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

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FORM APPROVED
OMB NO. 0938-0391

JAN 3 0 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345517	A. BUILDING ______ B. WING ______	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH CARE CENTER	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

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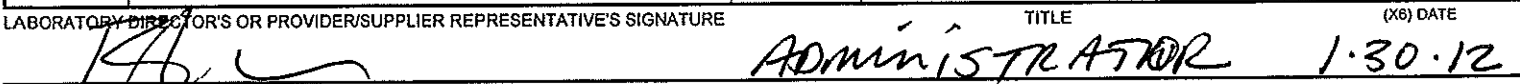
F 328 SS=J	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to maintain a secondary low pressure alarm to alert staff to ventilator changes for 1 (Resident #2) of 3 sampled ventilator dependent residents who was found unresponsive with a ventilator that was turned off. Immediate Jeopardy began on 12/29/11 at 7 PM and was identified on 1/5/12 at 12:30 PM. Immediate Jeopardy was removed on 1/6/12 at 5 PM when the facility provided a credible allegation of compliance. The facility remained out of compliance at a lower scope and severity level (D) (an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy). The facility remained out of compliance to ensure that the policies and procedures, necessary staff education, and monitoring of Secondary Low Pressure Alarms were implemented by the	F 328	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements. *F328* ***How corrective action will be accomplished for those resident(s) found to have been affected by the deficient practice;*** N/A Resident is discharged ***How corrective action will be accomplished for those resident(s) having potential to be affected by the same deficient practice;*** On 12-30-2011 audit was conducted by the Respiratory Director on all secondary low pressure alarm systems to verify that low pressure was detected. All were functioning properly. Ventilator dependent residents were assessed on 1-5-2012 by the Director of Nursing and Interdisciplinary Team for agitation which may put them at risk for altering ventilation. Care Plans for Ventilator Dependent Patients and those identified with agitation have been reviewed and updated by the Interdisciplinary team.	2-1-12 2-1-12

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



Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 328	Continued From page 1 facility. Findings include: Review of a facility policy entitled " Protocol for Management and Weaning of Patients from Prolonged Mechanical Ventilation " dated June 1, 2006, revealed in part: Documentation: 1.) " Ventilated patients will be visited and monitored every 2 hours. Ventilator settings and patient status will be documented every 4 hours during routine rounds on the Respiratory Care Record. Other patient checks in between the (every) 4 hours rounds will be documented in the appropriate section of the Respiratory Care Record. "	F 328	On 1-5-2012 Documentation for Ventilator dependent residents has been checked by the Respiratory Director to validate the documentation is compliant with the policy in relation to checking of alarms. Ventilators and back up ventilators have been inspected to verify the protective cover over the on/off switch on the machine. Any that was identified not to have the protective covering and was replaced. Low pressure alarms have been checked and tested to validate function on 12-30-2011 by the Respiratory Director.	2-1-12
	Review of a facility " Respiratory Care Record " for Resident #2, dated 12-29-11, revealed 31 areas that were to be checked during the Respiratory Therapist ' s (RT) rounds. The first documented set of rounds for Resident #2 was dated 12-29-11 at 5:45 PM. Each of the 31 areas were completed and initialed at the bottom by RT #1. The next documented set of rounds, dated 12-29-11 at 7 PM, revealed all areas were completed except the area for " Secondary Low (Pressure) Alarms. That category was left blank. The bottom of the document was initialed by RT #2. Two more sets of rounds were completed, however did not require documentation of the individual areas. The next two respiratory rounds ' checks were initialed by RT #2 at 9:03 PM and 10:55 PM. Review of a facility " Respiratory Care Record " for Resident #2 dated 12-30-11, no documented time, was completed for 9 areas, the remaining 22 areas were left blank. The " Secondary Low		***Measures that will be put into place or systemic changes made to ensure that the deficient practice will not occur;*** In-service education was initiated 12/30/11 covering the following topics: turning on low pressure alarms, checking low pressure alarms, notification of respiratory staff if alarms are not on, and the location of low pressure alarms for MSU staff. In-services were completed by 1/7/2012 by Respiratory Therapy staff/designee. In-service education was initiated 12/30/2011 with medical specialty unit (MSU) respiratory and nursing staff on symptoms of agitation for MSU resident, i.e. what to look for, what to do and who to notify. In-services were completed by 1/7/2012 by Respiratory Therapy staff/designee.	2-1-12

