PRINTED: 04/11/2012 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PEAN OF CORRECTION A BUILDING С B WING 345517 04/03/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CHY, STATE, ZIP CODE 3830 BLUE RIDGE ROAD **BLUE RIDGE HEALTH CARE CENTER** RALEIGH, NC 27612 PROVIDER'S PLAN OF CORRECTION (N5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX JEACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR USC IDENTIFYING INFORMATION) TAG IAG DEFICIENCY) " Preparation and/or execution of this plan F 000

F 000 INITIAL COMMENTS

The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section conducted a complaint investigation survey on 3/29/12 through 04/03/12. It was determined the facility had provided substandard quality of care at the immediate jeopardy level. A partial extended survey was conducted on 04/02/12 and an exit conference was held with the facility on 04/03/12. The Immediate Jeopardy began on 03/16/12 and is present and on-going.

F 157 483.10(b)(11) NOTIFY OF CHANGES SS=J (INJURY/DECLINE/ROOM, ETC)

> A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in

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of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."

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Resident #1 was discharged from the facility on March 20, 2012. An investigation was conducted, led by the Director of Nursing (DON). The investigation included but was not limited to: facts surrounding the incident involving Resident #1, facility processes for communication of resident changes in condition to the physician and/ or Medical Directors, nursing, respiratory and the IDT, review of the resident's medical record to determine evidence of potential risk factors for decannulation. Following the completion of the investigation, based on an analysis of the findings, the facility developed and implemented corrective action directed at areas identified with quality improvement opportunities. For residents residing in the facility in similar situations as Resident #1 and Resident #2, the following actions would be taken. The licensed nurse would initiate One-to-One supervision of the resident followed by: (a) inform the physician or Medical Director of the change : in the resident's condition and the behaviors exhibited, (b) obtain an order for one-to-one supervision and any other intervention the physician or Medical Director deems necessary. (c) charge nurse complete an SBAR (Situation, Background, Assessment/ Appearance and Request) report, (d) document the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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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CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391				
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F 157	regulations as specifications as specification. The facility must receive address and pholegal representative of the address and pholegal representative of the same of the facility staff, the physical staff are staff and the same night staff and the staff are staff and resulted in a critical staff and the staff a	Federal or State law or ied in paragraph (b)(1) of ord and periodically update me number of the resident's or interested family member. It is not met as evidenced views and interviews with sician, and respiratory of failed to notify the physician ulating the tracheostomy onnecting the ventilator 9 ght (Resident #1). The of the physician about e-on-one supervision of a resident who was attempting sident #2). This was evident the tracheotomies. It is not met as evidenced views and interviews with sician, and respiratory of the physician about e-on-one supervision of a resident who was attempting sident #2). This was evident the tracheotomies. It is notified of the immediate expected at 12:13 pm. The is present and ongoing. It is present and ongoing. It is present and ongoing at at a D level deficiency (an iest constitutes no actual harm the than minimal harm that is	F	change in the resident's con 24 hour report and the one-t supervision being provided, report and the SBAR report to the IDT for discussion, ac development and monitoring resident's progress. The resident would remain of report until his/her condition the resident's condition impr declined, the IDT would make recommendations to the phy Medical Director to modify of one-to-one supervision for the place the resident on Resident #2 was discharged facility on March 28, 2012 at readmitted on March 30, 200 readmission Resident #2, we dependent at night, upon readmission Resident #2, we dependent at night, upon readmissions. Resident #2 has obtained and implemented for pulse oximetry, anti-disconninght, and Resident Monitoric continues at this time. 2. Residents with tracheosted changes in condition have the affected by the same alle practice. On March 31, 2013 with tracheostomies checked for placement by the Respirator Director or his/her designed residents with tracheostomies residents with tracheostomies residents with tracheostomies properly placed. On March 33	o-one (e) the 24 hour would be given tion item g of the on the 24 hour improved. As oved, or de resident and ent Monitoring. I from the nd was 12. Following entilator admission was by collar and Resident # 2 r "emergent" had orders or continuous ect device at ng which omies with ne potential to ged deficient 2 residents ir proper y Therapy Of the 21 es all were 11, 2012 the		
	Findings include:	·		presence of a replacement t at the bedside was validated	racheostomy		

Review of the policy titled, "Ventilator (vent)

residents with tracheostomies to ensure a

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F 157	Patient with Agitation' indicated "Identify: Pulling at ed moving, crying, comb bed/chair." "Interventions: CNA // Itherapist) alert nurse. Reposition. Meet any Stay with resident duractive agitated reside medication/Antianxiet be appropriate -check first." "Monitor: Maintain a 1 resident is actively agithat the post effective leave an agitated resi Document, Document NOTE: Ensure physic of condition. Ensure reis notified." Resident # 1 was adm 08/29/11 with cumulat respiratory failure that ventilation, pulmonary hypertension, diabete insufficiency. The quarterly Minimur revealed Resident #1 long and short term m responded to direct sit was limited in her abili	which was not dated, uipment, uncontrolled ative, attempts to get out of It (nurse aide/respiratory Attempt to calm resident, red that is acceptable, ing crisis (do not leave an nt) Nurse - Pain y meds (medications) may for recent medication use I staff observation while itated. If medicated, ensure ness is documented. Never dent alone! Document, " ian is notified in the change esident's responsible party hitted to the facility on ive diagnoses including required the use of artificial rinsufficiency, dysphasia, s mellitus and renal In Data Set dated 1/22/12, had moderately impaired	F 157	Team reviewed the medical receach of the 21 residents in the tracheostomies to identify reside behaviors that put them at risk decannulation. "At risk" behaviors that put them at risk decannulation. "At risk" behavior that are not limited to: restless memotional distress or cognitive resulting in confusion, weeping or subjective signs of pain of di Nine (9) of the 21 residents revidentified with "at risk" behavior residents were placed on "Resi Monitoring" to provide increase supervision. During the record residents' care plans were revidented, as necessary to reflect residents' current care needs. On March 30, 2012 the facility's consultant conducted a review of medication regimen of current rewith tracheostomies, with behaven sure that the residents were pappropriate medication and dos During the month of April the Modification on the Medical Special (MSU) and is aware of any recein the residents' conditions. 3. On April 12, 2012 the facility policy titled "Status Changes: Nof". The modification explicitly following situations when the pharmacheostomy tube, (b) resident tracheostomy tube, (b) resident	sciplinary cords for facility with for fors include ess, changes or objective scomfort. iewed were s. All 9 dent d review ewed et the s pharmacy of the esidents, viors to receiving sages. edical sident ty Unit ent changes modified its otification adds the eysician is enpting to g attempting			
		nysical illness or injury to ily dependant on staff for all y living. She was	•	to or actually turning off ventilate worsening or change in behavio status, (d) attempts at or risk of	r or mental			

of her activities of daily living. She was

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F 157 Continued From page 3

incontinent of bowel and required an indwelling catheter. She was administered tube feedings daily.

The care plan dated 1/19/12 indicated the "Problem/Strength: Alterations in behavior AEB (as evidenced by) Disruptive Behavior Attempting multiple times to throw feet oob /(out of bed) trying to get oob even after redirection. Interventions/Approaches (specify behavior) increased anxiety and restlessness Keep resident safe and do not attempt to provide care while combative notify the nurse Assesses Behavior, attempt to redirect and educate resident Determine need for PRN, (as needed medications), administer (medications) per order, monitor for effectiveness of the medication. Redirect resident care Reapproach when calm Keep resident safe. Notify family, M.D. (physician), and Psych (psychiatry) service of changes in behavior."

Nurses' notes, dated 02/04/12 at 7:35 pm revealed in part, "pt(patient)was found sitting on the floor @ (at) the side of the bed and she was noted to be decannulated. RT (respiratory therapist) was called to the resident's room. The trach tube was reinserted and the resident was bagged. (manual artificial ventilation performed with a respirator bag). Family and MD were made aware. A sitter was placed at the bedside until the family arrived."

Nurses' notes, dated 02/09/12 at 4:30 pm, indicated the resident " resident sliding out of the geri chair and had the O2(oxygen)tubing pinched

self, (e) respiratory distress, respiratory failure, arrest, (f) requirement for or discontinuation of one-to-one supervision or change in Resident Monitoring and (g) development or resolution of "at risk" or

"emergent" behaviors. Additional systemic changes include; (1) The MSU charge nurse on each shift will add an entry to the 24 hour report for a particular resident whenever a physician is notified of a change in that resident's condition. The charge nurse, or House Supervisor will notify the physician of changes in the resident's condition and obtaining appropriate orders by placing a telephone call to attending physician or the Medical Director. (2) SBAR reports (Situation, Background, Assessment/ Appearance, and Request) will be required to be completed by the licensed nurse for situations requiring physician notification. The SBAR report will remain with the 24 hour report until the actions noted on the SBAR report have been accomplished ensuring communication of required actions to each shift until the SBAR is resolved. The SBAR reports will be forwarded to the IDT with the 24 hour report to ensure that any situation where a physician is called is communicated, (4) A new physicians log book has been initiated on MSU for attending physicians and the psychiatrists, the charge nurse will make entries in the book when a phone call is placed to the physician also to ensure that any situation is communicated back to the physician so the resident may be evaluated as indicated on the next visit, the physician signs off on each entry when reviewed (3) The 24 hour report and any SBAR reports are reviewed by the offgoing and on-coming nurses during each

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in between the chair and the night stand. O2 tubing fixed res.(resident) put to bed.1:1 sitter began." (The resident had a one-on-one supervison.).

Nurses' notes dated 02/24/12 at 5:10 pm, indicated the resident "attempted to crawl out of bed shift and was pulling at the trach tube. The note also indicated the resident was given Ativan with effectiveness."

Nurses' notes, dated 03/03/12 on the 7 am-7 pm shift, indicated the resident was agitated and was pulling at her trach and trying to get out of bed. The note also indicated the resident was given Ativan with effectiveness.

The respiratory note (written by RT #6) dated 3/16/12 revealed Resident #1 was on an aerosol tracheostomy collar (ATC) during the first respiratory therapist (RT) walkthrough at 1:45am. Resident #1 decannulated herself (removed the trach tube that kept the airway open) at 5:43 pm. The oxygen saturation rate dropped to 71% (normal values 92%-96%) because of the decannulation. The resident was suctioned, the tracheostomy was replaced and the resident was oxygenated back to 100%. She was then placed back on full ventilator support at 5:50 pm. There was no evidence that the physician was notified.

Nurse #5 was interviewed on 03/31/12 at 3:43 pm via telephone. Nurse #5 indicated she worked on 3/16/12 during the second shift (3 pm -11 pm). Nurse #5 said she was across the hall with another resident. Nurse #5 stated, "I heard (Resident #1) banging on the side of the chair. I saw her with the trach and the ties in her hand.

shift change. Once resolution is obtained the SBAR form will be placed in the resident's medical record.

Beginning April 25, 2012 re-education, with a new curriculum, will be completed with nurses and respiratory therapists working MSU on:

- 1)The new policy titled "Status Changes: Notification of".
- 2)The Why, How, and When of the SBAR tool
- 3)The 24 hour report process 4) Clinical Communication Process Licensed nurses and Respiratory Therapists working on the MSU that have not received the above training and education by May 7, 2012 will not be permitted to work until such re-education has been completed. Education and/or training will be provided at the beginning of their next scheduled shift, prior to providing resident care. The training will be provided by the MSU Unit Manager, House Supervisor, and/or DON at the beginning of each shift for persons that have not received the training, including agency staff. The above described training will be incorporated into the new hire orientation. New hires will not be permitted to provide resident care on the MSU until the training is completed.
- 4. The facility has developed and implemented new audit processes to access the effectiveness of the above plan related to supervision of residents with tracheostomies. (a) On a daily basis, the DON, Assistant Director of Nursing (ADON), MSU manager, or House Supervisor will review the 24 hour reports from the MSU to verify appropriate information is being communicated shift to

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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The banging was just for about 20 seconds. She was not banging for very long. She (the resident) was mouthing 'I can't breathe.' She had her hand up to her neck. I didn't ask her what happened. She looked scared at that moment because she didn't have a full airway. I put the old trach back in and then respiratory came in and I went to tell her nurse what happened. She was in the gerichair. Normally the call bell was by her side. I cannot remember. Her nurse was off the floor, and I was watching her patients."

On 04/02/12 at 9:39 am respiratory therapist (RT) #4 was interviewed. She stated Resident #1 needed the trach to be able to breathe and also for suctioning. The RT was on duty when the resident decannulated herself on 03/16/12. She said Resident #1 had been messing with the oxygen collar all day, was fidgety.

On 03/30/12 at 8:41 am respiratory therapist #4 was interviewed again. She said Resident #1 would move her oxygen mask and RT #4 told her not to mess with it. RT #4 stated "When the trach was out she did have trouble breathing, I felt she would rest more comfortably if she had a night on the vent."

RT #6 was interviewed at 12:11 pm on 03/30/12. RT #6 said Resident #1 had anxiety problems. RT #6 said that on 03/16/12, the resident looked very much in distress (after she decannulated herself) and it took just a couple of minutes to resolve the issue. The RT said, "When her secretions would get going (increased) she would get anxious."

Review of the respiratory note dated 03/17/12,

shift and that respiratory therapy and nursing are collaboratively reporting changes in resident condition and incidents via the 24 hour report. (b) On a daily basis, the DON, Assistant Director of Nursing (ADON), MSU Manager, or House Supervisor will review the 24 hour reports from the MSU to verify that an SBAR form has been completed appropriately for each item entered.

(c) On a daily basis, the DON, Assistant Director of Nursing (ADON), MSU Manager, or House Supervisor will observe shift to shift report to verify that information from the 24 hour report is being communicated to the on-coming shift nurse by the off-going nurse.

The daily audits will continue for 30 days and then will be completed weekly unless concerns are identified in which case daily audits will continue until a time determined by the QA & A committee.

The DON will report to the facility's Quality Assessment and Assurance (QA&A) Committee weekly with the results of the verification review of the above identified audits. Issues identified by the DON as a result of these audits will be reported to the QA&A Committee within one business day. The QA&A Committee will evaluate the effectiveness of the plan on a weekly basis, for 2 months and then every two weeks for 2 months, then monthly based on trends identified and develop and implement, additional interventions as needed to ensure continued compliance. On a weekly basis the Administrator, DON, Respiratory therapy Director, and MSU manager will meet to review the plan and ensure there are no issues with communication.

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	, ,,	was still on artificial	F ·	157 Weekly the Administr progress on the corre including any issues reviews with achievin compliance to the go	ective action plan identified in the ig or sustaining verning board of the	

from the ventilator at 1:52 am, 2:01 am, 2:12 am, 2:30 am, 3:05 am, 4:10 am, 5:50 am, 6:05 am, and 6:25 am. Resident #1 was removed from artificial ventilation to ATC at 8:35 am. She continued on the ATC until 11:45 pm when she was returned to artificial ventilation. There was no evidence the physician was notified of the resident disconnection from the vent.

On 03/30/12 at 4:02 pm RT #3 was interviewed. RT #3 worked with Resident #1 on 03/16/12 and 03/17/12 from 6:30pm until 7 am. RT #3 said she was aware that the resident decannulated herself earlier in the day on 03/16/12. The RT said the resident was on the vent that night. RT #3 said the early morning of 03/17/12, there were several disconnections of the resident from the vent, the circuit became disconnected at the neck each time. The nurse was aware of the disconnections. Many of the nurses know how to reconnect circuit. The RT said, "I felt like the resident was agitated."

On 03/31/12 at 11:12 am, Nurse #3 was interviewed. Nurse #3 said she worked on Saturday, 03/17/12 from 7am to 7pm (after the resident decannulated herself and disconnected herself from the vent). Nurse #3 stated "I was assigned to (Resident #1). She was on the oxygen mask. She was in the geri chair. I wasn't informed that she had pulled out her trach on Friday. I should have found out from the 24 hour report sheet. The sheet stayed on the medication cart for 24 hours. The decannulation should have

facility. The board will take any other actions they deem necessary based on the reports.

> Twice monthly, for 3 months, the Vice President of Clinical Services will attend the facility QA & A meetings and provide input on plan effectiveness as well as ensure continued compliance. The Administrator is responsible for ongoing compliance.

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, 101		t was not on the sheet. I got	•	.07			
		4)." Nurse #3 said the					
		were supposed to tell the					
		ent had agitation issues.					
		s the resident, to determine Once they were cleaned, or					
		s would use medications (to					
		at didn't help the nurses					
	should call the nursin doctor.	ng supervisor and call the					
	On 03/30/12 at 9:48	am, Nurse #2 was					
		rse said she worked during					
	•	t on 03/17/12 as the team					
		d that she was not aware that cannulated herself on					
		said no one told her that					
		connected herself 9 times					
		Respiratory therapists did					
	not report to the sup- something such as d	ervisors unless it was					
	Something Such as u	ecamulator.					
	The respiratory note	(written by RT #3) dated	•				
	•	Resident #1 was still on					
		nd her oxygen saturation rate . The tracheostomy became	:				
		ne ventilator at 4:10 am, 6:00	·				
		7:00 pm her oxygen					
	saturation rate fell to	82%. The cuff of the					
	tracheostomy was d						
	suctioned and oxyge	en saturation returned to 97%.					
	On 03/30/12 at 4:02	pm RT #3 was interviewed.					
	RT #3 worked with F	Resident #1 on 03/18/12 from					
	•	The RT said "on the early					
	morning of the 18th	she disconnected (the circuit)					

3 times. I asked her if she was tired and I asked her if she wanted to go on the trach collar and

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		ooked very worn out to me.					
		from 3 (am) until 6 (am) and					
	~	When she got secretions n she would cough and the					
	mucous would go into						
	ŭ	•					
	On 03/30/12 at 9:48 a						
		2 stated she was assigned					
		/18/12 on the 7am-3pm shift.					
	outgoing nurse that F	as not made aware by the					
		from the ventilator 9 times					
		nes on 03/18/12. Nurse #2					
		about the 9 disconnections					
	on the 17th and the 3	disconnections on the 18th					
	(Resident #1) would re	not be sitting alone."					
	On 03/30/12 at 3:15	om Nurse #7 was					
	•	7 stated she worked on					
	03/18/12 on the 3pm-	-11pm shift as a team leader					
	(term used when nurs	se supervisor is a licensed					
	practical nurse as op-	posed to registered nurse).					
		was not aware that the					
	· · · · · · · · · · · · · · · · · · ·	ut her trach on 03/16/12.					
	• '	vas a decannulation, the					
		upervisor know and she					
	would put it on the 24	-hour supervisor's report.					
	Review of the respira	tory note dated 03/19/12,					
		was on ATC at 1:50 am and	:				
		e was 97%. Bilateral breath					
		d as diminished. The FiO2					
		6 at 7:30am. The respiratory					
	therapist was notified	by the unit secretary at 7:40					

am that Resident #1 was tachypneic (very rapid breathing) and the oxygen saturation rate was found to have fallen to 85%. Rhonchi (sounds caused by secretion and narrowed airway) were

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	1, ,			DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER BLUE RIDGE HEALTH CARE CENTER		383	TADDRESS, CITY, STATE, ZIP CODE BLUE RIDGE ROAD LEIGH, NC 27612	04/03/2012
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL IAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	D. 4.4.5

F 157 Continued From page 9

heard. Resident was suctioned at that time. At 9:10 am, the oxygen saturation rate dropped to 86%. The resident was suctioned. Breath sounds were recorded as "coarse" and she was suctioned for blood tinged "mucoid" at 8:00 pm.

