing daily review and Administrator will initial daily showing review of compliance. QAPI team will review facility intervention monthly times 3 months and as needed to discuss any issues with compliance and/or training. TITLE OF PERSON RESPONSIBLE FOR IMPLEMENTING ACCEPTABLE PLAN OF CORRECTION The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: August 17, 2018	