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F 328	Continued From page 2 (Pressure) Alarm " was one of the categories that were left blank. There was no time or initials by a RT documented for the entry. During an observation of the physical plant on an initial tour of the facility 1-4-12 at 9 AM, revealed the 100 and 200 halls were at right angles to each other and the nurse desk was on the corner where the halls joined. The secondary low pressure alarms for all ventilator dependent residents were located in the resident ' s rooms near the ventilators and an additional alarm was located outside each room above the doorway to alert staff in the event the resident ' s room door was closed and the alarms was sounding. An observation of the secondary low pressure alarm for rooms 104, Resident #2 ' s room, and room 105 were located on the wall opposite the nurses ' desk. During an interview with the Director of Respiratory Care on 1-4-12 at 1:31 PM, the Director reported the secondary alarm for Room 104, the resident ' s room, was located outside the room on a wall in front of the nurses' station because of the distance of the room from the nurses ' desk. The Director stated the alarms for those rooms would be better heard by staff than if located in the resident ' s room. During an observation of a ventilator unit on 1-5-11 at 9 AM, revealed the unit measured 9.5 inches wide by 12.25 inches high. The unit was 10.25 inches deep and the unit rested on a pole 39 inches from the floor. The pole was attached to a rolling base that measured 25.5 inches wide. On the back of the ventilator was the on/off button for the unit. The on/off button was green and measured .5 by .5 inches wide. The on/off button was located 5 inches from the top of the unit and	F 328	Directed In-service education will be completed for MSU respiratory and nursing staff on monitoring and doing routine checks on the functionality of ventilators to include primary and secondary alarms, and effective interventions and monitoring of agitated residents. This education is being conducted by the Respiratory therapist from Rex hospital and will be completed by 2/1/2012. Employees will be audited against a current working roster. In-service education will be completed for Respiratory therapists on documentation requirements and frequency of checks by the Respiratory Director/designee by 2/1/2012. Employees will be audited against a current working roster. In-service education outlined in this plan is being provided by Facility Educator/designee for new employees during new hire orientation by 2/1/2012. New hire direct care staff for MSU will receive in-services on agitation and low pressure alarms. Education not completed by 2/1/2012 for respiratory and nursing staff presenting to work on the MSU unit will be in-serviced by the Respiratory Therapy Director/facility educator/designee prior to shift period. A list of signs, interventions and monitoring of agitation is located at the MSU unit nursing station for staff reference. It is the process of the facility that new admissions on ventilators are checked and cosigned by a second respiratory therapist or Nurse once admission set up is completed.	2-1-12

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F 328	Continued From page 3 1.5 inches from the right side of the unit. On the front of the unit on the ventilator tubing near the filter connection to the unit, was a connection for the Secondary Low Pressure Alarm tubing. Review of a statement by the Respiratory Director, dated 12-30-11 at 1:51 PM, revealed " The vents (ventilators) have internal alarms and one external alarm. The internal alarms monitor oxygen concentrations, rate, minute volume and pressures. They can be set to parameters that suit the patient ' s needs and the ventilator will alarm if those needs are no met or are exceeded. The external alarm is a low pressure alarm which has a remote outside of the patient ' s rooms in order to be heard in the hallways in the event that the doors are closed. Low pressure alarms are triggered when the pressure in the ventilator circuit does not exceed the set low pressure. Examples of this is when the patient becomes disconnected from the vent or the vent fails to generate the needed pressure to deliver a set volume. Review of the resident ' s medical record revealed the resident was admitted to the facility on 12-29-11. Review of the hospital Transfer Summary revealed discharge diagnoses as: ventilator dependent respiratory failure, bilateral pneumonia involving both lung fields primarily in the lung bases, status-post left bleb (blister) rupture and pneumothorax (collapsed lung)prior to admission, and paraparesis (partial paralysis especially of the lower extremities). Review of the nurse notes revealed a note documented on 12-29-11 at 11 PM, that indicated the resident arrived at the facility at 5:15 PM. The	F 328	Daily, Monday-Friday the DON or designee along with Unit Managers will meet and discuss ventilator dependant behavior, such as restlessness or agitation, and will be reviewed and discussed by the Interdisciplinary Team. Care Plan updates and interventions will be determined based on individualized case by case assessment. *How the facility plans to monitor its performance to make sure that solutions are sustained. Plan to ensure for ensuring that the correction is achieved and sustained. How implementation of the corrective action is evaluated for its effectiveness, and integration into the quality assurance system of the facility.* An audit is being conducted weekly on low pressure alarm function by the Respiratory therapist/designee. An audit is being conducted weekly on documentation for ventilator dependant residents of every 2, 4, and 6 hour checks by the Respiratory therapist/designee. A weekly audit of the power and functional status of each ventilator is being conducted by a Respiratory therapist/ designee. A weekly audit of ventilator dependant new admission will be completed by the Respiratory Director/designee to verify that a cosigner validated the ventilator set up upon admission. The results of the audits, trending and analysis will be presented to the Quality Assurance committee monthly for 3 months and then quarterly thereafter.	2-1-12