Nurses notes dated 3/20/12, indicated the resident was observed at 3:00 am in a recliner. An aide (NA#2) went to the room at 3:20 am, and found the resident unresponsive with the tracheostomy lying on the chest. Resident #1 was moved to the bed and CPR was initiated. Paramedics pronounced Resident #1 dead at 3:36 am. The physician, family and director of nursing were notified.

On 03/30/12 at 11:30 am, nurse #4 was interviewed. Nurse #4 worked on the 11 pm -7 am shift on 03/19/12. Nurse #4 said, "I didn't know that she had pulled out her cannula before until the cop told me she had decannulated on Friday." Nurse #4 said if she had known that the resident decannulated herself, she might have decided to call and get one-on-one supervision."

The medical director was interviewed on 03/29/12 at 8:57 am. The medical director stated, "The nurses call when they want a sitter (a facility employee sits by the bedside and monitor a patient), or we recommend to the nurse. A patient needs a sitter if they exhibit danger to themselves. Unfortunately she was sitting up in the chair and when it was pulled out, her positioning could have been such that, (indicating chin to chest) the airway became blocked. There was 14 minutes between periods when she was checked by the staff. She was being seen by a psychiatrist, for her behaviors of wanting to get

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391
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NAME OF PR	OVIDER OR SUPPLIER			STREET.	ADDRESS, CITY, STATE, ZIP CODE	
BLUE RIDGE HEALTH CARE CENTER				i .	BLUE RIDGE ROAD EIGH, NC 27612	
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F 157	out of bed. She was ago she did want pa her wishes then she and she was given a perked up." During an interview of medical director indiculdirector indiculdi	e 10 not depressed. A few months liative care, and we honored decided she wanted to live peg (feeding) tube and she on 4/2/12 at 3:05 pm the cated, the nursing staff when (Resident #1) exhibited a significant change in the 9 disconnections on ation was if a patient had a behavior then I should be admitted to the facility on lative diagnoses of chronic ostructive sleep apnea, bulmonary disease, ischemic mentia, and chronic kidney	F	157		
	3/16/12, revealed Recognitively impaired, extensive physical a toileting and was tota activity of daily living bed mobility. He recognitively created he neck and into the win Review of the last at 03/27/12, indicated faerosol tracheostom	imum Data Set (MDS) dated esident #2 was moderately had no behaviors, required esistance of 2 persons with ally dependent on staff for including transferring and puired oxygen and artificial tracheostomy (trach) (a ele through the front of the indpipe). Tailable respiratory note dated Resident #2 was put on y collar (ATC) at 2:45 pm in weaning him from artificial				

ventilation. At 9:25 pm, the resident's oxygen

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CENTERS	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391			
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BLUE KID	GE REALIN CARE CEN	TER	RAL	EIGH, NC 27612				
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F 157	Continued From pag	e 11	F 157					
		6% on the ATC. The						
	resident was returned	d to artificial ventilation and						
	oxygen saturation ra	te increased to 94%.						
	Review of the nurses	s' notes, dated 03/27/12,						
		Resident #2 was placed on						
	•	elp blow off the carbon						
	dioxide which contributed to a change in mental status. At 10:35 pm Resident #2 was off the vent.							
	The facility was not able to provide the respiratory therapy sheet dated 03/28/12.							
	indicated Resident # with several attempts antianxiety medicatio midnight. The reside of bed at 2:45 am. T	d 03/28/12 at 1:55 am, 2 had increased agitation is to get out of bed. Ativan (an in) 0.5mg was given at 12:00 int was attempting to get out the supervisor was notified ed in the room with the						
	(MAR) on 03/28/12, given Ativan 0.5mg a	ation administration record indicated the resident was at 12:00 midnight and 12:00 there was no documentation of the medication.						
	read: "1.Give Ativan 0.5m	dated 03/28/12 at 3:35 am g po (by mouth) now x1 (1						
	patient evaluation fo 3.Ok for patient to ha	ned) after 7 am 03/28/12 for flow up. ave one on one (1:1) sitter for						
	safety."							

Nurses' notes, dated 03/28/12 at 7:15 am,

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		E SURVEY PLETED
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		345517	B. WIN	G			C
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NAME OF TH	OVIDER OR SUPPLIER			I	ADDRESS, CITY, STATE, ZIP CODE		
BLUE RID	GE HEALTH CARE CENT	TER		1	ILUE RIDGE ROAD		
				RALE	IGH, NC 27612		
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F 157	Continued From page	12	F	157 ·			
		as made aware of Resident	•	101			:
	#2's agitation.						
	Nurses' notes, dated	03/28/12 at 9:40 am.					:
	indicated the resident						į
	required assistance w	ith feeding. At 12:00 noon,					
		pedside, voicing concerns of					
		sed lethargy and agitation.					
		lled and gave an order for					
	Risperdal (antipsycho	•					
	consult with behaviora						
	-	sident #2 to the hospital evaluation. The physician					
		order and the resident was					
	·-	pital by Emergency Medical					
	Services.	, , , , ,					
	During a telephone in	terview on 04/03/12 at 7:18	:				
		ne worked the day shift on					
	03/28/12 starting at 7	· ·	•				
		trach collar, on the day he	•				
	went out. Nurse #10:	said he had to be sent out					
		ng confusion. Nurse #10					
		worked the 11pm -7am	!				•
		quired one-on-one." Nurse	1				
	#10 said there was no						
		me to work on the 7 am- 3					
		was asleep. Nurse #10					<u> </u>
		in that afternoon and they	•	i			
	· ·	d no sitter, they were told family wanted the resident					Į
		EMS was called. Nurse #10					
		nt needed one-on-one	i				
		rtried to get out of bed,					
	were anxious and agit						
		didn't work. Nurse #10 said,	í				
	"Then she would tell ti		;				
		o one-on-one supervision.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES.

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE COMP	
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NAME OF PROVIDER OR SUPPLIER BLUE RIDGE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COI 3830 BLUE RIDGE ROAD RALEIGH, NC 27612		
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F 157 Continued From page 13

The physician would be called. Nurse #10 did not know if a physician order was needed for the one-on-one supervision. She did not know the policy on one-on-one. Nurse #10 said, "I have never had anyone who was on one-on-one. The supervisor will pull someone to sit (with the resident). Usually an aide."

During an interview on 4/3/12 at 10:18 pm, NA #5, indicated she came in at 7:00 am on 03/28/12 and was assigned to Resident #2. NA #5 said, "He did not have a sitter. He was asleep. He was on a trach collar. He was breathing hard. He was moving his legs off the bed like he wanted to get up. I redirected him to stay in bed and asked him if he was ok. He followed my directions. I let the nurse know he was trying to get up." NA # 5 said that a resident had one-on-one supervision when they (residents) won't stay in bed, or were a risk to themselves. NA# 5 said, "we work with four aides. When we have to pull one of our persons. we have to work with only three (aides). It is horrible to only work with three (aides) during the day. The load is heavy on the vent unit. The 200 hall (vent) was a heavy unit. There isn't enough of us to do the care we need to do. The residents are more acute, and it requires two persons to manage each patient because the majority of residents need the hoyer. I don't know how they manage on the 3rd shift with only two aides. I have been assigned to do a one-on-one. I stay until someone comes to relieve me." During an interview on 03/30/12 at 9:20 am, the Director of Nursing indicated the physician was not notified when the facility discontinued 1:1 supervision. It was a nursing judgment.

During an interview on 04/02/12 at 3:05 pm the

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WAVE OF DE	ROVIDER OR SUPPLIER	070011		Γ		04/03/	2012
	GE HEALTH CARE CEN	TER		3830	FADDRESS, CITY, STATE, ZIP CODE BLUE RIDGE ROAD FIGH. NO. 27642		
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F 157	Continued From page	e 14	F	157			
	medical director indic "should contact me, v a different pattern or behavior. My expects significant change of notified. He indicated in the physicians ord take place."	cated, the nursing staff when (Resident #1) exhibited a significant change in sation was if a patient had a behavior then I should be the should be more specific der how long 1:1 should					
F 323 SS=J	323 483.25(h) FREE OF ACCIDENT		F	323	F 323 1. Resident #1 was discharged facility on March 20, 2012. An ir was conducted, led by the Direct Nursing (DON). The investigation but was not limited to; facts sure the incident involving Resident processes for communication of changes in condition to the physical Directors, nursing, reand the IDT, review of the resident medical record to determine evi	nvestigation ctor of on included rounding #1, facility f resident sician and/ espiratory ent's	5/7/12
	by: Based on record revifacility staff, the physistherapists, the facility interventions for two of tracheostomy (trach) #2) who both had agil removed her tracheostomy and shortness of breatherapists. Immediate jeopardy by Resident #1 when the and resulted in a critic The administrator was jeopardy on 04/01/12	r failed to implement of five oxygen dependent residents (Resident #1 and itation. Resident #1 stomy and died. Resident #2 ital for increased agitation ath. began on 03/16/12 for e resident removed her trach cal oxygen saturation rate. is notified of the immediate			potential risk factors for decann Following the completion of the investigation, based on an analyfindings, the facility developed a implemented corrective action of areas identified with quality improportunities. For residents restacility in similar situations as Reand Resident #2, the following a would be taken. The licensed minitiate One-to-One supervision resident followed by: (a) inform physician or Medical Director of in the resident's condition and the behaviors exhibited, (b) obtain a one-to-one supervision and any intervention the physician or Medical Director deems necessary, (c) of	ysis of the and directed at rovement siding in the esident #1 actions urse would of the the ithe change he an order for other edical	

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STAR MENT OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		СОМР	(X3) DATE SURVEY COMPLETED C	
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(X4) ID PREFIX IAG	PREFIX (FACH DEFICIENCY MUST BE PRECEDED		ID PREE TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
				nurse would then complet	te an SBAR		

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Example 2 (Resident #2 lack of supervision) was cited at a D level deficiency (an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy).

Findings include:

Tracheostomy (trach) is a surgical incision into the trachea (windpipe) that forms a temporary or permanent opening. The opening is called a stoma. A tube (tracheostomy tube) is inserted through the stoma to allow passage of air and removat of secretions. Instead of breathing through the nose and mouth, the person will now breathe through the tracheostomy tube. Some people can not breathe on their own through the stoma/trach, therefore oxygen is supplied through an oxygen mask to assist with breathing. The concentration of the oxygen needed depends on the person's condition. Some people need mechanical ventilation (vent) to assist or replace spontaneous breathing.

Review of the policy titled "Ventilator (vent) Patient with Agitation," which was not dated, indicated .

"Identify: Pulling at equipment, uncontrolled moving, and crying, combative, attempts to get out of bed/chair.

Interventions: CNA /RT (nurse aide/respiratory therapist) alert nurse.

Attempt to calm resident.

Reposition.

Meet any need that is acceptable.

Stay with resident during crisis (do not leave an active agitated resident)

Nurse-Pain medication/Anti-anxiety meds (medications) may be appropriate -check for F 323

(Situation, Background, Assessment/ Appearance and Request) report, (d) document the change in the resident's condition on the 24 hour report, and the one-to-one supervision being provided. (e) the 24 hour report and the SBAR report would be given to the IDT for discussion, action item development and monitoring of the resident's progress. The resident would remain on the 24 hour report until his/her condition improved. As the resident's condition improved, or declined, the IDT would make recommendations to the physician or Medical Director to modify or discontinue one-to-one supervision for the resident and place the resident on Resident Monitoring. Resident #2 was discharged from the facility on March 28, 2012 and was readmitted on March 30, 2012. Following readmission Resident #2, ventilator dependent at night, upon readmission was provided a new tracheostomy collar and was observed for behaviors. Resident # 2 did not exhibit any "at risk" or "emergent" behaviors. Resident #2 has had orders obtained and implemented for continuous pulse oximetry, anti-disconnect device at night, and Resident Monitoring which

2. Residents with tracheostomies with changes in condition have the potential to be affected by the same alleged deficient practice. On March 31, 2012 residents with tracheostomies had their tracheostomies checked for proper placement by the Respiratory Therapy Director or his/her designee. Of the 21 residents with tracheostomies all were

continues at this time.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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recent medication use first. Monitor:

Maintain a 1:1 staff observation while resident is actively agitated.

If medicated, ensure that the post effectiveness is documented.

Never leave an agitated resident alone!
Document, Document.
NOTE: Ensure physician is notified in the change of condition. Ensure resident's responsible party is notified."

 Resident # 1 was admitted to the facility on 08/29/11 with cumulative diagnoses including respiratory failure that required the use of artificial ventilation, pulmonary insufficiency, dysphasia, hypertension, diabetes mellitus and renal insufficiency.

Psychiatry notes dated 9/12/11 read "Creative with dangerous behavior pulling at trach (tracheostomy) and g-tube. Patient has poor insight in her disabilities and worse judgement when it comes to pulling at devices. If she is to be weaned we must temper this behavior." Seroquel (antipsychotic medication to treat behaviors) and Zoloft (antidepressant) to temper behaviors were recommended.

Review of the most current physician orders dated 01/04/12, revealed "tracheostomy (trach collar (oxygen mask) settings of FiO2 (Fraction of Inspired Oxygen is the percentage of Oxygen that is inspired) 40%. May wean per protocol. Tracheostomy collar, patient and SpO2 (the amount of oxygen in the blood) monitoring Q 4 hours (every 4 hours). Full ventilator, patient and SpO2 monitoring Q 4 hours. Respiratory

properly placed. On March 31, 2012 the presence of a replacement tracheostomy at the bedside was validated for all residents with tracheostomies to ensure a replacement was immediately available. On March 30, 2012 the Interdisciplinary Team reviewed the medical records for each of the 21 residents in the facility with tracheostomies to identify residents with behaviors that put them at risk for decannulation. "At risk" behaviors include but are not limited to: restlessness, emotional distress or cognitive changes resulting in confusion, weeping or objective or subjective signs of pain of discomfort. Nine (9) of the 21 residents reviewed were identified with "at risk" behaviors. All 9 residents were placed on "Resident Monitoring" to provide increased supervision. During the record review residents' care plans were reviewed updated, as necessary to reflect the residents' current care needs.

On March 30, 2012 the facility's pharmacy consultant conducted a review of the medication regimen of current residents, with tracheostomies, with behaviors to ensure that the residents were receiving appropriate medication and dosages. During the month of April the Medical Director has assessed each resident residing on the Medical Specialty Unit (MSU) and is aware of any recent changes in the residents' conditions.

3. The facility developed a new policy titled "One-to-One supervision of Residents on the Medical Specialty Unit (MSU)". The facility policy titled "Pulse Oximetry" and "Trachostomy tube change" will be

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				202	reviewed by the facility QA & A c	ommittee	
F 323	Continued From pag		r	323	and modify if indicated.	niona of	v.
	Therapist may replace	e tracheostomy tube			The facility has contracted the se		
		ergently for dislocation,			an additional Pulmonologist to ex residents on MSU and to consult		
	plugging or inadverte	ent decannulation."			attending physican regarding the		
					care need for a period of 6 month		
	The quarterly Minimu	ım Data Set dated 1/22/12,			services began on April 23, 2012		
		I had moderately impaired			The facility has contracted the se	rvices of	
		memory. The resident			an additional Psychiatrist to prov		
		simple communication and			initial assessment of the resident		•
		ility to make needs known.			and any new admissions and pe	riodically	
	Her behavior was ide	entified to put the resident at			as deemed appropriate for each		
	a significant risk for p	physical illness or injury to			individual's plan of care for a per	iod of 6	
		ally dependant on staff for all			months. This contract was signe	d on April	
	of her activities of da	ily living.			24, 2012.The facility has contracted with a	<u> </u>	
	The Care plan dated	1/19/12 indicated the			Respiratory Therapist to provide		
		priate disruptive behavior,			to the on-site Respiratory Therap		
	was attempting multi	iple times to throw feet out of			evaluate current practices, make	· }	
		to get out of bed even after			recommendations and provide tr	aining on	
	redirection. The inter	- -			systems utilized by the facility fo		
		d anxiety and restlessness,			of 6 months. These services we	re began	
	notify the nurse, deta	ermine the need for PRN (as			on April 11, 2012.		
), administer (medications)			The facility has contracted with S	System	
		or effectiveness of the			Electronics to install a new call s		
	medication.	., 000			enables plug in of the ventilator		
		empt to redirect and educate	1		oximeter to allow alarms to be a		
	resident.	Simple to realization and a manufacture			the nurses station. The system purchased and is scheduled for		
		Notify family, MD (physician)			upon delivery.	HISTAII	
		ry) service of changes in			upon delivery.		
	behavior. 2/27/12				The 24 hour report process has	been	
	day/evening as toler				modified to include participation		
	dayleverning as toler	4.04.			Respiratory therapy and charge		
	Murepet notae data	d 02/04/12 at 7:35 pm			The 24 hour report is maintained		
		nt was found sitting on the		:	on MSU. The 24 hour report an		
		ne bed and she was noted to			to communicate changes in resi		1
		er trach tube was removed			condition and incidents that occu	ur during a	
		T (respiratory therapist) was			24 hour period to other MSU nu		

respiratory therapy staff members on

different shifts and to the Interdisciplinary

Facility ID: 20020003

from the stoma). RT (respiratory therapist) was

reinserted and the resident was bagged. Family

called to the resident's room. The trach was

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	DER OR SUPPLIER HEALTH CARE CEN	TER		STREET ADDRESS, CHY, STATE, ZIP CODE 3830 BLUE RIDGE ROAD RALEIGH, NC 27612		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF IAG		TION SHOULD BE COMPLETE THE APPROPRIATE DATE	
				Team (IDT) thereby ensur	ing that chanc	IAS

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F 323 Continued From page 18

and MD (medical doctor) were made aware. A sitter was placed at the bedside until the family arrived.

Nurses' notes, dated 02/09/12 at 4:30 pm, indicated the resident slid out of the geri chair and had the oxygen tubing pinched in between the chair and the night stand. The resident had one-to-one sitter.

Nurses' notes dated 02/24/12 at 5:10 pm indicated the resident attempted to crawl out of bed this shift and was pulling at the trach. Ativan was given and was effective.

Review of the physician's orders dated 03/01/12, revealed the resident was prescribed Ambien 5mg by mouth or via tube at bedtime as needed for sleep (a narcotic used to induce sleep), Ativan 0.5mg via tube every 6 hours as needed for anxiety, Percocet 5/325mg (a narcotic pain reliever) by mouth via tube every four hours as needed for pain. Seroquel 25 mg (an antipsychotic medication) via tube every evening and Seroquel 12.5 mg at 8:00 am and 1:00 pm, Zoloft 50 mg (an antidepressant) via tube every day.

Nurses' notes, dated 03/03/12 on the 7 am-7 pm shift, indicated the resident was agitated and was pulling at her trach and trying to get out of bed. Ativan was given and was effective.

The nurses notes dated 03/16/12 revealed the resident was agitated and confused during the evening. An antianxiety medication was given at 5:30 pm and was effective. Resident #1 remained in a reclined chair.

in the resident conditions are timely recognized and interventions are timely and consistently implemented. The charge nurse for every shift will be responsible for making entries to the report regarding changes in resident condition, including but not limited to, new and escalated "at risk" behaviors. The Respiratory Therapist (RT) for every shift will be required to make similar entries on the 24 hour report. The 24 hour report is reviewed, discussed and action items identified by the IDT in morning meeting, Monday through Friday. The Weekend Supervisor will review the completed 24 hour reports and follow-up on any items that require attention during weekend hours. The 24 hour reports from the weekends will also be reviewed by the IDT during the morning meeting on Monday following the weekend. (b) SBAR reports (Situation, Background, Assessment/ Appearance, and Request) will be required to be completed by the licensed nurse or RT for situations requiring physician notification. The SBAR reports will remain with the 24 hour report until the actions noted on the SBAR report have been accomplished ensuring communication of required actions to each shift until the SBAR is resolved. The SBAR reports will be forwarded to the IDT with the 24 hour report to ensure that any situation where a physician is called is communicated. (c) A new physicians log book has been initiated on MSU for attending physicians and the psychiatrists, the charge nurse will make entries in the book when a phone call is placed to the physician also to ensure that any situation is communicated back to the physician so the resident may be evaluated as indicated

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-039	
					Contactitionist		-
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345517	13. WIN	G		C 04/03/2012	
	OVIDER OR SUPPLIER			ì	ET ADDRESS, CITY, STATE, ZIP CODE 10 BLUE RIDGE ROAD		
BLUE RID	GE HEALTH CARE CEN'	TER		RA	LEIGH, NC 27612		
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F 323	Continued From page		F	323	on the next visit, the physiciar each entry when reviewed (d) report and any SBAR reports a	The 24 hour are reviewed	
	via telephone. Nurse	ewed on 03/31/12 at 3:43 pm #5 indicated she worked on			by the off-going and on-coming during each shift change. Once is obtained the SBAR form will	ce resolution	
	3/16/12 during the se Nurse #5 said she wa	cond shift (3 pm -11 pm).			the residents' medical record.		
		rse #5 stated, "I heard			MSU clinical stand down meet	ing has been	
	(Resident #1) banging	g on the side of the chair. I			implemented to provide addition		
		n and the ties in her hand.			opportunity for close communi between nursing and respirato		
		for about 20 seconds. She			regarding the care and treatme		
		ery long. She (the resident)			tracheostomy residents. The s		
	-	t breathe.' She had her			meeting will be conducted to d		
	hand up to her neck.				MSU residents' conditions, foll		
	* *	d scared at that moment			completion status of the action		
		ave a full airway. I put the old new a full airway. I put the old new architecture are new architecture.			identified by the IDT during mo		
		what happened. She was in			meeting and to ensure that info		
		y the call bell was by her			regarding "at risk" behaviors is communicated to the nursing a		
		ber. Her nurse was off the			respiratory team. Participants i		
	floor, and I was watch				clinical stand down meeting in	clude the	
	noon, and made made	g panze.			Director of Nursing (DON), the		
	The respiratory note of	dated 3/16/12 revealed			Respiratory Therapy, the MSU		
	•	an aerosol tracheostomy			and the Staffing Coordinator. T	he stand	
		e first respiratory therapist			down meeting will occur each		
	(RT) walkthrough at 1				Monday through Friday. The o		
		at 5:43 pm. The oxygen	1		down meeting includes staffing		
		ed to 71% (normal values			the next 24 hours, Monday thre		
	92%-96%) because of	of the decannulation. The			Thursday, and for the following during Friday's stand down me	/ /2 nours	
		ed, the tracheostomy was			Staffing Coordinator will arrang		
		dent was oxygenated back			additional staffing, as needed,		
	to 100%. She was the	en placed back on full			discussion during the stand do		
	ventilator support at 5	5:50 pm.			(d) As part of the morning mee		
					discusses the residents with		
	On 04/02/12 at 9:39 a	am respiratory therapist (RT)	•		tracheostomies identified as ex	chibiting	
	#4 was interviewed.	She stated Resident #1			"emergent" behaviors and new		

needed the trach to be able to breathe and also

resident decannulated herself on 03/16/12. She

for suctioning. The RT was on duty when the

said Resident #1 had been messing with the

escalated behaviors to determine if such

implemented interventions and whether

such residents require implementation of

residents are responding to the

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345517		(X2) M A BUI B. WIN	LDING	E CONSTRUCTION	COM	E SURVEY APLETED C 04/03/2012	
NAME OF PROVIDER OR SUPPLIER BLUE RIDGE HEALTH CARE CENTER				38	EF ADDRESS, CIFY, STATE, ZIP CODE 30 BLUE RIDGE ROAD ALEIGH, NC 27612	-	
(X4) ID PREFIX IAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF IAG		PROVIDER'S PLAN OF CORRECTI (FACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON SHOULD BE COMPLETION TE APPROPRIATE DATE	
E 222 O		- 00			additional interventions. (e) To fur	ther	

F 323 Continued From page 20

oxygen mask all day. When the resident decannulated herself, she pulled out the trach tube and the oxygen mask. The RT put the trach tube back into the stoma. The RT indicated there should be some type of a monitoring system in place on residents who were on a trach collar.

On 03/30/12 at 8:41 am RT #4 was interviewed again. She said Resident #1 would move her oxygen mask and RT #4 told her not to mess with it. RT #4 stated "We put her back on the vent as a precaution. When the trach was out she did have trouble breathing, I felt she would rest more comfortably if she had a night on the vent."

RT #6 was interviewed at 12:11 pm on 03/30/12. RT #6 said Resident #1 had anxiety problems. RT #6 said that on 03/16/12, the resident looked very much in distress (after she decannulated herself). The RT indicated the resident didn't indicate why she decannulated herself, she didn't have enough strength to get the words out. RT stated, "We educated her and she seemed to understand. When her secretion would get going (increase) she would get anxious."

Interview with nurse #12 on 03/30/12 at 2 pm revealed the nurse was assigned to the resident on the 3 pm-11 pm shift on 03/16/12. The nurse said, before the decannulation on 03/16/12, the resident was in her geri chair sleeping. When the resident pulled out her trach, the nurse gave her sedation. The nurse said she called the supervisor. The nurse said the Ativan worked and she (the resident) slept the rest of the night. Nurse #12 said she let the oncoming nurse (nurse #4) know of the decannulation.

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enhance resident safety, an audible alarm system to immediately alert staff of potential changes in the condition of tracheostomy residents not on ventilator assistance was obtained. The facility purchased 10 Continuous Pulse Oximetry units for Non-Ventilator Dependent residents with tracheostomies. The new pulse oximeters are programmed to sound an alarm if the pulse oximeter becomes dislodged or if the residents' oxygen saturation level falls below 93% or settings specifically ordered by the physician. The pulse oximeters are housed in protective bags with a clear window through which the pulse oximeter controls are visible and a large Veicro flap that securely closes the bag. The facility has covered the control buttons on the pulse oximeters, including the On/Off button, so a resident would not be able to visualize the On/Off button and to prevent the machines from being intentionally or unintentionally turned off by staff or residents. Residents have the right to refuse treatment, including the use of continuous pulse oximetry. In the event a resident refuses the use of the continuous pulse oximetry, the resident and their family will, again, be educated on the purpose of continuous pulse oximetry and the risks related to the refusal of such treatment. Resident refusals and subsequent education will be documented in the resident's medical record. The resident's physician or the Medical Director will be notified of the resident's refusal and an order obtained, as appropriate, for alternate interventions. The IDT will be notified as well of the resident's refusal. If a resident is exhibiting "emergent" or "at risk" behaviors, the staff member

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			38	30 BLUE RIDGE ROAD		
BLUE RID	GE HEALTH CARE CEN	TER	R/	ALEIGH, NC 27612		
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	11:30 am, she said si #1 on 03/16/12 on the #4 said she was not a decannulation on 03/ found out about the of when the resident de and died. Review of staffing for (MSU) for 03/16/12 of hours per patient per Registered Nurse co- not meet the State Li PPD and having a Re- time. On 03/30/12 at 4:02 RT #3 worked with R 03/17/12 from 6:30 p she was aware that therself earlier in the	with nurse #4 on 03/30/12 at the was assigned to Resident at 11 pm - 7 am shift. Nurse made aware of the 16/12. Nurse #4 said she decannulation on 03/20/12 cannulated herself again The Medical Speciality Unit evealed staffing was 4.59 day (PPD) and there was no everage for that day. This did censure requirement of 5.5 egistered Nurse on staff at all pm RT #3 was interviewed. esident #1 on 03/16/12 and m until 7 am. RT #3 said he resident decannulated day on 03/16/12. The RT	F 323	identifying this will remain at the bedside and uses the nurse call call for help. (h) The RN charge perform an assessment of the recondition. Based on assessment the charge nurse, if warranted, vimplement one-to-one supervision. Resident Monitoring and notify the attending physician or the Medic of the change in the ventilator does the intervention implemented by nurse and any other intervention physician or Medical Director does necessary. Newly admitted residents to the routinely be placed on Resident for the 1st week of their admission to the reviewed by the IDT. If at an during the 1st week of admission risk be notified and the level of smay be increased. The Nursing Respiratory assessments will deappropriate level of ongoing suppropriate l	button to nurse will esident's t findings will on, or he cal Director ependent orders for the charge n the eems MSU will Monitoring on and will y time n an "at supervision and etermine an oervision,	
	said the resident was #3 said the early mo several disconnection vent, the circuit because each time. The RT's many disconnections resident was taking in the vent instead of unurse. It was used faware of the disconnections who was the vector of the disconnections.	s on the vent that night. RT rining of 03/17/12, there were ns of the resident from the ame disconnected at the neck said when there were that s, usually it was because the toff. Residents disconnected sing the call bell to get the or attention. The nurse was nections. Many of the nurses ect circuit. I felt like the d. This (behavior) was not		based on available information. will be reviewed by the IDT and needed to reflect the residents' care needs. Respiratory therapist working o CPR certified. Beginning April 26, 2012 re-edu a new curriculum, will be compl nurses and respiratory therapis on MSU on: 1)The new policy titled "Status Notification of".	Care plans updated as current n MSU are ucation, with eted with ts working	

2)The Why, How, and When of the SBAR

3)The 24 hour report process

Facility ID: 20020003

4)Clinical Communication process

like her to do this for attention by disconnection.

Review of the respiratory note dated 03/17/12,

revealed Resident #1 was still on artificial

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DELYMENT OF REVELLIVE				FOF	RM APPROVED
CENTERS FOR MEDICARE &	MEDICAID SERVICES				O. 0938-0391
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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CHY, STATE, ZIP CODE		
BLUE RIDGE HEALTH CARE CEN	TER		3830 BLUE RIDGE ROAD		
			RALEIGH, NC 27612		
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the ventilator at 1:52 am, 3:05 am, 4:10 an 6:25 am. Resident # ventilation to ATC at 8 the ATC until 11:45 properties artificial ventilation. An interview with nurse 03/30/12 at 11:54 am 11 pm -7am on 03/16 nurse #4 has called he Resident #1 was agited did not recall being to decannulated herself arrival at the facility of the second shift would sheet and then pass if on duty as a shift sup would be documented 24-hour note. Nurse #8 Resident #1 had been or 12 am and then she wasn't aware of any period was not aware of the occurred during the exact 3/17/12." Nurse #13 supervision was requified from the vent, or is again climbing out of the best team leader) have to a or a nurse to sit in the the supervisor will call Someone has to stay #13 said, "If she (Resionce, I would have so	m (since 5:50 pm on became disconnected from am, 2:01 am, 2:12 am, 2:30 n, 5:50 am, 6:05 am, and a was removed from artificial 3:35 am. She continued on m when she was returned to se #13 (RN supervisor) on revealed the nurse worked #12. The nurse said that are and told her that ated. Nurse #13 said she and told her that are said she supervisor's and write it on the supervisor. While servisor, the information of the supervisor's are 13 said she was told that a medicated around 11 pm are slept. Nurse #13 said "I roblem during the night. I multiple disconnections that arly morning hours of	F:	5)Physician Log process 6)Pulse Oximeter 7)Resident Monitoring, include admissions. 8)One-to-One Supervision 9)Anti-disconnect devices/tra 11) At risk vs. Emergent behappropriate staff actions when 12)Resident decannulation 13)Staffing MSU for direct catons, and Resident monitor. Licensed nurses and Respiration Therapists working on the Minot received the above training education by May 7, 2012 with permitted to work until such that been completed. Educatraining will be provided at the their next scheduled shift, princesident care. The training with their next scheduled shift, princesident care. The training with the MSU Unit Manager, His Supervisor, and/or DON at the each shift for persons that has received the training, including staff. The above described traincorporated into the new him New hires will not be permitted resident care on the MSU units completed. Beginning April 25, 2012 reseations and curriculum, will be concertified Nursing Assistants (1)Resident Monitoring, including admissions. 2)One-to-One Supervision 3)At risk vs Emergent behaving appropriate staff actions whe 4)Pulse oximeter observation 5)Resident decannulation working on the MSU that have the above training and education working on the MSU that have the above training and education working and education to the mSU that have the above training and education to the mSU that have the above training and education to the mSU that have the above training and education to the mSU that have the above training and education to the mSU that have the above training and education to the mSU that have the above training and education the mSU that have the above training and education the mSU that have the above training and education the mSU that have the above training and education the mSU that have the above training and education the mSU that have the above training and education the mSU that have the above training and education the mSU that have the above training and education the mSU that have the above training and education the mSU that h	ach tie avior and en identified. are, One-to-atory SU that have ng and II not be re-education tion and/or e beginning of or to provided ouse ne beginning of agency aining will be e orientation. ed to provide til the training education, with apleted with (CNA) on: ling new or and on identified.	

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DELVIA	MENT OF HEVETT WE	NO HOMAN SERVICES					MADDDOLUTE
CENTER	RS FOR MEDICARE &	MEDICAID SERVICES					M APPROVE <u>C</u> O. 0938-0391
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()/ () ()	CHIMADVOT			<u> </u>	ALEIGH, NC 27612		
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F 323	Continued From page	. 23		000	such re-education has been con	mistad	
+			F	323.	Education and/or training will be	nrovided	
	would absolutely self-	her shift. If she knew she			at the beginning of their next sch	eduled	
	would absolutely call t	ine doctor.			 shift, prior to providing resident of 	are. The	
	On 03/31/12 at 11:12	am nuraa #2a			training will be provided by the M	ISU Unit	
	interviewed. Nurse #3				Manager, House Supervisor, and	l/or DON	
		m 7am to 7 pm (after the			at the beginning of each shift for	persons :	
	resident decannulator	herself and disconnected			that have not received the training	g,	
	herself from the yent)	Nurse #3 stated "I was			including agency staff. The abov	θ	
	assigned to (Regident	#1). She was on the trach			described training will be incorpo	rated into ±	
	collar. She was in the	gericheir Lucen't			the new hire orientation. New hir be permitted to provide resident	es will not l	
	informed that she had	pulled out her trach on			the MSU until the training is com	care on	
	Friday, I should have t	ound out from the 24 hour			In addition to the above listed tra	pieteu.	
	report sheet. The sheet	et stayed on the medication		•	contracted Respiratory Therapist	with IDT	
	cart for 24 hours. The	decannulation should have			involvement began a didactic trai	nina :	
	been on the sheet. It	was not on the sheet. I got			course for MSU nurses that cons	ists of 18	
	report from (nurse #4)	She told me that			 hours of training followed by com 	petency	
		ng to get out of bed during			testing on care of a ventilator pat	ent. This	
	the night and that was	why she was in the geri	1		training is being conducted a min	imum of 📙	
	chair. On the 17th I di	dn't give (Resident #1) any	:		monthly for 6 months.	1	
	Ativan." Nurse #3 sai	d the respiratory therapists	!		4. The facility has developed and	1	
	were supposed to tell t	he nurses when a resident			implemented new audit processe	s to	
	had agitation issues. I	Nurses would assess the			access the effectiveness of the al related to supervision of residents	ove plan]
	resident, to determine	what they needed. Once	1		tracheostomies. (a) On a daily ba	S WITH	
	they were cleaned, or	suctioned, the nurses	1	:	DON, Assistant Director of Nursin	315, 1116	
	would use medications	(to treat agitation). If that	1		(ADON), MSU manager, or House	9	
	didn't help the nurses s	should call the nursing			Supervisor will review the 24 hour	reports	
	supervisor and call the	doctor. A resident has a		:	from the MSU to verify appropriate	э :	1
	sitter when they were o	lisconnecting the vent or			information is being communicate	d shift to 🗀	Ī
	decannulating the track	٦."	1		shift and that respiratory therapy a	and :	ł
	_				nursing are collaboratively reporting	na 🗀	ĺ
	On 03/30/12 at 9:48 an	n, nurse #2 was			changes in resident condition and	incidents	-
	interviewed. The nurse	said she worked during	•		via the 24 hour report. (b) On a c	laily	ĺ
	the 3 pm -11 pm shift o	n 03/17/12 as the team			basis, the DON, Assistant Directo	r of	Į
	leader. She reported ti	nat she was not aware that	:		Nursing (ADON), MSU Manager,	or House	ĺ
i	Resident #1 had decan	nulated herself on	•		Supervisor will review the 24 hour	reports	Į

03/16/12. Nurse #2 said no one told her that

Resident #1 had disconnected herself from the

vent 9 times earlier that morning. Respiratory

item entered.

from the MSU to verify that an SBAR form

has been completed appropriately for each

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	JETIPLE CONSTRUCTION	(X3) DATE S	HOVEV	
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therapists did not report to the supervisors unless it was something such as decannulation.

Nurse #6 was interviewed on 03/30/12 at 11:20 pm. Nurse #6 said she worked with Resident #1 on 03/17/12 from 7pm -7am. Nurse #6 said Resident #1 moved around a lot, was fidgety and she would throw her leg over the edge of the bed. The nurse stated that most of the time the resident tried to get out of the bed and the biggest concern was her falling. Nurse #6 said the resident had a mat and her bed was in the low position. The nurse stated the resident got her Ativan early in the shift (around 1:30 am) for agitation. The nurse said the resident was being monitored. The hall was busy with staff and never empty. Nurse #6 said if the resident didn't respond to the Ativan and the vent was going off constantly then the nurse would have an aide sit by the room. Nurse #6 said, even with her trach being pulled out on Friday, the resident's behavior was not that required to be monitored on a one to one supervision. The family would be called if the resident was agitated to a point and a supervisor would be notified. Nurse #6 said there was no set way to monitor the resident.

Review of staffing for the Medical Speciality Unit (MSU) for 03/17/12 revealed staffing was 4.6 hours per patient per day (PPD) and there was no Registered Nurse coverage for the 7 am - 7 pm shift. This did not meet the State Licensure requirement of 5.5 PPD and having a Registered Nurse on staff at all time.