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F 328	Continued From page 4 resident was documented as alert and oriented, lung sounds were clear to auscultation. The note further documented that earlier in the shift, the resident was noted banging on the ventilator machine and turned the machine backwards facing him. During a telephone interview with NA (nursing assistant) #1 on 1-5-12 at 10:08 AM, the NA reported she worked with the resident on 12-29-11 on the 3 PM to 11 PM shift, and saw the resident pulling the tubing to the ventilator which pulled the ventilator closer to him. NA #1 stated she provided incontinent care to the resident on her last rounds at 10:30 PM and the resident was calm at that time. A nurse note written by Nurse #1 of 12-29-11 at 11:30 PM revealed the resident was alert and responsive, and the ventilator was in place. The note reported the resident was not able to sleep and Ambien (sedative/hypnotic) was administered without any positive effect. The note documented the resident was noted banging the ventilator and grabbing the tube feeding pump A nurse note written by Nurse # 1 of 12-30-11 at 1 AM revealed Ativan 0.5 ml (1 milligram) was administered for increased anxiety. The note indicated a nursing assistant (NA) reported the resident was banging the ventilator. During a telephone interview with NA #2 on 1-5-12 at 11:28 AM, the NA reported she worked with the resident on 12-29-11 on the 11 PM to 7 AM shift, and stated the resident was confused and agitated during her shift. NA #2 described the resident's behaviors as pulling the ventilator toward him, pulling at the feeding tube and Intra-Venous (IV) lines. The NA stated she checked on him frequently because of these	F 328		

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F 328	Continued From page 5 behaviors and moved the ventilator away from the resident on 2 to 3 occasions. The NA stated the nurse gave him something, because the last time she checked on him between 1:30 AM and 1:45 AM, the resident had calmed down and she provided incontinent care to the resident at that time. The next nurse note, written by Nurse #1, was documented 12-30-11 at 2:30 AM, which revealed the resident was found unresponsive and the ventilator was " pulled off " . The note further documented Cardio Pulmonary Resuscitation was initiated, EMS (Emergency Management System) was called, and the resident was transferred at 2:45 AM to the Emergency Room for further evaluation. During an interview with Nurse #1 at 11:15 am on 1-6-11, the nurse stated she worked with the resident on the 11 PM to 7 AM shift beginning 12-29-11. The nurse stated she made rounds at the beginning of her shift at 11 PM, and stated the resident had the ventilator running, an IV infusing, and a tube feeding running. The nurse stated the resident was calm at that time. The nurse reported at 11:30 PM, she checked on the resident and he was awake. The nurse stated she asked the resident if he was in pain, or if he needed something to help him sleep. The nurse stated the resident nodded his head "yes" for something to help him sleep. The nurse stated she checked the resident's medications orders and then administered an Ambien tablet at about 12:30 AM. The nurse stated NA #2 reported to her that the resident was banging his hand on his equipment, so she went to see the resident. The nurse stated she asked him again if he was in	F 328		

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F 328	Continued From page 6 pain, did he need something for anxiety. The nurse reported the resident nodded "yes" to something for anxiety. The nurse said she checked the resident's medication orders and administered Ativan at about 1 AM. The nurse stated the last time she checked on him was about 1:30 AM and the resident was resting calmly in bed with his arms stretched out into the air in front of him, not near any equipment. The nurse stated shortly after her last check, she heard the Nursing Supervisor calling a " code ", meaning she needed help. Nurse #1 stated when she heard the call for help, she went for the crash cart to take to the resident ' s room. The nurse stated there were many staff in the room and she saw the RT provide manual ventilation to the resident ' s airway and some one else providing chest compressions. The nurse stated she was unaware of any problems with the resident until she heard the Supervisor call for help. Review of Medication Administration Record (MAR) revealed the resident was administered a dose of Klonopin (sedative, anti-anxiety medication) and Remeron (antidepressant) scheduled to be given at 9 PM per physician ' s orders. The medications were signed of by as given. Further documentation on the MAR revealed Ambien was given at 11:30 PM for insomnia, and Ativan (anti-anxiety medication) was given at 12:30 AM on 12-30-11 for increased anxiety. Review of a written statement by the 11 PM to 7 AM Nursing Supervisor dated 1-2-12, revealed she was walking down the 100 hall at approximately 2:15 AM, when she heard the RT #2 say " what ' s going on? The vent is off, I	F 328		