Review of the nurses notes dated 03/18/12, indicated Resident #1 was restless on the 1st

(c) On a daily basis, the DON, Assistant F 323 Director of Nursing (ADON), MSU Manager, or House Supervisor will observe shift to shift report to verify that information: from the 24 hour report is being communicated to the on-coming shift nurse by the off-going nurse, (d) On a daily basis, the DON, Assistant Director of Nursing (ADON), MSU manager or House Supervisor will verify that the Pulse oximeters and resident monitor (15 minute check) documentation on the MAR has been completed by each charge nurse, (e) On a daily basis, the DON, Assistant Director of Nursing (ADON), MSU manager or House Supervisor will review the documentation and interventions and verify that the resident monitor (15 minute check) sheets are completed, (f) On a daily basis a Respiratory therapist will conduct an audit of Pulse oximeter bags, controls covered, and anti disconnect devices are inplace. (a) On a daily basis M - F the Administrator (NHA) will review the staffing sheet for the prior day(s) to verify staffing ratios and per patient day (ppd) hours are met. The daily audits will continue for 30 days and then will be completed weekly unless concerns are identified in which case daily audits will continue until a time determined by the QA & A committee. The NHA/DON/Respiratory Therapy Director will report to the facility's Quality Assessment and Assurance (QA&A) Committee weekly with the results of the verification review of the above identified audits. Issues identified by the NHA/DON/Respiratory therapy director as a result of these audits will be reported to the QA&A Committee within one business day. The QA&A Committee will evaluate

the effectiveness of the plan on a weekly

	MENT OF HEALTH AN RS FOR MEDICARE &				FO	RM APPROVED NO. 0938-039	
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F 323	shift (7:00am-3:00pm) While sitting in a reclir was attempting to get she was incontinent or resulting in the resider physician and family von 03/30/12 at 4:02 p RT #3 worked with Re 6:30 pm until 7 am. Tomorning of the 18th shifts the state of the said 'No.' She need to go she said 'No.' She need to go s	and 2nd shift (3pm-11pm), ner chair at 10:30 am she out of the recliner because f a large amount of stool, nt falling to the floor. The	F	basis, for 2 months and then a weeks for 2 months, then month on trends identified and development, additional interven needed to ensure continued on a weekly basis the Medica Administrator, DON, Respirate Director, and MSU manager was review the plan and ensure the issues with communication. Weekly the Administrator will reprogress on the corrective actincluding any issues identified reviews with achieving or sustant compliance to the governing be facility. The board will take any actions they deem necessary in the supplications.	othly based op and tions as compliance. I Director, by therapy cill meet to be are no eport on plan in the aining oard of the vother	:	

On 03/30/12 at 9:48 am, nurse #2 was interviewed. Nurse #2 stated she was assigned to Resident #1 on 03/18/12 on the 7am-3pm shift. Nurse #2 said she was not made aware by the outgoing nurse that Resident #1 had disconnected herself from the ventilator 9 times on 03/17/12 and 3 times on 03/18/12. Resident #1 was already on the oxygen mask sitting in the geri chair. She had soiled herself heavily. Nurse #2 stated, "Had I known about the 9 disconnections on the 17th and the 3 disconnections on the 18th (Resident #1) would not be sitting alone."

bound to be doing it herself and that night I really

felt she needed a sitter. There is no alarm on the

trach collar. There could be (an alarm) if there

was a continuous pulse ox (oximeter) to notify

staff when they (residents) are getting a low

(oxygen) saturation rate."

Review of the medication administration record (MAR) on 03/18/12 revealed Resident #1 was

reports. Twice monthly, for 2 months, and then monthly for 2 months, the Vice President of

Clinical Services will attend the facility QA & A meetings and provide input on plan effectiveness as well as ensure continued compliance.

The Administrator is responsible for ongoing compliance.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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F 323 Continued From page 26

administered promethazine 25mg for nausea, (time unknown), Ativan 0.5mg at 1:30 am for agitation, and a narcotic pain reliever at 4:00 am.

On 03/30/12 at 3:15 pm nurse #7 was interviewed. Nurse #7 stated she worked on 03/18/12 on the 3 pm-11pm shift as a team leader (term used when nurse supervisor is a licensed practical nurse as opposed to registered nurse). Resident #1 fell and her feet were hanging off the bed. The nurse told the aide to transfer the resident to the chair and to make sure she was clean and dry. She had no injury. The nurse revealed she did not document her assessment of the resident after the fall because there was no injury. Nurse #7 stated she was not aware that the resident has pulled out her trach on 03/16/12. Usually, when there was a decannulation, the nurse would let the supervisor know and she would put it on the 24-hour supervisor's report.

Review of staffing for the Medical Speciality Unit (MSU) for 03/18/12 revealed staffing was 4.8 hours per patient per day (PPD) and there was no Registered Nurse coverage for the 7 am - 3 pm shift. This did not meet the State Licensure requirement of 5.5 PPD and having a Registered Nurse on staff at all time.

Review of the medication administration record (MAR) on 3/20/12, revealed Ativan 0.5mg was given at 1:45am and noted to be effective at 2:30 am.

Nurses' notes dated 3/20/12 indicated Ativan 0.5mg was given at 12:30 am, and was noted to be effective at 1:00 am. The resident was

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F 323	observed at 3:00 am went to the room at 3 resident unresponsive on the chest. Resider and CPR was initiate Resident #1 dead at family and director of Review of the respirar revealed the RT #1 d Resident #1 was on the not suctioned from 8 am on 03/20/12. At the	in a recliner. An aide (NA#2) :20 am, and found the e with the tracheostomy lying at #1 was moved to the bed d. Paramedics pronounced 3:36 am. The physician, nursing were notified. tory note for 03/20/12 id a walkthrough at 1:45 am. he ATC. The resident was pm on 03/19/12 until 1:45 hat time, the resident was mount of mucoid secretions.	F	323				

During a telephone interview on 03/31/12 at 5:15 am, NA #1 said she was assigned to Resident #1 on 03/19/12 from 11 pm-7 am. The aide stated, "When I came to work, I was told (Resident #1) had fallen on the 2nd shift, and that we were to keep our eyes on her and watch her closer. Instead of the two hour rounds, we were to go and check on her every 30 minutes. I would go into her room and turn on her gospel music and she would be fine. She was already up in her

observed Resident #1 from the hallway at 3:05 am and no sound was heard from the room. Respiratory therapy was called to the room by a nurse aide (NA#2) at 3:20 am. Resident #1 had removed her tracheostomy which was observed in her left hand. The tracheostomy was reinserted into the stoma site and Resident #1 was bagged with good chest rise. She was moved to the bed and cardiopulmonary resuscitation (CPR) was started. Emergency Medical Services (EMS) arrived and pronounced Resident #1 dead at 3:36

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F 323	Continued From page chair. She didn't slee		F	323			
	During a telephone in am, NA #2 said she with pm -7 am shift. The been told to watch he her closer, we actuall to her room (Residen (pm)-12 (midnight). The passing medications are something to calm he we went in was about place, she was asleed she moved her feet. We rounds and started or 200 hall. We were alst to (Resident #1) room didn't look right to me her tongue was not pit her mouth open. She feet up. The trach conton to her name. Her heat when I realized the trach with the straps when I realized the trach when I realized the I was a straps whe	Aterview on 03/31/12 at 5:39 by orked on 03/19/12 on the he NA stated, "We had by go into the room. We got the triple of the room. We got the triple of the room. We got the triple of the room. We got the room. Then the next time the room. Then the room and the ro					

Nurse #4 said, "She did the shaky (shaking her

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F 323 Continued From page 29

hands) movement and I knew that meant she felt anxiety. She was in her recliner resting with her eyes closed about 1:45 am -2 am. I had another resident that had called. I went to that room. I looked into her room at 3:00 am then I went to the front desk. About 20 minutes later the aide (NA #2) came and got me. We went in and I saw her trach on her chest. Her head was down and toward the right. Her eyes were closed. The aide told me her chin was over the stoma, and she (NA) moved her head. I called respiratory, and (RT #1) came in. He inserted another trach, we had to get her out of the chair to do CPR." Nurse #4 said RT #1 "had the trach in by the time I called the code blue. I didn't know that she had pulled out her cannula before until the cop told me she had decannulated on Friday." Nurse #4 said if she had known that the resident decannulated herself, she might have decided to call and get one-on-one supervision. There was no formal way of monitoring (through an alarm or device). The supervisor will decide who to pull to do the one-on-one or to call someone from home or pull some one from the unit. Nurse #4 said, "We only have one aide on each hall at night. The aide or nurse are not able to sit. The supervisor decides what to do."

RT #1 was interviewed on 03/30/12 at 1:15 pm and again on 03/31/12 at 4:00 pm. RT worked on 03/19/12 from 6:30 pm until 7 am. RT #1 said when Resident #1 "was active she had a lot of secretions. She was able to cough into the trach and you could hear her. She couldn't put the trach in by herself. She was active. She was always trying to get out of bed. She would slide out of the bed with her feet hanging. I was aware that the resident had decannulated herself (on

F 323

Facility ID: 20020003

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

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F 323 Continued From page 30

03/16/12). She was doing well on the trach on 03/19/12. She didn't need to be on the vent. She did not have signs of hypoxia. She was more agitated (on 03/20/12) than usual. I saw her with her legs between the rails and her feet were on the floor. She pulled out the trach sponge at 8:10 pm that shift and I changed it. I suctioned her at 1:45am. I told the nurse she needed something about 1:45 am and that she needed someone to sit with her. There was a shortage of staff, and that is why she didn't have a sitter. I heard the nurse tell the supervisor we needed a sitter. Between 1:45 (am) and 3 (am) there was no one to sit. She got her sedation at 1:45 am and she needed more sedation. She could not take any more of her prn (as needed) medication (for agitation) because she took the maximum she can take. I didn't feel that the Ativan she received was effective. I thought she needed to be restrained but they told me that she could not be. I passed by the resident's room at 3:05 am. She was laying to the right side with her head laying to the right side. From the door all that is visible was the trach collar. So I didn't go in and check her. She appeared to be sleeping. The trach collar was in the correct position. She was already dusky when I arrived. We do trach care because there may be secretions build up in the trach. My point is that she wasn't monitored because they were short staffed that night. If there was a continuous pulse oximeter, or a telemetry, or one-on-one (human supervision) then that would alert staff if the trach was pulled. The temperature of her body was only a degree from her normal body temperature. She had cyanosis when I got there. When residents disconnect from a vent the alarms would alert the staff. When residents decannulate from a trach,

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F 323	Continued From page	e 31	·	323			
	there are no alarms to	to alert staff. It takes about exygen for a resident to die."		020			
	(NP) was conducted on the resident was refe	psychiatry nurse practitioner on 04/02/12 at 10:40 am. erred to psychiatry because rach out. The resident was					
	(MSU) for 03/19/12 re hours per patient per e Registered Nurse cov shift. This did not med	the Medical Speciality Unit evealed staffing was 4.8 day (PPD) and there was no verage for the 4 pm - 7 am set the State Licensure PD and having a Registered ime.					
	#3 said Resident #1 m time. She would try to	on 03/30/12 at 9:13 am, NA messed with her trach all the popur water over it. She he bit. She would alert the tory (therapist).					
	RT #5 said Resident # she was in no way abl or the trach. Resident collar (oxygen mask) of the side, she would tall throw it on the floor. We ducated about the ris she would laugh and sagain. She would clim the resident's oxygen swithout her oxygen. She	am, RT #5 was interviewed. #1 required suctioning, and ble to breathe without oxygen t #1 would take off her trach often. She would move it to ake it off and she would When the resident was sk of pulling on the trach, smile. But she would do it mb out of bed. RT said that saturation would fall quickly the needed a sitter, a lot of the state					

them on the MSU (Medical Speciality Unit). RT said he reported the behavior and oxygen

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F 323 Continued From page 32

saturation rate to the nurses. The MSU unit needed a monitoring system that would attach trach residents with leads to a device at the nurses' station. A technician would sit at the nurse's station and monitor the residents 24 hours a day, 7 days a week to alert staff when the trach got pulled out or when the oxygen saturation would fall below a safe level.

The Respiratory Therapy Director was interviewed on 03/29/12 at 4:09 pm. The director revealed he conducted his investigation about Resident #1's decannulation. She had been weaned off the vent since February 26, 2012. She had the habit of moving her trach collar about her neck. She liked the cool air on her neck. He determined Resident #1 pulled her trach out accidentally on 03/16/12 at about 5:30 pm. Her blood oxygen saturation level had fallen to 71%. The respiratory therapist reinserted it and bagged her and she returned to 100% oxygen saturation in 2 minutes. The stoma was patent which allowed easy insertion of the trach tube.

On 04/2/12 at 2:48 pm the Respiratory Therapy Director was interviewed. He indicated there was no policy for monitoring oxygen dependent trach residents. The respiratory therapist checked heart rate, oxygen saturation rate, and respiratory rate and the breathing pattern every 6 hours. Any oxygen saturation rate below 87% is considered critical. 71% is an immediate response issue.

The medical director was interviewed on 03/29/12 at 8:57 am. The medical director stated, "The nurses call when they want a sitter, or we recommend to the nurse. A patient needs a sitter if they exhibit danger to themselves.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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Unfortunately she was sitting up in the chair and when it was pulled out, her positioning could have been such that, (indicating chin to chest) the airway became blocked. There was 14 minutes between periods when she was checked by the staff. She was being seen by a psychiatrist, for her behaviors of wanting to get out of bed. She was not depressed. A few months ago she did want palliative care, and we honored her wishes then she decided she wanted to live and she was given a peg (feeding) tube and she perked up,"

During an interview on 04/03/12 at 11:31 am, with the staff coordinator, she indicated staffing was always 4 aides and 3 nurses (either RN or LPN), on the first and second shift. On the third shift (11p-7am) 2 nurses and 2 aides were scheduled to work. The nurses worked 8 hour shifts and the aides worked 7.5 hour shifts. The number of hours per patient per day on the MSU was 4.3. When a resident is agitated the staffing coordinator will look for a sitter . Sometimes, the staff on duty on the 400 Hall were reassigned to be sitters for agitated residents. Otherwise, the supervisor would call someone to come on duty and sit with an agitated resident. On the 11pm -7am shift it was very hard to get a sitter. The staff coordinator stated, "We would pull from the 400 hall, and that would cause a staff shortage on the 400 hall. If it was more than one resident who needs a sitter then one person will rotated and not stay in the room continuously. The staff coordinator said that the sitters are added to the staffing schedule. Some times we have two sitters per week. One person from the 400 hall would have to sit with however many people need to be on one-on-one. We keep the PPD at 4.39 for the MSU but it will go below it and it may go

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F 323	323 Continued From page 34 up if I have to add a sitter."		F;	323			
	01/17/12, with cumul respiratory failure, ob chronic obstructive p	admitted to the facility on ative diagnoses of chronic ostructive sleep apnea, ulmonary disease, ischemic mentia, and chronic kidney					
	3/16/12; revealed Re cognitively impaired, extensive physical as toileting and was tota activity of daily living, bed mobility. He requentilation through a	imum Data Set (MDS) dated esident #2 was moderately had no behaviors, required esistance of 2 persons with ally dependent on staff for including transferring and uired oxygen and artificial tracheostomy (trach) (a le through the front of the adpipe).				· .	
	03/27/12, indicated Raerosol tracheostomy an attempt to begin wentilation. At 9:25 p saturation rate was 8	ailable respiratory note dated Resident #2 was put on y collar (ATC) at 2:45 pm in yeaning him from artificial on, the resident's oxygen 6% on the ATC. The					

oxygen saturation rate increased to 94%.

Review of the nurses' notes, dated 03/27/12, indicated at 3:28 pm, Resident #2 was placed on ventilator (vent) to help blow off (remove carbon dioxide from the blood) the carbon dioxide which contributed to a change in mental status. At 10:35 pm Resident #2 was off the vent.

Nurses' notes, dated 03/28/12 at 1:55 am, indicated Resident #2 had increased agitation

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F 323	antianxiety medication midnight. The reside of bed at 2:45 am. The and a sitter was placed resident. Review of the medication (MAR) on 03/28/12, it given Ativan 0.5mg an anoon for agitation. The of the effectiveness of	to get out of bed. Alivan (an n) 0.5mg was given at 12:00 nt was attempting to get out the supervisor was notified ed in the room with the ation administration record ndicated the resident was t 12:00 midnight and 12:00 there was no documentation of the medication. ated 03/28/12 at 3:35 am ag po (by mouth) now x1 (1 med) after 7 am 03/28/12 for ow up. we one on one (1:1) sitter for 03/28/12 at 7:15 am, was made aware of Resident 03/28/12 at 9:40 am,	F	323					
	The physician was ca Risperdal (antipsycho consult with behaviora requested to send Re emergency room for e	illed and gave an order for tic medication) and a							

transported to the hospital by Emergency Medical

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F 323	Continued From page Services.	∍ 36	F	323			
	3/28/2012 indicated to						
	am, nurse #10 said si 03/28/12 starting at 7 Resident #2 was on a went out. Nurse #10 because he was havi said, "The nurse who indicated to me he re #10 said there was no resident when she capm shift. Resident #2 said "His family came were upset that he had a sitter." The to go to the hospital. 10 indicated that a re supervision when the were anxious and agi needed) medications said, "Then she would not know if a physicial one-on-one supervision policy on one-on-one never had anyone who	a trach collar, on the day he said he had to be sent out ing confusion. Nurse #10 to worked the 11pm -7am quired one-on-one." Nurse to body sitting with the ime to work on the 7 am- 3 2 was asleep. Nurse #10 to in that afternoon and they ad no sitter, they were told to family wanted the resident EMS was called. Nurse # sident needed one-on-one by tried to get out of bed, itated, and the prn (as didn't work. Nurse # 10 ld tell the supervisor that she do one-on-one supervision. be called. Nurse # 10 did in order was needed for the on. She did not know the . Nurse # 10 said, "I have no was on one-on-one. The imeone to sit (with the					

During an interview on 4/3/12 at 10:18 pm, NA #5,

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F 323 Continued From page 37

indicated she came in at 700 am on 03/28/12 and was assigned to Resident #2. NA #5 said, "He did not have a sitter. He was asteep. He was on a trach collar. He was breathing hard. He was moving his legs off the bed like he wanted to get up. I redirected him to stay in bed and asked him if he was ok. He followed my directions. Het the nurse know he was trying to get up." NA # 5 said that a resident had one-on-one supervision when they (residents) wont stay in bed, or were a risk to themselves. NA# 5 said, "we work with four aides. When we have to pull one of our persons, we have to work with only three (aides). It is horrible to only work with three (aides) during the day. The load is heavy on the vent unit. The 200 hall (vent) was a heavy unit. There isn't enough of us to do the care we need to do. The resident are more acute, and it requires two persons to manage each patient because the majority of residents need the hoyer. I don't know how they manage on the 3rd shift with only two aides. I have been assigned to do a one-on-one. I stay until someone comes to relieve me."

During an interview on 04/03/12 at 11:31 am, with the staff coordinator, she indicated staffing was always 4 aides and 3 nurses (either RN or LPN), on the first and second shift. On the third shift (11p-7am) 2 nurses and 2 aides were scheduled to work. The nurses worked 8 hour shifts and the aides worked 7.5 hour shifts. The number of hours per patient per day on the MSU was 4.3. When a resident is agitated the staffing coordinator will look for a sitter. Sometimes, the staff on duty on the 400 Hall were reassigned to be sitters for agitated residents. Otherwise, the supervisor would call someone to come on duty and sit with an agitated resident. On the 11pm

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F 323	Continued From page	e 38	F	323				
	, ,	hard to get a sitter. The	•	323				
	•	ed, "We would pull from the						
		uld cause a staff shortage on						
		more than one resident who						
		ne person will rotated and						
		continuously. The staff						
		the sitters are added to the						
		ome times we have two						
	-	person from the 400 hall	:					
	·	however many people need						
	to be on one-on-one.	We keep the PPD at 4.39	1					
	for the MSU but it will	go below it and it may go						
	up if I have to add a s	eitter.:						
	During an interview of	n 04/03/12 at 12:25 pm, the						
	administrator indicate	ed, "A RN was on every						
		at the ratio for the MSU unit.	•					
		of this type. They should	T.	4				
	_	o is off duty to cover a	i					
	_	w they are using light duty						
		strator said that in "an					:	
	•	e, the resident can be pulled	1					
		When a physician had	1					
		e, we should have individual					:	
		h individual resident. I do						
	unit to cover the MSL	be pulled off from another	•					
	utilit to cover the Moc	o dint.					1	
	During an interview o	n 04/03/12 at 9:27 am, the					•	
		ON) indicated that she did	1					
		affing ratio for the MSU						
		nit) should be and referred all	į.					
		ng coordinator. The DON	į.				:	
		duty staff for one-on-one						
	· · · · · · · · · · · · · · · · · · ·	as no sign off sheet, and no						
	documentation to sho	w who sat with which						
	resident and for how	long. The DON stated, "I					•	
	expect the nurses to	document in the chart when						
	one-on-one supervisi	on had been put into place.						

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		determination when to	1 02				
		n-one. The doctor was not					
		ontinued the one-on-one."					
F 328		NT/CARE FOR SPECIAL	гэг	20			, ,
SS=J	NEEDS	TITORINE FOR SPECIAL	F 32		328		5/7/10
22-1	TILLOO				. Resident #1 was discharged fro		기깨역
	The facility must ensu	re that residents receive			icility on March 20, 2012. An inve as conducted, led by the Director		
	proper treatment and				ursing (DON). The investigation i		
	special services:	g			ut was not limited to; facts surrou		
	Injections;				e incident involving Resident #1,		
	Parenteral and entera	ıl fluids;			rocesses for communication of re		
	Colostomy, ureterosto	omy, or iteostomy care;			nanges in condition to the physici		
	Tracheostomy care;	,			Medical Directors, nursing, resp		
	Tracheal suctioning;				nd the IDT, review of the resident		
	Respiratory care;				edical record to determine evider		
	Foot care; and				otential risk factors for decannula	tion.	
	Prostheses.				ollowing the completion of the vestigation, based on an analysis	s of the	
					ndings, the facility developed and		
				in	plemented corrective action dire	cted at	i
		is not met as evidenced			eas identified with quality improv		
	by:				portunities. For residents residin		
		ews and interviews with			cility in similar situations as Resid		1
	facility staff, the physic	•		ar	nd Resident #2, the following action	ons	
		failed to provide an effective			ould be taken. The licensed nurse		· i
	- •	alert staff to tracheostomy ay patency and loss of			itiate One-to-One supervision of t		[
		ng in one of five oxygen			sident followed by: (a) inform the nysician or Medical Director of the		1
		lecannulating herself and		in	the resident's condition and the	change	
	expiring (Resident #1)	•			phaviors exhibited, (b) obtain an o	order for	
	sopring (reducitor)	•			ne-to-one supervision and any oth		
	Immediate ieopardy h	egan on 03/16/12 when		ini	tervention the physician or Medic	al	nantachin's
		her trach resulting in a		Di	rector deems necessary. (c) char	rge	{
		ion rate. The administrator			irse complete an SBAR (Situation		
	was notified of the imr				ackground, Assessment/ Appeara		
		The immediate jeopardy is			nd Request) report , (d) document		
	present and ongoing.				nange in the resident's condition of	on the	. 1
		-		24	hour report and the one-to-one		
	mander of the state of	(4 4 11) 4 124 4 7 1)		ទប	pervision being provided, (e) the	24 nour	

Review of the policy titled "Ventilator (vent)

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Patient with Agitation," which was not dated, indicated

"Identify: Pulling at equipment, uncontrolled moving, and crying, combative, attempts to get out of bed/chair.

Interventions: CNA/RT (nurse aide/respiratory therapist) alert nurse. Attempt to calm resident. Reposition. Meet any need that is acceptable. Stay with resident during crisis (do not leave an active agitated resident) Nurse-Pain medication/Antianxiety meds (medications) may be appropriate -check for recent medication use first.

Monitor:

Maintain a 1:1 staff observation while resident is actively agitated. If medicated, ensure that the post effectiveness is documented. Never leave an agitated resident alone! Document, Document, Document.

NOTE: Ensure physician is notified in the change of condition. Ensure resident's responsible party is notified."

The Respiratory Care Department policy, dated 06/01/06, read in part "Protocot for Management and Weaning of Patient from Prolonged Mechanical Ventilation." This policy indicated that one of the physical signs of respiratory fatigue or failure was agitation.

Ventilator Weaning Protocol revealed the weaning procedure is comprised of consistent steps in which the patient moves one step each day from full ventilatory support to 24 hours of spontaneous unassisted breathing. The patient should not be fatigued during this assessment. The patient should not unduly be anxious, fearful, agitated or in pain."

report and the SBAR report would be given to the IDT for discussion, action item development and monitoring of the resident's progress.

The resident would remain on the 24 hour report until his/her condition improved. As the resident's condition improved, or declined, the IDT would make recommendations to the physician or Medical Director to modify or discontinue one-to-one supervision for the resident and place the resident on Resident Monitoring. Resident #2 was discharged from the facility on March 28, 2012 and was readmitted on March 30, 2012. Following readmission Resident # 2, ventilator dependent at night, upon readmission was provided a new tracheostomy collar and was observed for behaviors. Resident # 2 did not exhibit any "at risk" or "emergent" behaviors. Resident #2 has had orders obtained and implemented for continuous pulse oximetry, anti-disconnect device at night, and Resident Monitoring which continues at this time.

2. Residents with tracheostomies with changes in condition have the potential to be affected by the same alleged deficient practice. On March 31, 2012 residents with tracheostomies had their tracheostomies checked for proper placement by the Respiratory Therapy Director or his/her designee. Of the 21 residents with tracheostomies all were properly placed. On March 31, 2012 the presence of a replacement tracheostomy at the bedside was validated for all residents with tracheostomies to ensure a replacement was immediately available. On March 30, 2012 the Interdisciplinary Team reviewed the medical records for

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Weaning Procedure Summary read in part, "Evaluate patient daily prior to attempting the next weaning step. Do not attempt next weaning step if any one is present:

- 2. Pulse <50 or >130 beats/minute
- 8. SpO2 < 92% (the amount of the oxygen in the blood).
- 11. Diaphoresis, agitation, etc."

Tracheostomy (trach) is a surgical incision into the trachea (windpipe) that forms a temporary or permanent opening. The opening is called a stoma. A tube (tracheostomy tube) is inserted through the stoma to allow passage of air and removal of secretions. Instead of breathing through the nose and mouth, the person will now breathe through the tracheostomy tube. Some people can not breathe on their own through the stoma/trach, therefore oxygen is supplied through an oxygen mask to assist with breathing. The concentration of the oxygen needed depends on the person's condition. Some people need mechanical ventilation (vent) to assist or replace spontaneous breathing.

An interview with the Respiratory Therapy Director on 03/29/12 at 4:09 pm revealed complete ventilator checks were done at 7 am, 1 pm, 7 pm and 1 am. Walkthroughs were conducted every 2 hours. Trach care (the inner cannula were cleaned, sponges were changed and the resident was suctioned) was done daily.

Resident # 1 was admitted to the facility on 08/29/11 with cumulative diagnoses including respiratory failure that required the use of artificial ventilation, pulmonary insufficiency, dysphasia,

each of the 21 residents in the facility with tracheostomies to identify residents with behaviors that put them at risk for decannulation. "At risk" behaviors include but are not limited to: restlessness. emotional distress or cognitive changes resulting in confusion, weeping or objective or subjective signs of pain of discomfort. Nine (9) of the 21 residents reviewed were identified with "at risk" behaviors. All 9 residents were placed on "Resident Monitoring" to provide increased supervision. During the record review residents' care plans were reviewed updated, as necessary to reflect the residents' current care needs.

On March 30, 2012 the facility's pharmacy consultant conducted a review of the medication regimen of current residents, with tracheostomies, with behaviors to ensure that the residents were receiving appropriate medication and dosages. During the month of April the Medical Director has assessed each resident residing on the Medical Specialty Unit (MSU) and is aware of any recent changes in the residents' conditions.

3. The facility developed a new policy titled "One-to-One supervision of Residents on the Medical Specialty Unit (MSU)".

The facility policy titled "Pulse Oximetry" and "Trachostomy tube change" will be reviewed by the facility QA & A committee and modify if indicated.

The facility has contracted the services of an additional Pulmonologist to evaluate the residents on MSU and to consult with the attending physican regarding the residents care need for a period of 6 months. These services began on April 23, 2012.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 328 Continued From page 42

hypertension, diabetes mellitus and renal insufficiency.

Psychiatry notes dated 9/12/11 read "Creative with dangerous behavior pulling at trach (tracheostomy) and g-tube. Patient has poor insight in her disabilities and worse judgement when it comes to pulling at devices. If she is to be weaned we must temper this behavior." Seroquel (antipsychotic medication to treat behaviors) and Zoloft (antidepressant) to temper behaviors were recommended.

Psychiatry notes on 10/17/11 revealed the resident pulled out trach recently. No medication changes were recommended.

An interview with the psychiatry nurse practitioner (NP) was conducted on 04/02/12 at 10:40 am. The resident was referred to psychiatry because she was pulling the trach out. The resident was impulsive. The RN did not feel there was any suicidal intent or ideation. She was typically depressed and had anxiety as any resident with a trach.

The quarterly Minimum Data Set dated 1/22/12, revealed Resident #1 had moderately impaired long and short term memory. The resident responded to direct simple communication and was limited in her ability to make needs known. Her behavior was identified to put the resident at a significant risk for physical illness or injury to herself.

Review of the most current physician orders dated 01/04/12, revealed "tracheostomy (trach) collar settings of FiO2 (Fraction of Inspired

The facility has contracted the services of an additional Psychiatrist to provide an initial assessment of the residents on MSU and any new admissions and periodically as deemed appropriate for each individual's plan of care for a period of 6 months. This contract was signed on April 24, 2012.

The facility has contracted with a Respiratory Therapist to provide oversight to the on-site Respiratory Therapy staff to evaluate current practices, make recommendations and provide training on systems utilized by the facility for a period of 6 months. These services were began on April 11, 2012.

The facility has contracted with System Electronics to install a new call system that enables plug in of the ventilator and pulse oximeter to allow alarms to be audible at the nurses station. The system has been purchased and is scheduled for install upon delivery.

The 24 hour report process has been modified to include participation from Respiratory therapy and charge nurses. The 24 hour report is maintained in a book on MSU. The 24 hour report and is used to communicate changes in resident condition and incidents that occur during a 24 hour period to other MSU nursing and respiratory therapy staff members on different shifts and to the Interdisciplinary Team (IDT), thereby ensuring that changes in the resident conditions are timely recognized and interventions are timely and consistently implemented. The charge nurse for every shift will be responsible for making entries to the report regarding changes in resident condition, including but not limited to, new and escalated "at risk"

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Oxygen is the percentage of Oxygen that is inspired) 40%. May wean per protocol. Tracheostomy collar, patient and SpO2 (the amount of oxygen in the blood) monitoring Q 4 hours (every 4 hours). Full ventilator, patient and SpO2 monitoring Q 4 hours. Respiratory Therapist may replace tracheostomy tube routinely and for emergently for dislocation, plugging or inadvertent decannulation."

Nurses' notes, dated 02/04/12 at 7:35 pm revealed the resident was found sitting on the floor at the side of the bed and she was noted to be decannulated. RT (respiratory therapist) was called to the resident's room. The trach was reinserted and the resident was bagged. Family and MD were made aware. A sitter was placed at the bedside until the family arrived.

Nurses' notes, dated 02/09/12 at 4:30 pm, indicated the resident slid out of the geri chair and had the oxygen tubing pinched in between the chair and the night stand. The resident had one-to-one sitter.

Nurses' notes dated 02/24/12 at 5:10 pm, indicated the resident attempted to crawl out of bed this shift and was pulling at the trach. Ativan was given with effectiveness.

Review of the physician's orders dated 03/01/12, revealed the resident was prescribed Ambien 5mg by mouth or via tube at bedtime as needed for sleep (a narcotic used to induce sleep), Ativan 0.5mg via tube every 6 hours as needed for anxiety, Percocet 5/325mg (a narcotic pain reliever) by mouth via tube every four hours as needed for pain. Seroquel 25 mg (an

behaviors. The Respiratory Therapist (RT) for every shift will be required to make similar entries on the 24 hour report. The 24 hour report is reviewed, discussed and action items identified by the IDT in morning meeting, Monday through Friday. The Weekend Supervisor will review the completed 24 hour reports and follow-up on any items that require attention during weekend hours. The 24 hour reports from the weekends will also be reviewed by the IDT during the morning meeting on Monday following the weekend. (b) SBAR reports (Situation, Background, Assessment/ Appearance, and Request) will be required to be completed by the licensed nurse or RT for situations requiring physician notification. The SBAR reports will remain with the 24 hour report until the actions noted on the SBAR report have been accomplished ensuring communication of required actions to each shift until the SBAR is resolved. The SBAR reports will be forwarded to the IDT with the 24 hour report to ensure that any situation where a physician is called is communicated. (c) A new physicians log book has been initiated on MSU for attending physicians and the psychiatrists. the charge nurse will make entries in the book when a phone call is placed to the physician also to ensure that any situation is communicated back to the physician so the resident may be evaluated as indicated on the next visit, the physician signs off on each entry when reviewed (d) The 24 hour report and any SBAR reports are reviewed by the off-going and on-coming nurses during each shift change. Once resolution is obtained the SBAR form will be placed in the residents' medical record. (e) A new

MSU clinical stand down meeting has been

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F 328	antipsychotic medica and Seroquel 12.5 m Zoloft 50 mg (an anti day. Nurses' notes, dated shift, indicated the re pulling at her trach an Ativan was given and	tion) via tube every evening g at 8:00 am and 1:00 pm, depressant) via tube every 03/03/12 on the 7 am-7 pm sident was agitated and was and trying to get out of bed.	F	implemented to provide addition opportunity for close communicated between nursing and respiratory regarding the care and treatment tracheostomy residents. The state meeting will be conducted to dis MSU residents' conditions, follow completion status of the action it identified by the IDT during more meeting and to ensure that information and the communicated to the nursing and respiratory town. Portionate in	ation teams t of nd down cuss the v-up on the ems ning mation dearly

Nurse #5 was interviewed on 03/31/12 at 3:43 pm via telephone. Nurse #5 indicated she worked on 3/16/12 during the second shift (3 pm -11 pm). Nurse #5 said she was across the hall with another resident. Nurse #5 stated, "I heard (Resident #1) banging on the side of the chair. I saw her with the trach (tube) and the ties in her hand. The banging was just for about 20 seconds. She was not banging for very long. She (the resident) was mouthing 'I cant breathe.' She had her hand up to her neck. I didn't ask her what happened. She looked scared at that moment because she didn't have a full airway. I put the old trach back in and then respiratory came in and I went to tell her nurse what happened. She was in the gerichair. Normally the call bell was by her side. I cannot remember. Her nurse was off the floor, and I was watching her patients."

The respiratory note dated 3/16/12 revealed Resident #1 was on an aerosol tracheostomy collar (ATC) during the first respiratory therapist (RT) walkthrough at 1:45am. The resident was suctioned at that time and then again at 4:40 am, 11:15 am, 1:20 pm, and 2:10 pm. There was no oxygen saturation rate (the amount of oxygen in the blood) or pulse recorded from 12:01 am on 03/16/12, until the walkthrough at 2:23 pm when

respiratory team. Participants in the MSU clinical stand down meeting include the Director of Nursing (DON), the Director of Respiratory Therapy, the MSU manager and the Staffing Coordinator. The stand down meeting will occur each afternoon. Monday through Friday. The clinical stand down meeting includes staffing levels for the next 24 hours, Monday through Thursday, and for the following 72 hours during Friday's stand down meeting. The Staffing Coordinator will arrange for additional staffing, as needed, based on discussion during the stand down meeting. (d) As part of the morning meeting, the IDT discusses the residents with tracheostomies identified as exhibiting "emergent" behaviors and new and escalated behaviors to determine if such residents are responding to the implemented interventions and whether such residents require implementation of additional interventions. (e) To further enhance resident safety, an audible alarm system to immediately alert staff of potential changes in the condition of tracheostomy residents not on ventilator assistance was obtained. The facility purchased 10 Continuous Pulse Oximetry units for Non-Ventilator Dependent

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F 328 Continued From page 45

the oxygen saturation rate dropped down to 91%. The resident was suctioned at 3:57 pm. There was no documentation of a recheck of the oxygen saturation rate to determine if it had improved. The next walkthrough was at 5:01 pm. Resident #1 decannulated herself (removed the trach tube that kept the airway open) at 5:43 pm. The oxygen saturation rate dropped to 71% (normal values 92%-96%) because of the decannulation. The resident was suctioned, the trach tube was replaced and the resident was oxygenated back to 100%. She was then placed back on full ventilator support at 5:50 pm. The resident was suctioned at 9:19 pm and at 11:15 pm.

On 04/02/12 at 9:39 am respiratory therapist (RT) #4 was interviewed. She stated Resident #1 needed the trach to be able to breathe and also for suctioning. She needed a high amount of oxygen that was in the range of 40%-50% (oxygen should be 28% or less for the resident to breathe independently). The RT was on duty when the resident decannulated herself on 03/16/12. She said Resident #1 had been messing with the oxygen mask all day, and was restless. When the resident decannulated (removed the trach tube from the stoma) herself, she pulled out the trach tube and the oxygen mask. The RT put the trach tube back into the stoma. The RT stated it would be impossible to pull out the trach tube without pulling off the oxygen mask. The RT indicated there should be some type of a monitoring system in place on residents who were on a trach.