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F 328	Continued From page 7 need help " . The statement further documented RT #2 " explained that he found the patient with the ventilator turned off and facing him (the resident) " . The statement documented after the resident was transferred to the hospital, RT #2 stated he " observed the resident pulling on his ventilator " . Review of a statement, dated 1-2-12, by RT #3 who was also on duty 7 PM to 7 AM beginning 12-29-11, revealed the RT entered the resident ' s room while CPR was in progress. The statement indicated RT #3 assisted with CPR by suctioning the resident ' s mouth. During the activities of CPR, RT #3 ' s statement documented RT #2 reported he walked into the resident ' s room and the ventilator was off, but the circuit was still attached to the resident. RT #3 ' s statement indicated RT #2 asked how he hear any alarms if the resident ' s vent was turned off . RT #3 explained even if a vent was off, the back up alarm (Secondary Low Pressure Alarm) would have been beeping. The statement further documented RT #3 looked at the resident ' s ventilator and the pressure line/adapter was in place. RT #3 went to the back up alarm and it was off through the night. During an interview with the Director of Respiratory Care on 1-4-12 at 1:31 PM, the Director reported when a Respiratory Therapist (RT) initiated ventilation therapy for a resident, that RT was also responsible for turning on the secondary low pressure alarm. Once the alarms were set, a ventilator check was done every 6 hours and a walk through was done every 2 hours. The Director stated the 2 hour checks included the same areas that were reviewed with	F 328		

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F 328	Continued From page 8 each walk through, but the only documentation that was done was the RT's initial's and time the system was checked. The Director stated, in the case for the Secondary Low Pressure Alarm for Resident #2, the RT' still had to walk past the secondary alarm located on the wall facing the nurse station throughout the shift and could have looked up at it at any time to see that it was on. The Director reported RT #2 was honest and reported he did not document he checked the secondary alarm on the 7 PM hour check. The Director stated even though the RT signed the 2 hours checks as having been completed, he didn't do the Secondary Low Pressure Alarm checks at all since 7 PM. The Director stated the Secondary Low Pressure Alarm check were the most part of the 2-hour checks because it alerted staff to a problem with a ventilator. During the continued interview with the Respiratory Director, the Director stated when the ventilator power was " cut off " , the ventilator ' s internal alarm would not sound. He reported that was why they had the secondary alarm. The Director reported there was no way of knowing when the secondary alarm was turned off for Resident #2 or if the Secondary Low Pressure Alarm had a mechanical problem. The Director stated the Secondary Low Pressure Alarms were battery run and alarmed when the battery got low to alert staff the battery needed replaced. The ventilator used by the resident used was a rental unit. The Director provided a ventilator " Preventive Maintenance " report completed by the rental company for the resident ' s machine when it was delivered. Review of the document, dated 12-2-11 revealed the unit passed all of the 28 tested areas.	F 328		

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During a telephone interview with RT #1 on 1-5-12 at 9:56 AM, the RT reported she assisted the transport team to transfer the resident into the bed on his arrival to the facility on 12-29-11, then she connected him to the ventilator, and checked everything on the machine after set-up. The RT stated she then went out to the nurses ' station and made sure the Secondary Low Pressure Alarm was turned on. The RT stated her responsibilities to ventilator dependent residents was to check them every 2 hours to assure the ventilators worked properly and the Secondary Low Pressure Alarms were turned on.

Review of a statement written by RT #2, dated 1-1-12, revealed the resident was found unresponsive a few minutes after 2 AM. The RT found Resident #2 with the ventilator completely off and the back of the machine was very close to the edge of the resident ' s bed. The RT documented he reasoned the resident might have turned the ventilator off because he had been pulling on it. The RT further documented the pressure alarm did not go off because the alarm was not turned on. The RT documented when he did his 7 PM rounds, he did not immediately spot check the Secondary Low Pressure Alarm because the alarm was not in the resident ' s room.