On 03/30/12 at 8:41 am respiratory therapist #4 was interviewed again. She said Resident #1 would move her oxygen mask and RT #4 told her

residents with tracheostomies. The new pulse oximeters are programmed to sound an alarm if the pulse oximeter becomes dislodged or if the residents' oxygen saturation level falls below 93% or settings specifically ordered by the physician. The pulse oximeters are housed in protective bags with a clear window through which the pulse oximeter controls are visible and a large Velcro flap that securely closes the bag. The facility has covered the control buttons on the pulse oximeters, including the On/Off button, so a resident would not be able to visualize the On/Off button and to prevent the machines from being intentionally or unintentionally turned off by staff or residents. Residents have the right to refuse treatment, including the use of continuous pulse oximetry. In the event a resident refuses the use of the continuous pulse oximetry, the resident and their family will, again, be educated on the purpose of continuous pulse oximetry and the risks related to the refusal of such treatment. Resident refusals and subsequent education will be documented in the resident's medical record. The resident's physician or the Medical Director will be notified of the resident's refusal and an order obtained, as appropriate, for alternate interventions. The IDT will be notified as well of the resident's refusal. If a resident is exhibiting "emergent" or "at risk" behaviors, the staff member identifying this will remain at the resident's bedside and uses the nurse call button to call for help. (h) The RN charge nurse will

perform an assessment of the resident's condition. Based on assessment findings

the charge nurse, if warranted, will

Resident Monitoring and notify the

implement one-to-one supervision, or

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	not to mess with it. R' back on the vent as a was out she did have would rest more combined the vent. There is a property of the vent and the vent and the vent and RT #6 was interviewe RT #6 said Resident # and her oxygen saturation in the said the looked very much in the decannulated herself) minutes to resolve the the resident didn't individual herself, she didn't have the words out. RT states would get going (increasions." Review of staffing for the (MSU) for 03/16/12 reproductive the state Licenty and the state Licenty and the said the said the words out. RT states are seemed to understand the words out. RT states are seemed to understand the words out. RT states are seemed to understand the words out. RT states would get going (increasing the words out and the words out	T #4 stated "We put her precaution. When the trach trouble breathing, I felt she fortably if she had a night on rotocol to go by; I used the proposition of the previously." I d at 12:11 pm on 03/30/12. If had anxiety problems ation rate was in the mat on 03/16/12, the resident istress (after she and it took just a couple of the issue. The RT indicated icate why she decannulated are enough strength to get ed, "We educated her and stand. When her secretion	F	attending physician or of the change in the veresident's condition and the intervention implementation and the intervention implementation or Medical Discussion of Medical Disc	entilator dependent d obtain orders for mented by the charge tervention the irector deems Ints to the MSU will Resident Monitoring admission and will admission an "at ed, the physician level of supervision Nursing and its will determine an going supervision, rmation. Care plans IDT and updated as sidents' current orking on MSU are the tracheostomy market to a variable that safety and security spiratory therapists y collars to a new I out of a single		

Review of the respiratory note dated 03/17/12,

03/16/12). The oxygen saturation rate at that

2:30 am, 3:05 am, 4:10 am, 5:50 am, 6:05 am,

and 6:25 am. Resident #1 was removed from

artificial ventilation to ATC at 8:35 am. The

time was 98%. The trach became disconnected

from the ventilator at 1:52 am, 2:01 am, 2:12 am,

revealed Resident #1 was still on artificial

ventilation at 12:37 am (since 5:50 pm on

from the ventilator.

points.

To increase safety for tracheostomy

dependent. The TrachStay™ device

stabilizes the ventilator connection and

residents that are ventilator dependent,

facility RT staff has implemented the use of

TrachStay™ anti-disconnect devices for all

tracheostomy residents who are ventilator

aids in the prevention of the disconnection

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F 328	Continued From page 47 oxygen saturation rate was 94% (at 8:35 am) and the resident required suctioning at 8:35 am, 10:30		F	Beginning April 26, 2012 re- a new curriculum, will be co nurses and respiratory thera on MSU on:	mpleted with	
		m, 2:50 pm, 5:28 pm, 7:25		1)The new policy titled "Stat Notification of".	us Changes:	
	completed at 11:25 ar The oxygen saturation	m, 12 noon and 11:45 pm. n rate was 95% and pulse		2)The Why, How, and Wher tool		
		nd 98% at 7:20 pm. She		3)The 24 hour report proces		
		until 11:45 pm when she		4)Clinical Communication p	rocess	
	was returned to artifici	ial ventilation.		5)Physician Log process 6)Pulse Oximeter		
	0 - 00/00/40 -1 4-00			7)Resident Monitoring, inclu	idina new	
		om RT #3 was interviewed.		admissions.	ully new	
		esident #1 on 03/16/12 and		8)One-to-One Supervision		
		n until 7 am. RT #3 said she	i.	9)Anti-disconnect devices/tr	ach tie	
		sident decannulated herself 3/16/12. The RT said the		11) At risk vs. Emergent bet	navior and	1
		rs/16/12. The RT said the ent that night, RT #3 said		appropriate staff actions who	en identified.	
		ent that night. RT #3 said 3/17/12, there were several		12)Resident decannulation		
		resident from the vent, the		13)Staffing MSU for direct c	are, One-to-	
		nected at the neck each		One, and Resident monitor.	•	
		nected at the neck each ien there were that many		Licensed nurses and Respir		
	disconnections, usuall	en mere were mar many		Therapists working on the M not received the above train		
	recident was taking it.	off. Residents disconnected		education by May 7, 2012 w		•
		ing the call bell to get the	į,	permitted to work until such	m not be	
		r attention. Sometimes		has been completed. Educa		
		because there is always		training will be provided at the	ne beginning of	
		ven in the middle of the		their next scheduled shift, pr	rior to providing	•
				resident care. The training w	ill be provided	
		ident #1 could be confused		by the MSU Unit Manager, I		
		es she wasn't confused.	i !	Supervisor, and/or DON at the		[
	The nurse was aware			each shift for persons that he		
	Many of the nurses knowing the received the			received the training, includi		
		sident was agitated." During	:	staff. The above described to	raining will be	[
		2 at 2 pm, RT #3 indicated	1	incorporated into the new his		
		#1 disconnected and "I		New hires will not be permitt		
		e (Nurse #6). Everyone	1	resident care on the MSU ur	ntil the training	
	was aware of the alarn			is completed.	•	!
	discussed with the nur	rsing staff; they determine		Beginning April 25, 2012 re-		ĺ
		d be called. The respiratory the doctor, nursing staff		a new curriculum, will be cor Certified Nursing Assistants		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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do. I would recommend to the staff when I felt the nurse needs to call the doctor. They don't tell me if they have called or not."

On 03/31/12 at 11:12 am, nurse #3 was interviewed. Nurse #3 said she worked on Saturday 03/17/12 from 7am to 7pm (after the resident decannulated herself and disconnected herself from the vent). Nurse #3 stated "I was assigned to (Resident #1). She was on (oxygen mask). I wasn't informed that she had pulled out her trach on Friday. I should have found out from the 24 hour report sheet. The sheet stayed on the medication cart for 24 hours. The decannulation should have been on the sheet. It was not on the sheet. On the 17th I didn't give (Resident #1) any Ativan." Nurse #3 said the respiratory therapists were supposed to tell the nurses when a resident had agitation issues. Nurses would assess the resident, to determine what they needed. Once they were cleaned, or suctioned, the nurses would use medications (to treat agitation). If that didn't help the nurses should call the nursing supervisor and call the doctor. A resident has a sitter when they were disconnecting the vent or decannulating the trach."

Review of staffing for the Medical Speciality Unit (MSU) for 03/17/12 revealed staffing was 4.6 hours per patient per day (PPD) and there was no Registered Nurse coverage for the 7 am - 7 pm shift. This did not meet the State Licensure requirement of 5.5 PPD and having a Registered Nurse on staff at all time.

The respiratory note dated 03/18/12, revealed Resident #1 was still on artificial ventilation and

F 328 1)Resident Monitoring, including new admissions.

2)One-to-One Supervision 3)At risk vs Emergent behavior and appropriate staff actions when identified. 4) Pulse oximeter observations 5)Resident decannulation working on the MSU that have not received the above training and education by May 7. 2012 will not be permitted to work until such re-education has been completed. Education and/or training will be provided at the beginning of their next scheduled shift, prior to providing resident care. The training will be provided by the MSU Unit Manager, House Supervisor, and/or DON at the beginning of each shift for persons that have not received the training. including agency staff. The above described training will be incorporated into the new hire orientation. New hires will not be permitted to provide resident care on the MSU until the training is completed. In addition to the above listed training the contracted Respiratory Therapist with IDT involvement began a didactic training course for MSU nurses that consists of 18 hours of training followed by competency testing on care of a ventilator patient. This training is being conducted a minimum of monthly for 6 months.

4. The facility has developed and implemented new audit processes to access the effectiveness of the above plan related to supervision of residents with tracheostomies. (a) On a daily basis, the DON, Assistant Director of Nursing (ADON), MSU manager, or House Supervisor will review the 24 hour reports from the MSU to verify appropriate information is being communicated shift to shift and that respiratory therapy and

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her oxygen saturation rate was 98% at 1:42 am. She was suctioned at 2:40 am and 3:10 am. The tracheostomy became disconnected from the ventilator at 4:10 am, 6:00 am and 6:05 am. At 7:55 am, her oxygen saturation rate was 98%. She required suctioning at 8:10am. Resident #1 was placed back on the ATC at 9:20 am. There was no oxygen saturation rate or pulse recorded between 7:55 am until 7 pm. At 7:00 pm her oxygen saturation rate fell to 82%. The cuff of the tracheostomy was deflated and she was suctioned and oxygen saturation returned to 97%. No tracheostomy care was recorded for the whole 24 hours on 03/18/12.

On 03/30/12 at 4:02 pm RT #3 was interviewed. RT #3 worked with Resident #1 on 03/18/12 from 6:30 pm until 7 am. The RT said "on the early morning of the 18th she disconnected (the circuit) 3 times. It asked her if she was tired and I asked her if she wanted to go on the trach collar and she said 'No.' She looked very worn out to me. She was wide awake from 3 (am) until 6 (am) and somewhat agitated. When she got secretions she would panic when she would cough and the mucous would go into the cannula. I gave report to oncoming RT who took over (and) told him the resident stated she was tired. She needed a sitter for a long time. I think with all the disconnection she was bound to be doing it herself and that night I really felt she needed a sitter. There is no alarm on the trach collar. There could be (an alarm) if there was a continuous pulse ox to notify staff when they (residents) are getting a low (oxygen) saturation rate. She was a rare patient who liked to be on the vent. Most patients like being off the vent and on the trach collar."

changes in resident condition and incidents via the 24 hour report. (b) On a daily basis, the DON, Assistant Director of Nursing (ADON), MSU Manager, or House Supervisor will review the 24 hour reports from the MSU to verify that an SBAR form has been completed appropriately for each item entered. (c) On a daily basis, the DON, Assistant Director of Nursing (ADON), MSU Manager, or House Supervisor will observe shift to shift report to verify that information from the 24 hour report is being communicated to the on-coming shift nurse by the off-going nurse, (d) On a daily basis, the DON, Assistant Director of Nursing (ADON), MSU manager or House Supervisor will verify that the Pulse oximeters and resident monitor (15 minute check) documentation on the MAR has been completed by each charge nurse, (e) On a daily basis, the DON, Assistant Director of Nursing (ADON), MSU manager or House Supervisor will review the documentation and interventions and verify that the resident monitor (15 minute check)

sheets are completed, (f) On a daily basis

covered, and anti disconnect devices are in

sheet for the prior day(s) to verify staffing ratios and per patient day (ppd) hours are

met. The daily audits will continue for 30

case daily audits will continue until a time

days and then will be completed weekly

unless concerns are identified in which

determined by the QA & A committee.

The NHA/DON/Respiratory Therapy Director will report to the facility's Quality

a Respiratory therapist will conduct an

audit of Pulse oximeter bags, controls

place. (g) On a daily basis M – F the Administrator (NHA) will review the staffing

nursing are collaboratively reporting

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F 328	On 03/30/12 at 9:48 a interviewed. Nurse # to Resident #1 on 03/1 Nurse #2 said she was outgoing nurse that R disconnected herself on 03/17/12 and 3 tim stated "Had I known on the 17th and the 3 (Resident #1) would r Review of staffing for (MSU) for 03/18/12 rehours per patient per Registered Nurse covahift. This did not me requirement of 5.5 PF Nurse on staff at all tim Review of the respiral revealed Resident #1	am, nurse #2 was #2 stated she was assigned #18/12 on the 7am-3pm shift. as not made aware by the Resident #1 had from the ventilator 9 times mes on 03/18/12. Nurse #2 about the 9 disconnections 8 disconnections on the 18th not be sitting alone." The Medical Speciality Unit evealed staffing was 4.8 day (PPD) and there was no verage for the 7 am - 3 pm set the State Licensure PD and having a Registered	F	Assessment and Assurance (Committee weekly with the reverification review of the above audits. Issues identified by the NHA/DON/Respiratory therape a result of these audits will be the QA&A Committee within a day. The QA&A Committee withe effectiveness of the plant of basis, for 2 months, then more on trends identified and develoned implement, additional interver needed to ensure continued and the continued of	sults of the ve identified selection as a reported to one business sill evaluate on a weekly every two onthly based op and ontions as compliance. If Director, ory therapy will meet to ere are no report ion plan in the aining oard of the		

sounds were recorded as diminished. The resident was suctioned at 1:50 am 4:10 am, and 6:05 am. The FiO2 was increased to 70% at 7:30am. The respiratory therapist was notified by the unit secretary at 7:40 am that Resident #1 was tachypneic (very rapid breathing) and the oxygen saturation rate was found to have fallen to 85%. Rhonchi (sounds caused by secretion and narrowed airway) were heard. Resident was suctioned at that time. The oxygen saturation rate went up to 98%. The resident was suctioned again at 8:29 am. At 9:10 am, the oxygen saturation rate dropped to 86%. The resident was suctioned. The oxygen saturation rate was not rechecked to determine if it had improved. At 11:15 am, the resident was suctioned. The

compliance.
The Administrator is responsible for ongoing compliance.

actions they deem necessary based on the

monthly for 2 months, the Vice President of

Clinical Services will attend the facility QA & A meetings and provide input on plan

effectiveness as well as ensure continued

Twice monthly, for 2 months, and then

reports.

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	pulse was 58 at that it suctioned at 1:20 pm, and 8:00 pm. No oxy recorded at 8:00 pm. recorded as "coarse" blood tinged "mucoid Tracheostomy care was:10 pm. Review of the nurses' revealed at 8:45 pm, It bed to the floor with microphysician were notified revealed, Resident #1 anxious and was redired:1.1. She fell a second the recliner. Review of the medicate (MAR) on 3/19/12, revestlessness. Zolpider pm for insomnia and rewas given at 9:00 pm to mass given at 1:45am and mass. Nurses' notes dated 3 0.5mg was given at 1:20 am observed at 3:00 am in went to the room at 3:20 resident unresponsive	e had increased to 93% and ime. The resident was 1:50 pm, 3:10 pm, 5:30 pm gen saturation rate was Breath sounds were and she was suctioned for "at 8:00 pm. as done at 10:15 am and at notes dated 03/19/12, Resident #1 fell from the o injury. Family and d. Nurses notes at 9:30 pm was observed to be ected and responded to time and was assisted to ion administration record ealed acetaminophen nknown time for pain and m 5 mg was given at 9:00 estlessness. Ativan 0.5mg for restlessness. ion administration record ealed Ativan 0.5mg was oted to be effective at 2:30 //20/12, indicated Ativan :30 am, and was noted to i. The resident was a recliner. An aide (NA#2)	F	328			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER BLUE RIDGE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COI 3830 BLUE RIDGE ROAD RALEIGH, NC 27612	DE	04/03/2012	
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and CPR was initiated. Paramedics pronounced Resident #1 dead at 3:36 am. The physician, family and director of nursing were notified.

Review of the respiratory note for 03/20/12 revealed the RT #1 did a walkthrough at 1:45 am. Resident #1 was on the ATC. The resident was not suctioned from 8 pm on 03/19/12 until 1:45 am on 03/20/12. At that time, the resident was suctioned for large amount of mucoid secretions. Breath sounds were recorded as coarse. RT #1 observed Resident #1 from the hallway at 3:05 am and no sound was heard from the room. Respiratory therapy was called to the room by a nurse aide (NA#2) at 3:20am. Resident #1 had removed her tracheostomy which was observed in her left hand. The tracheostomy was reinserted into the stoma site and Resident #1 was bagged with good chest rise. She was moved to the bed and cardiopulmonary resuscitation (CPR) was started. Emergency Medical Services (EMS) arrived and pronounced Resident #1 dead at 3:36 am. The resident was not suctioned from 1:45 am until around 3:20 am when she was discovered unresponsive. No oxygen saturation rate or pulse was recorded since 8:00 pm on 03/19/12 until the resident's death.

During a telephone interview on 03/31/12 at 5:15 am, NA #1 said she was assigned to Resident #1 on 03/19/12 from 11 pm-7 am. The aide stated, "When I came to work, I was told (Resident #1) had fallen on the 2nd shift, and that we were to keep our eyes on her and watch her closer. Instead of the two hour rounds, we were to go and check on her every 30 minutes. I would go into her room and turn on her gospel music and she would be fine. She was already up in her

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		345517		103		0	14/03/2012
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al HE RIC	DGE HEALTH CARE CEN	izeb		j	BLUE RIDGE ROAD		
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F 328	Continued From page	o 52		· one			
•			F [*]	328			
	chair. She didn't slee	ap well in bed."					
	During a telephone in	nterview on 03/31/12 at 5:39					
		worked on 03/19/12 on the					
		The NA stated, "We had					
		er more closely. When we					
		actually go into the room.					
		had banged on her chair,					
	that was how she got	t attention. We got to work					
	at 11:00 pm. As soon	n as we got there we started					
	answering call bells.						
	(Resident #1) on roun	nds about 11:30 (pm)-12					
		was on the hall passing	4				
		ve (Resident #1) something	i i				
		en the next time we went in					
		trach was in place, she was					
		he was alive, she moved her		!			
		ext set of rounds and started	*				
		to the 200 hall. We were					
		. I went to (Resident #1)					
		n and she didn't look right to					
		ice and her tongue was not	1				
		ept with her mouth open.	1				
		er with her feet up. The		:			
		e right place. Then I tapped	•				
		didn't respond to her name.	•				
		ck and that is when I realized					
		out. The trach with the	i				
		hand near her left leg. I ran					
		rse #1) came back with me,					
		pist (RT #1) came and he put					
		bagged her, we picked her	1	:			
	up and put her on the got out of the way, wh	bed on the board. Then I					
	got out of the way, wit	ille they coded her.					
	On 03/30/12 at 11:30 a	am nuran #A waa	•				
		4 worked on the 11 pm -7					
	HILDERICALOR. LANGO 11	* WOLVER OF THE LIBIT AT					

am shift on 03/19/12. Resident #1 had a fall

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earlier in the shift and she said she had slid onto her mat. She was given medication for agitation. Nurse #4 said, "She did the shaky (shaking her hands) movement and I knew that meant she felt anxiety. She was in her recliner resting with her eyes closed about 1:45 am -2 am. I looked into her room at 3:00 am then I went to the front desk. About 20 minutes later the aide (NA #2) came and got me. We went in and I saw her trach on her chest. Her head was down and toward the right. Her eyes were closed. The aide told me her chin was over the stoma, and she (NA) moved her head. I called respiratory, and (RT #1) came in. He inserted another trach; we had to get her out of the chair to do CPR." Nurse #4 said RT #1 "had the trach in by the time I called the code blue. I didn't know that she had pulled out her cannula before until the cop told me she had decannulated on Friday." Nurse #4 said if she had known that the resident decannulated herself, she might have decided to call and get one-to-one supervision. There was no formal way of monitoring (through an alarm or device). The supervisor will decide who to pull to do the one-to-one or to call someone from home or pull some one from the unit. Nurse #4 said, "We only have one aide on each hall at night. The aide or nurse are not able to sit. The supervisor decides what to do."

RT #1 was interviewed on 03/30/12 at 1:15 pm and again on 03/31/12 at 4:00 pm. RT worked on 03/19/12 from 6:30 pm until 7 am. RT #1 said when Resident #1 "was active she had a tot of secretions. She was able to cough into the trach and you could hear her. She couldn't put the trach in by herself. She was active. She was always trying to get out of bed. She would slide

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F 328 Continued From page 55

out of the bed with her feet hanging. I was aware that the resident had decannulated herself (on 03/16/12). She was doing well on the trach on 03/19/12. She didn't need to be on the vent. She did not have signs of hypoxia. She was more agitated (on 03/20/12) than usual. I saw her with her legs between the rails and her feet were on the floor. She pulled out the trach sponge at 8:10 pm that shift and I changed it. I suctioned her at 1:45am. I told the nurse she needed something about 1:45 am and that she needed someone to sit with her. There was a shortage of staff, and that is why she didn't have a sitter. I heard the nurse tell the supervisor we needed a sitter. Between 1:45 (am) and 3 (am) there was no one to sit. She got her sedation at 1:45 am and she needed more sedation. She could not take any more of her prn (as needed) medication (for agitation) because she took the maximum she can take. I didn't feel that the Ativan she received was effective. I thought she needed to be restrained but they told me that she could not be. I passed by the resident's room at 3:05 am. She was lying to the right side with her head lying to the right side. From the door all that was visible was the trach collar. So I didn't go in and check her. She appeared to be sleeping. The trach collar was in the correct position. She was already dusky when I arrived. We do trach care because there may be secretions build up in the trach. My point is that she wasn't monitored because they were short staffed that night. If there was a continuous pulse oximeter, or a telemetry, or one-to-one (human supervision) then that would alert staff if the trach was pulled. The temperature of her body was only a degree from her normal body temperature. She had cyanosis when I got there. When residents

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disconnect from a vent the alarms would alert the staff. When residents decannulate from a trach, there are no alarms to alert staff. It takes about 3-5 minutes without oxygen for a resident to die."

Review of staffing for the Medical Speciality Unit (MSU) for 03/19/12 reveated staffing was 4.8 hours per patient per day (PPD) and there was no Registered Nurse coverage for the 4 pm - 7 am shift. This did not meet the State Licensure requirement of 5.5 PPD and having a Registered Nurse on staff at all time.

During an interview on 03/30/12 at 9:13 am, NA #3 said, "She messed with her trach all the time. She would try to pour water over it. She would pull at it quite a bit. I would alert the nurse and tell respiratory (therapist). I would sit with her and she would calm down and it would be an easy day."

On 04/2/12 at 10:08 am, RT #5 was interviewed. RT #5 said Resident #1 required suctioning, and she was in no way able to breathe without oxygen or the trach. Resident #1 would take off her trach collar (oxygen mask) often. She would move it to the side, she would take it off and she would throw it on the floor. When the resident was educated about the risk of pulling on the trach, she would laugh and smile. But she would do it again. She would climb out of bed. RT said that the resident's oxygen saturation would fall quickly without her oxygen. She needed a sitter, a lot of people needed sitters, and they did not have them on the MSU (Medical Speciality Unit), RT said he reported the behavior and oxygen saturation rate to the nurses. The MSU unit needed a monitoring system that would attach

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NAME OF PROVIDER OR SUPPLIER BLUE RIDGE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3830 BLUE RIDGE ROAD RALEIGH, NC 27612		
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trach residents with leads to a device at the nurses' station. A technician would sit at the nurse's station and monitor the residents 24 hours a day, 7 days a week to alert staff when the trach got pulled out or when the oxygen saturation would fall below a safe level. Oxygen saturation rate must be at 97%. The minimum amount of oxygen delivered through the resident's trach (FiO2) was 28%. If a resident needed less than 28%, then they were a candidate for weaning off the oxygen.

On 04/2/12 at 2:48 pm the Respiratory Therapy Director was interviewed. He indicated there was no policy for monitoring oxygen dependent trach residents. The respiratory therapist checked heart rate, oxygen saturation rate, and respiratory rate and the breathing pattern every 6 hours. Any oxygen saturation rate below 87% is considered critical. 71% is an immediate response issue.

The medical director was interviewed on 03/29/12 at 8:57 am. The medical director stated, "The nurses call when they want a sitter. A patient needs a sitter if they exhibit danger to themselves. Unfortunately she was sitting up in the chair and when it was pulled out, her positioning could have been such that, (indicating chin to chest) the airway became blocked. There was 14 minutes between periods when she was checked by the staff. She was being seen by a psychiatrist, for her behaviors of wanting to get out of bed. She was not depressed" During an interview on 4/2/12 at 3:05 pm the medical director indicated, the nursing staff "should contact me, when (Resident #1) exhibited a different pattern or a significant change in behavior."

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During an interview on 04/01/12 at 2:13 pm, RT #1 indicated a new respiratory sheet was initiated for every trach resident at midnight every day. The sheets were kept at the bedside for 24 hours. At the end of the 24 hours, the sheets were consolidated in the daily note chart in the respiratory therapy room. They were kept in the respiratory therapy room in a large note book for respiratory therapy to refer to.

During an interview on 04/01/12 at 2:16 pm, nurse #8 stated the respiratory sheets were filed in the resident's chart on Sunday morning by the Saturday night shift respiratory therapy staff.

During an interview on 03/31/12 at 12:45 pm nurse #8 indicated nursing and the respiratory therapist needed to have better way of communication. The nurse said nurses didn't have access to the respiratory therapist reports (the daily sheets. Upon reviewing the respiratory notes about the 9 disconnections, nurse #8 indicated the therapist should have shared that information with the nurse on duty. The nurse said that If some one was on a trach collar they should be on a continuous pulse ox. It would alarm if the oxygen sat had dropped. That would be the only way to monitor. We have alarm for the vent and nothing for the trach collar.

During an interview on 04/03/12 at 11:31 am, with the staff coordinator, she indicated staffing was always 4 aides and 3 nurses (either RN or LPN), on the first and second shift. On the third shift (11p-7am) 2 nurses and 2 aides were scheduled to work. The nurses worked 8 hour shifts and the aides worked 7.5 hour shifts. The number of

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F 353	When a resident is accoordinator will look fe staff on duty on the 4th be sitters for agitated supervisor would call and sit with an agitated -7am shift it was very staff coordinator state 400 hall, and that wouthe 400 hall, and that wouthe 400 hall. If it was needs a sitter then on not stay in the room of coordinator said that it staffing schedule. So sitters per week. One would have to sit with to be on one-to-one, for the MSU but it will up if I have to add a siden 483.30(a) SUFFICIEN PER CARE PLANS The facility must have provide nursing and remaintain the highest pand psychosocial well determined by resider individual plans of car. The facility must provinumbers of each of the personnel on a 24-hot care to all residents in care plans:	day on the MSU was 4.3. initated the staffing or a sitter. Sometimes, the 20 Hall were reassigned to residents. Otherwise, the someone to come on duty and resident. On the 11pm hard to get a sitter. The d, "We would pull from the ald cause a staff shortage on more than one resident who e person will rotated and ontinuously. The staff he sitters are added to the me times we have two person from the 400 hall however many people need We keep the PPD at 4.39 go below it and it may go itter." IT 24-HR NURSING STAFF sufficient nursing staff to elated services to attain or practicable physical, mental, being of each resident, as at assessments and e. de services by sufficient e following types of ur basis to provide nursing accordance with resident ander paragraph (c) of this	F 35	F 353 1. Resident #1 was discharge facility on March 20, 2012. An was conducted, led by the Dir Nursing (DON). The investiga but was not limited to; facts so the incident involving Residen processes for communication changes in condition to the processes for Medical Directors, nursing, and the IDT, review of the res	n investigation rector of ation included urrounding at #1, facility of resident hysician and/respiratory sident's evidence of anulation. The ations of the directed at approvement esiding in the Resident #1 actions nurse would nof the an order for an order for ey other fedical	5/7/12

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F 353	Continued From page 60 personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.			35	nurse complete an SBAR (Situation SBAR)	rance nt the on the e 24 hour I be given em		
	This REQUIREMENT by: Based on record revifacility staff, the physistherapists, the facility staffing to monitor and residents with agitatic decannulated herself failed to provide one-ordered by the physic agitated and trying to evident in 2 of 5 resident #1 removed critical oxygen satural was notified of the important of the important of the important present and ongoing.			resident's progress. The resident would remain on the 24 hour report until his/her condition improved. As the resident's condition improved, or declined, the IDT would make recommendations to the physician or Medical Director to modify or discontinue one-to-one supervision for the resident and place the resident on Resident Monitoring. Resident #2 was discharged from the facility on March 28, 2012 and was readmitted on March 30, 2012. Following readmission Resident #2, ventilator dependent at night, upon readmission was provided a new tracheostomy collar and was observed for behaviors. Resident # 2 did not exhibit any "at risk" or "emergent" behaviors. Resident #2 has had orders obtained and implemented for continuous pulse oximetry, anti-disconnect device at night, and Resident Monitoring which continues at this time.				
	1. Cross referencing to tag F 157. Based on record reviews and interviews with facility staff, the physician, and respiratory therapists, the facility failed to notify the physician of a resident decannulating the tracheostomy (trach) tube and disconnecting the ventilator 9 times in the same night (Resident #1). The facility failed to notify the physician about discontinuing the one-on-one supervision of a ventilator dependent resident				2. Residents on the Medical Spec (MSU) have the potential to be aft the same alleged deficient practic on a review of the North Carolina home licensing regulations as it reventilator dependent residents an review of the facility's direct care in for the weeks of the incidents iden	ected by e based nursing elates to d a nursing		

who was attempting to get out of bed (Resident

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- #2). This was evident in 2 of 5 residents with tracheotomies.
- 2. Cross referencing to tag F 323. Based on record reviews and interviews with facility staff, the physician and respiratory therapists, the facility failed to implement interventions for two of five oxygen dependent tracheostomy residents (Resident #1 and #2) who both had agitation. Resident #1 removed her tracheostomy and died. Resident #2 was sent out to the hospital for increased agitation and shortness of breath.
- 3. Cross referencing to tag F 328. Based on record reviews and interviews with facility staff, the physician, and respiratory therapists, the facility failed to provide an effective monitoring system to alert staff to tracheostomy residents' lack of airway patency and loss of oxygen supply resulting in one of five oxygen dependent residents decannulating herself and expiring (Resident #1).

3. Systemic Changes include(a) New Direct Care Staffing Levels-the facility has increased their daily staffing ratios on the MSU to meet the state requirement of 5.5 hours per patient day, including RN coverage for each shift. The increased staffing ratios will continue for a minimum of 30 days for the entire MSU, though nonventilator residents also reside on the unit. The facility will review staffing again after 30 days and make adjustments to maintain a 5.5 hours per tracheostomy resident day (ventilator and non-ventilator dependent) and an adequate level of staffing for all residents on the MSU that do not have a tracheostomy. Individuals who are performing one-to-one resident supervision and the Resident Monitor for each shift are not included in the daily direct care nursing hours when scheduling or confirming the direct care nursing staff for each shift. (b) The facility has 3 (three) back-up plans to ensure the level of direct care staff on the each shift on the MSU is maintained. In the event additional direct care nursing staff is needed for a shift on the MSU, the Staffing Coordinator (Monday through Friday for the afternoon shift) or the House Supervisor (morning, night and weekend shifts) will contact the following in the order given; (1) MSU staff not scheduled to work that shift; (2) staffing agencies (the facility has existing agreements with such agencies) and if unable to locate staff by one of these two methods, the on-call management nurse will be called in to staff that shift. The on-call management nurses include the DON, the Facility Educator, the House Supervisors and the Unit Managers. To the extent staffing agency personnel are utilized to maintain the staffing levels on the MSU, such personnel will receive

training on general facility orientation, MSU, and 1)The new policy titled "Status Changes: Notification of". 2) The Why, How, and When of the SBAR tool 3)The 24 hour report process 4)Clinical Communication process 5)Physician Log process 6)Pulse Oximeter 7)Resident Monitoring, including new admissions. 8)One-to-One Supervision 9)Antidisconnect devices/trach tie 11) At risk vs. Emergent behavior and appropriate staff actions when identified. 12)Resident decannulation 13)Staffing MSU for direct care, One-to-One, and Resident monitor. The training for agency personnel will be provided by the Facility Educator, Director of Respiratory Therapy, the DON and/or the House Supervisor at the beginning of the first shift scheduled to work on the MSU if training has not already been completed. (c) New One-to-one resident supervision staffing plan, policy and oneto-one form has been implemented. Oneto-one resident supervision is ordered by the attending physician or the Medical Director to provide continuous supervision to residents exhibiting emergent behaviors that constitute a risk to their continued safety. In one-to-one resident supervision, a person remains at the bedside on a continuous basis until an order to modify or discontinue one-to-one supervision is written by the physician or Medical Director. In situations where a tracheostomy resident displays 'emergent" behaviors that put the resident at risk for decannulation, the licensed nurses on the MSU are authorized to institute one-to-one supervision, in addition to any other appropriate interventions, followed by a call to a Medical Director to inform him/her of the new or escalated behavior and to

obtain an order for one-to-one supervision. "Emergent" behaviors that indicate the need for one-to-one supervision are overt behaviors that pose an immediate threat to the integrity and stability of the resident's tracheostomy tube (such as pulling at the tracheostomy tube, or climbing or attempting to climb out of bed) in addition to other behaviors that indicate the resident is at risk for decannulation such as verbalization of respiratory difficulty or distress, objective and subjective signs of distress/pain, heart rate elevation to abnormal levels for that resident, oxygen saturation levels below 85% and resident handling or pulling at the tracheostomy. One-to-one supervision will be provided by a licensed nurse, C.N.A. or RT who will not be counted in the direct care nursing hours for the MSU. In emergent situations, oneto-one supervision will be performed by personnel available at the facility when the need is identified until another licensed nurse, C.N.A. or RT can be called in to provide such supervision. For subsequent shifts, a C.N.A. will be scheduled to provide the one-to-one supervision. In the event additional one-to-one staff are needed for a shift (or a person scheduled for to provide such supervision does not report as scheduled) the Staffing Coordinator (Monday through Friday for the afternoon shift) or the House Supervisor (morning, night and weekend shifts) will contact the following in the order given; (1) MSU staff not scheduled to work that shift; (2) staffing agencies (the facility has existing agreements with such agencies) and if unable to locate staff by one of these two methods, the on-call management nurse will be called in to staff that shift. The on-call management nurses

include the DON, the Facility Educator, the House Supervisors and the Unit Managers. One-to-one supervision will continue until the physician deems the resident's emergent behavior has improved to the point that such supervision is no longer required or such supervision can be modified and the physician writes an order for discontinuation or modification of such supervision. The physician or Medical Director is responsible for making the determination of whether modification or discontinuation of continuous one-to-one supervision is clinically appropriate, based on review of the resident's condition and the one-to-one supervision documentation forms. If a physician or Medical Director orders modification of one-to-one supervision, he / she will write a specific order, indicating the time period(s) that continuous one-to-one monitoring must be provided. In those situations, the physician or medical director will also write an order for continuous Resident Monitoring during the times the resident does not have oneto-one supervision. Any orders for modification or discontinuation or one-toone supervision (and associated orders for Resident Monitoring) will be noted on the 24 hour report (in the designated area associated with that resident's name) by the charge nurse. (d) New Position Created-Resident Monitor. The Resident Monitor position provides a solely dedicated staff member on each shift to perform continuous regularly scheduled (15 minute intervals) rounds on all nonventilator dependent tracheostomy residents (include all tracheostomy residents that do not require 24 hour ventilation support) exhibiting new or escalating "at risk" behaviors and ventilator

dependent tracheostomy residents exhibiting at risk behaviors. Non-ventilator tracheostomy residents were placed on continuous Resident Monitoring, "At risk behaviors include, but are not limited to, restlessness, emotional distress, or cognitive changes resulting in confusion, weeping or objective or subjective signs of pain or discomfort. Unlike "emergent" behaviors, a resident with "at risk" behaviors does not exhibit overt behaviors that pose an immediate threat to the integrity and stability of the resident's tracheostomy tube (such as pulling at tracheostomy tube or climbing, or attempting to climb out of bed). The Resident Monitors performing this monitoring are dedicated to support resident safety and well-being through direct observation and interaction on an assigned shift. Prior to performing this monitoring, each Resident Monitor received specific training described below. Resident Monitoring is order for a resident by one of the attending physicians or the Medical Director. In situations where a resident exhibits new 'at risk" behaviors, the licensed nurses are authorized to institute Resident Monitoring, followed by a call to a Medical Director to inform him/her of the new "at risk" behavior and to obtain an order for Resident Monitoring. The Resident Monitor will document the monitoring he/she performs on residentspecific Resident Monitoring check sheets. During the monitoring performed at 15 minute intervals, the Resident Monitor checks the tracheostomy collar to verify that the collar is properly secured and the pulse oximeter if turned on and properly placed. In addition, the Resident Monitors have been trained to observe for any

changes in the tracheostomy resident's behavior that may indicate the resident is exhibiting emergent behaviors. If a Resident Monitor observes a tracheostomy resident with emergent behaviors, the Resident Monitor will remain with the resident and notify the nurse via the nurse call system or RT of the emergent behaviors. The nurse or RT will evaluate the resident and take appropriate action. The tracheostomy resident's primary C.N.A. will take the Resident Monitors place at the bedside as soon as possible and will remain with the resident while the Resident Monitor resumes his/her duties. The resident's physician will be informed by the nurse when emergent behaviors are identified or when escalated at risk behaviors are not lessened or relieved by the interventions initiated by the nurse or respiratory therapist. The Resident Monitor is not calculated in the direct care hours on the MSU. (e) The IDT performs a weekly review of all MSU residents that have been placed on Resident Monitoring. The IDT will make recommendations to the physician regarding discontinuing of Resident Monitor when the resident is no longer exhibiting at risk behavior. The physician then assesses the resident and determines whether discontinuation of Resident Monitoring is appropriate. (f) Monitoring of Direct Care Nursing Staffing Levels and One-to-one supervision (New). To ensure that direct care staffing levels are maintained and that a sufficient number of one-to-one supervisors are present for all residents for whom such supervision is ordered, the facility has implemented monitoring at the beginning of every shift. At the onset of each shift in the MSÚ, Monday through Friday, the charge

nurse calls the DON or ADON to inform them of the direct care nursing levels, verify a registered nurse is included in the shift's staffing on the MSU, and to confirm that in addition to the direct care nursing staff, an adequate number of one-to-one supervisors are present to meet the needs of the residents. During weekend hours the Weekend Supervisor performs the same function for every shift. In the event direct care nursing levels are below those scheduled and/or needed the DON or Weekend Supervisor will begin the back-up plan described above. The process for calling in additional direct care nursing staff and the phone numbers for MSU direct care nursing staff are maintained in the staffing book on the MSU. In addition, the facility's Administrator will review staffing levels for the prior day(s) on a daily basis, Monday through Friday.

Beginning April 26, 2012 re-education, with a new curriculum, will be completed with nurses and respiratory therapists working on MSU on:

- 1)The new policy titled "Status Changes: Notification of".
- 2)The Why, How, and When of the SBAR tool
- 3)The 24 hour report process
- 4) Clinical Communication process
- 5)Physician Log process
- 6)Pulse Oximeter
- 7)Resident Monitoring, including new admissions.
- 8)One-to-One Supervision
- 9)Anti-disconnect devices/trach tie
- 11) At risk vs. Emergent behavior and appropriate staff actions when identified.
- 12)Resident decannulation
- 13)Staffing MSU for direct care, One-to-One, and Resident monitor.

Licensed nurses and Respiratory Therapists working on the MSU that have not received the above training and education by May 7, 2012 will not be permitted to work until such re-education has been completed. Education and/or training will be provided at the beginning of their next scheduled shift, prior to providing resident care. The training will be provided by the MSU Unit Manager, House Supervisor, and/or DON at the beginning of each shift for persons that have not received the training, including agency staff. The above described training will be incorporated into the new hire orientation. New hires will not be permitted to provide resident care on the MSU until the training is completed.

Beginning April 25, 2012 re-education, with a new curriculum, will be completed with Certified Nursing Assistants (CNA) on: 1)Resident Monitoring, including new admissions.

2)One-to-One Supervision 3)At risk vs Emergent behavior and appropriate staff actions when identified. 4) Pulse oximeter observations 5)Resident decannulation working on the MSU that have not received the above training and education by May 7, 2012 will not be permitted to work until such re-education has been completed. Education and/or training will be provided at the beginning of their next scheduled shift, prior to providing resident care. The training will be provided by the MSU Unit Manager, House Supervisor, and/or DON at the beginning of each shift for persons that have not received the training, including agency staff. The above described training will be incorporated into the new hire orientation. New hires will not

be permitted to provide resident care on the MSU until the training is completed. In addition to the above listed training the contracted Respiratory Therapist with IDT involvement began a didactic training course for MSU nurses that consists of 18 hours of training followed by competency testing on care of a ventilator patient. This training is being conducted a minimum of monthly for 6 months.

4. The facility has developed and implemented new audit processes to access the effectiveness of the above plan related to supervision of residents with tracheostomies. (a) On a daily basis, the DON, Assistant Director of Nursing (ADON), MSU manager, or House Supervisor will review the 24 hour reports from the MSU to verify appropriate information is being communicated shift to shift and that respiratory therapy and nursing are collaboratively reporting changes in resident condition and incidents via the 24 hour report. (b) On a daily basis, the DON, Assistant Director of Nursing (ADON), MSU Manager, or House Supervisor will review the 24 hour reports from the MSU to verify that an SBAR form has been completed appropriately for each item entered.

(c) On a daily basis, the DON, Assistant Director of Nursing (ADON), MSU Manager, or House Supervisor will observe shift to shift report to verify that information from the 24 hour report is being communicated to the on-coming shift nurse by the off-going nurse, (d) On a daily basis, the DON, Assistant Director of Nursing (ADON), MSU manager or House Supervisor will verify that the Pulse oximeters and resident monitor (15 minute check) documentation on the MAR has

Division o	f Health Service Regu	lation				m-p-1-202-1-2000-1-2	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES		(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBI		(X2) MULTIPLE CONSTRUCTION A BUILDING B WING		(X3) DATE SURVEY COMPLETED	
		NH0428				04/0	3/2012
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L 183	.3003(3) VENTILATO	R DEPENDENCE		L 183		•	, 1
	staffing ratios establis Subchapter shall not services for patients of long-term care. The restaff shall be 5.5 hour on a per shift basis as appropriately meet the required that regardle census, the direct carbelow a registered many time during a 24-Based on observation interviews, the facility nursing staff was ass specialty unit MSU (Vaudited and lacked 2 coverage 3 of 4 days	cordance with ction. as evidenced by: t care nursing personne shed in Rule .2303 of to be applied to nursing who require brain injury minimum direct care nursing per patient day, allows the facility chooses, the patients' needs. It is a per patients' needs. It is a per patient of the patie	rsing cated to also ent tot fall at taff ent tags ee		1.No resident was named in this 2. Residents on the Medical Spe (MSU) have the potential to be a the same alleged deficient praction a review of the North Carolina home licensing regulations as it ventilator dependent residents a review of the facility's direct care for the weeks of the incidents ide 3. Systemic Changes include(a) Direct Care Staffing Levels-the frincreased their daily staffing ratio MSU to meet the state requirement hours per patient day, including a coverage for each shift. The increatifing ratios will continue for a serior of 30 days for the entire MSU, the ventilator residents also reside on The facility will review staffing agong 30 days and make adjustments to a 5.5 hours per tracheostomy residents on the MSU that do not tracheostomy. Individuals who as performing one-to-one residents.	5/1/12	
	the MSU (vent unit) of 3/19/12 revealed: No Registered Nurse	lated 3/16/12 through worked on the MSU uit, 2nd shift and 3rd s	nit ;		and the Resident Monitor for each not included in the daily direct cathours when scheduling or confirm direct care nursing staff for each The facility has 3 (three) back-up	th shift are are nursing ming the shift. (b)	
	3/17/12, 7:00am-7:00 No Registered Nurse 3/18/12, 7:00am-3:00 No Registered Nurse 3/19/12 4:00pm-7:00	worked on the MSU un Opm. e worked on the MSU u am.	nit :		ensure the level of direct care state each shift on the MSU is maintal event additional direct care nursi needed for a shift on the MSU, the	ned. In the ng staff is	
	The patient census/P	PD (per patient day) w	ao				

Division of Health Service Regulation

TITLE

(X6) DATE

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 04/03/2012 NH0428 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3830 BLUE RIDGE ROAD **BLUE RIDGE HEALTH CARE CENTER** RALEIGH, NC 27612 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ١D (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR USC IDENTIFYING INFORMATION) TAG ŧΛG DEFICIENCY) L 183 L 183 Continued From page 1 Coordinator (Monday through Friday for the afternoon shift) or the House follows: Supervisor (morning, night and weekend 3/16/12 30 residents, actual hours of direct care shifts) will contact the following in the order staff: 137.75 = 4.59 PPD given; (1) MSU staff not scheduled to work 3/17/12 32 residents actual hours of direct care that shift; (2) staffing agencies (the facility staff: 148.25 = 4.6 PPD has existing agreements with such 3/18/12 32 residents actual hours of direct care agencies) and if unable to locate staff by staff: 156.75 = 4.89 PPD one of these two methods, the on-call 3/19/12 39 residents actual hours of direct care management nurse will be called in to staff staff: 154 = 4.81 PPD that shift. The on-call management nurses During an interview on 3/31/12 at 5:36 pm, Nurse include the DON, the Facility Educator, the #11 worked on 3/16/12, from 7:00 pm-11:00 pm, House Supervisors and the Unit Managers. as the team leader she indicated, an LPN To the extent staffing agency personnel (licensed practical nurse) who was assigned and are utilized to maintain the staffing levels worked as a 24 hour supervisor were referred to on the MSU, such personnel will receive training on general facility orientation. as a "team leader" not as a supervisor. During an interview on 4/2/12 at 5:03 pm, the MSU, and 1)The new policy titled "Status Changes: Notification of". 2) The Why, Director of Nursing indicated, the facility How, and When of the SBAR tool 3)The 24 calculated the unit manager or the charge nurse hour report process 4)Clinical as part of the direct care staff. This nurse did not Communication process 5) Physician Log have a direct care assignment. She indicated the process 6)Pulse Oximeter 7)Resident nurse may do direct care at some point, and gave Monitoring, including new admissions. the example performing an assessment. 8)One-to-One Supervision 9)Antidisconnect devices/trach tie 11) At risk vs. During an interview on 4/3/12 at 9:27 am, the Emergent behavior and appropriate staff Director of Nursing indicated, on MSU (vent unit) actions when identified, 12) Resident the staffing was as follows, 1st shift (7 am-3 pm) decannulation 13)Staffing MSU for direct had 3 nurses and 4 aides, on 2nd shift (3 pm-11 care, One-to-One, and Resident monitor. pm) had 3 nurses and 4 aides, and 3rd shift The training for agency personnel will be (11pm-7am) had 2 nurses and 2 aides. Nurses provided by the Facility Educator, Director work 8 hours and aides work 7.5 hours. Eight of Respiratory Therapy, the DON and/or nurses a day work 8 hours and 10 aides a day the House Supervisor at the beginning of work 7.5 hours. When asked what was the ratio the first shift scheduled to work on the MSU if training has not already been for the vent unit, she replied, "I do not know, the completed. (c) New One-to-one resident staffing coordinator does it." supervision staffing plan, policy and one-

During an interview on 4/3/12 at 11:31 am, Staff

Coordinator, indicated the staff on the MSU (vent

LPN) worked 8 hours, and an RN on every shift. Four (4) aides on the 1st shift (7 am-3 pm)

unit) was as follows: 3 nurses (either RN/or

to-one form has been implemented. One-

to-one resident supervision is ordered by

Director to provide continuous supervision

the attending physician or the Medical

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Division o	f Health Service Regu	lation				FORM	IAPPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A BUILDING B WING		(X3) DATE SURVEY COMPLETED 04/03/2012		
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. L 183	4 aides worked 7.5 hd 3rd shift (11pm-7am shours and 2 aides worked out (did not contelephoned to come is staffing coordinator of the fill the absence. The calls for 2nd and 3rd day(PPD) for the MS The staffing program staffing based on the those staff positions sheet there was enough the staffing based on the those staff positions sheet there was enoughter scheduled was To provide a sitter a be used or would so asked to work. Usual on who was already 11pm-7am shift it was We would pull from the cause a staff shortage then one resident neperson would rotate a continuously. Thirty minutes in an other, hall would have to sitt need to have 1:1 supported t	nurses worked 8 hours ours on the 2nd shift. Oshift) 2 nurses worked worked 7.5 hours. When me to work), staff was n. During the week the replaced staff during 1s ne shift supervisor made shifts. The patient per U unit (vent unit) was 4 nused guided the daily census. She indicated are filled on the spreugh people to work. The counted as part of the staff who was on duty omebody was called an ly we would use someton the the hall. On the servery hard to get a sittle work as very hard to get a sittle work and not stay in the room minute in one room: 30 One person from the 4 with how ever many pervison. When the ficalculated on the PPD at 4.39 for the vental work as wellow the 4.39 PPD, if a fincreased.	On the 8 n staff s n staff s st shift de r 1.39. / I if ad ne PPD. would not one ser. ould ore m 1.000 neople acility D at unit, a sitter the ng 8	L 183	to residents exhibiting emergent be that constitute a risk to their continsafety. In one-to-one resident supera person remains at the bedside of continuous basis until an order to a discontinue one-to-one supervision written by the physician or Medical Director. In situations where a tracheostomy resident displays for behaviors that put the resident at a decannulation, the licensed nurses MSU are authorized to institute on supervision, in addition to any other appropriate interventions, followed to a Medical Director to inform him the new or escalated behavior and obtain an order for one-to-one supervision at behaviors that pose an immediate the integrity and stability of the restracheostomy tube, or climbing or attempting to climb out of bed) in a to other behaviors that indicate the is at risk for decannulation such as verbalization of respiratory difficult distress, objective and subjective a distress/pain, heart rate elevation abnormal levels for that resident, of saturation levels below 85% and rehandling or pulling at the tracheos One-to-one supervision will be proal licensed nurse, C.N.A. or RT whose counted in the direct care nursifor the MSU. In emergent situation to-one supervision will be perform personnel available at the facility who need is identified until another lice	ued ervision, n a modify or n is I mergent" isk for s on the e-to-one er I by a call wher of to ervision. e the re overt threat to sident's g at the addition e resident s y or signs of to oxygen esident tomy. ovided by no will not ing hours as, one- ed by when the ensed	
		working 7.5 hours Du fts(7am-11pm), During			nurse, C.N.A. or RT can be called provide such supervision. For sub		

3rd shift (11pm-7am) there were 2 nurses working 8 hours (RNor LPN) and 2 aides

shifts, a C.N.A. will be scheduled to

Division	of Health Service Requ	lation				FORM APPROVED	
AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB NH0428				(X3) DATE SURVEY COMPLETED	
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l. 183	RN on every shift. He aware of the 5.5 PPD ratio for the (vent unit During a telephone in pm, the Administrato period 3/29/12-4/3/12 assigned anywhere n (vent unit). There was	e expected there was a indicated he was not (state licensure) staff). Interview on 4/10/12 at 3 r indicated during the s2, the RN coverage was ot necessarily on the Mas no Registered Nurse t unit on 3/16/12, 1st	an fing 3:18 urvey s ISU (RN)	_ 183	provide the one-to-one supervision event additional one-to-one staff a needed for a shift (or a person so for to provide such supervision do report as scheduled) the Staffing Coordinator (Monday through Friethe afternoon shift) or the House Supervisor (morning, night and wishifts) will contact the following in given; (1) MSU staff not schedule that shift; (2) staffing agencies (the has existing agreements with such agencies) and if unable to locate one of these two methods, the oneone of these two methods is unable to locate one of the supervision will continue that such supervision is not required or such supervision can modification of modification of discontinuation of whether modification of discontinuation of whether modification of review of the resident's condition of the resident's condition of the resident's condition of the resident's condition of the time of the time period of the time period of the resident does not have one supervision. In those situations, the or medical director will also write for continuous Resident Monitoring the times the resident does not have one supervision. Any orders for the times the resident does not have one supervision. Any orders for the times the resident does not have one supervision. Any orders for the times the resident does not have one supervision. Any orders for the times the resident does not have one supervision.	cheduled ces not day for eekend the order do to work de facility th staff by call in to staff int nurses cator, the Managers. The until 's to the longer be an order of such dical g the ation or c-to-one te, based ion and mentation birector specific s) that g must be physician an order ng during ave one-	

modification or discontinuation or one-toone supervision (and associated orders for Resident Monitoring) will be noted on the 24 hour report (in the designated area associated with that resident's name) by the charge nurse. (d) New Position Created-Resident Monitor. The Resident Monitor position provides a solely dedicated staff member on each shift to perform continuous regularly scheduled (15 minute intervals) rounds on all nonventilator dependent tracheostomy residents (include all tracheostomy residents that do not require 24 hour ventilation support) exhibiting new or escalating "at risk" behaviors and ventilator dependent tracheostomy residents exhibiting at risk behaviors. Non-ventilator tracheostomy residents were placed on continuous Resident Monitoring, "At risk behaviors include, but are not limited to, restlessness, emotional distress, or cognitive changes resulting in confusion, weeping or objective or subjective signs of pain or discomfort. Unlike "emergent" behaviors, a resident with "at risk" behaviors does not exhibit overt behaviors that pose an immediate threat to the integrity and stability of the resident's tracheostomy tube (such as pulling at tracheostomy tube or climbing, or attempting to climb out of bed). The Resident Monitors performing this monitoring are dedicated to support resident safety and well-being through direct observation and interaction on an assigned shift. Prior to performing this monitoring, each Resident Monitor received specific training described below. Resident Monitoring is order for a resident by one of the attending physicians or the Medical Director. In situations where a

resident exhibits new 'at risk" behaviors, the licensed nurses are authorized to institute Resident Monitoring, followed by a call to a Medical Director to inform him/her of the new "at risk" behavior and to obtain an order for Resident Monitoring. The Resident Monitor will document the monitoring he/she performs on residentspecific Resident Monitoring check sheets. During the monitoring performed at 15 minute intervals, the Resident Monitor checks the tracheostomy collar to verify that the collar is properly secured and the pulse oximeter if turned on and properly placed. In addition, the Resident Monitors have been trained to observe for any changes in the tracheostomy resident's behavior that may indicate the resident is exhibiting emergent behaviors. If a Resident Monitor observes a tracheostomy resident with emergent behaviors, the Resident Monitor will remain with the resident and notify the nurse via the nurse call system or RT of the emergent behaviors. The nurse or RT will evaluate the resident and take appropriate action. The tracheostomy resident's primary C.N.A. will take the Resident Monitors place at the bedside as soon as possible and will remain with the resident while the Resident Monitor resumes his/her duties. The resident's physician will be informed by the nurse when emergent behaviors are identified or when escalated at risk behaviors are not lessened or relieved by the interventions initiated by the nurse or respiratory therapist. The Resident Monitor is not calculated in the direct care hours on the MSU. (e) The IDT performs a weekly review of all MSU residents that have been placed on Resident Monitoring. The IDT will make recommendations to the

physician regarding discontinuing of Resident Monitor when the resident is no longer exhibiting at risk behavior. The physician then assesses the resident and determines whether discontinuation of Resident Monitoring is appropriate. (f) Monitoring of Direct Care Nursing Staffing Levels and One-to-one supervision (New). To ensure that direct care staffing levels are maintained and that a sufficient number of one-to-one supervisors are present for all residents for whom such supervision is ordered, the facility has implemented monitoring at the beginning of every shift. At the onset of each shift in the MSU, Monday through Friday, the charge nurse calls the DON or ADON to inform them of the direct care nursing levels, verify a registered nurse is included in the shift's staffing on the MSU, and to confirm that in addition to the direct care nursing staff, an adequate number of one-to-one supervisors are present to meet the needs of the residents. During weekend hours the Weekend Supervisor performs the same function for every shift. In the event direct care nursing levels are below those scheduled and/or needed the DON or Weekend Supervisor will begin the back-up plan described above. The process for calling in additional direct care nursing staff and the phone numbers for MSU direct care nursing staff are maintained in the staffing book on the MSU. In addition, the facility's Administrator will review staffing levels for the prior day(s) on a daily basis, Monday through Friday. Beginning April 26, 2012 re-education, with a new curriculum, will be completed with nurses and respiratory therapists working

on MSU on:

- 1)Resident Monitoring, including new admissions.
- 2)One-to-One Supervision
- 3) At risk vs. Emergent behavior and appropriate staff actions when identified. 4)Staffing MSU for direct care, One-to-One, and Resident monitor. Licensed nurses and Respiratory Therapists working on the MSU that have not received the above training and education by May 7, 2012 will not be permitted to work until such re-education has been completed. Education and/or training will be provided at the beginning of their next scheduled shift, prior to providing resident care. The training will be provided by the MSU Unit Manager, House Supervisor, and/or DON at the beginning of each shift for persons that have not received the training, including agency staff. The above described training will be incorporated into the new hire orientation. New hires will not be permitted to provide resident care on the MSU until the training is completed.
- 4. The facility has developed and implemented new audit processes to access the effectiveness of the above plan related to supervision of residents with tracheostomies.

On a daily basis M – F the Administrator (NHA) will review the staffing sheet for the prior day(s) to verify staffing ratios and per patient day (ppd) hours are met. The daily audits will continue for 30 days and then will be completed weekly unless concerns are identified in which case daily audits will continue until a time determined by the QA & A committee.

The NHA/DON/Respiratory Therapy Director will report to the facility's Quality Assessment and Assurance (QA&A)

Committee weekly with the results of the verification review of the above identified audits. Issues identified by the NHA/DON/Respiratory therapy director as a result of these audits will be reported to the QA&A Committee within one business day. The QA&A Committee will evaluate the effectiveness of the plan on a weekly basis, for 2 months and then every two weeks for 2 months, then monthly based on trends identified and develop and implement, additional interventions as needed to ensure continued compliance. On a weekly basis the Medical Director, Administrator, DON, Respiratory therapy Director, and MSU manager will meet to review the plan and ensure there are no issues with communication. The Administrator is responsible for ongoing compliance.