During an interview with RT #2 on 1-5-12 at 10:55 AM, the RT reported he was on duty 12-29-11 for his shift 7 PM to 7 AM. RT #2 went to Room 104, the resident ' s room. The RT demonstrated the ventilator in the position he found when he entered the resident's room on 12-30-11 at 2 AM when he found the resident unresponsive. During

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F 328	Continued From page 10 a further demonstration, the RT positioned the ventilator with the back of the machine against the bed, facing the resident. The RT explained the ventilator used by the resident did not have a protective covering over the on/off button. The RT reported the secondary alarm was necessary to alert staff problems with the ventilator. The RT stated he had not checked the resident ' s Secondary Low Pressure Alarm at any time during his shift (7 PM to 7 AM) to assure it was turned on because he was very busy that shift. Review of a statement by the Assistant Director of Respiratory Therapy dated 12-30-11, revealed RT #2 " went to perform his ventilator check, that the ventilator was very close to the patients bed and the back of the ventilator was facing the patient. The ventilator was off. The off/on switch to the ventilator is in the back of the ventilator and this vent model does not have a protective covering " . During an interview with the facility ' s Medical Director on 1-5-12 at 8:57 AM, the Director reported the resident entered the facility after 5 PM on 12-29-11. The Medical Director stated he went to see the resident the following morning but the resident left the facility to the emergency room early that morning. During an interview with the Administrator on 1-5-12 at 11:05 AM, the Administrator stated " one person didn ' t do their job completely " . The Administrator stated RT #2 did not check the secondary alarm for Resident #2. Review of a hospital Discharge Summary dated 1-2-12, revealed current diagnoses for Resident	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345517	A. BUILDING ______ B. WING ______	C 01/06/2012

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F 328	Continued From page 11 #2 as: 1) Anoxic (lack of oxygen) brain injury due to ventilator disconnection; and 5) Acute respiratory failure due to ventilator disconnection causing anoxic brain injury. The resident remained at the hospital during the survey. The Administrator provided the credible allegation of compliance on 1-6-12 at 4:55 PM. 1) Resident #2 is no longer in the facility. Resident #2 was found by facility nursing staff as unresponsive and without pulse or respirations. The immediate assessment indicated there was no cyanosis and he was warm to touch. A code was announced and CPR was immediately initiated. When EMS arrived, Resident #2 had a pulse and respirations. Resident #2 was transported to (name of hospital). The resident's ventilator machine and low pressure alarm have been removed from use. The facility conducted an immediate investigation which revealed that the low pressure alarm did not sound to indicate a problem or failure with the ventilator. 2) A 100% audit was conducted on 12/30/11 by the Assistant Respiratory Manager, on all secondary low pressure alarm systems to verify that low pressure was detected. All were functioning properly. An in-service was conducted on 12/30/11 with 30 staff members (21 Nursing Staff, 5 Respiratory Staff, and 4 Rehab staff) covering the following topics: turning on low pressure alarms, checking low pressure alarms, notification of respiratory staff if alarms are not on, and the location of low pressure alarms. In-services were conducted by the Assistant Respiratory Director and the ADON. Since 12/31/11, a daily 100% audit has been conducted	F 328		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 328	Continued From page 12 on all secondary low pressure alarms by the Respiratory Director or Designee. (The remaining) 18 of 19 ventilator dependent residents have been assessed for agitation which may put them at risk for altering ventilation. Care Plans have been reviewed and updated by IDT (Interdisciplinary Team). DON or designee has conducted in-services beginning on 12/30/11 with medical specialty unit (MSU), respiratory and nursing staff on symptoms of agitation for MSU residents, i.e. what to look for, what to do and who to notify. 100% in-servicing will be completed on respiratory and nursing staff on MSU unit by 1/7/12. Until then, all respiratory and nursing staff presenting to work on the MSU unit will be in-serviced prior to shift period. A list of signs, interventions and monitoring of agitation is located at the MSU unit nursing station. 3) All nursing staff associated with the respiratory unit will be in-serviced on purpose and placement of low pressure alarms by the DON or designee before they work on the respiratory unit. All Respiratory staff will be in-serviced on low pressure alarms before working on the respiratory unit by the Respiratory Director or designee. A daily audit will be conducted of low pressure alarms 7 times per week for 2 weeks; then, 3 times per week for 2 weeks; then once weekly for 2 weeks; then, at each time the resident is connected to ventilator by the Respiratory Therapist. Employees will not work on the respiratory unit without being in-serviced on low pressure alarms. 4) An additional daily audit of the power and functional status of each ventilator and low pressure alarm will be conducted by the	F 328		

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F 328	Continued From page 13 Respiratory Director, or designee, 7 times per week for 2 weeks; then, 3 times per week for 2 weeks; then once weekly for 2 weeks; then, at each point of connection of patient to ventilator by Respiratory Therapist. Low pressure alarm in-service on their purpose and placement will be conducted upon orientation for unit staff. All ventilators that are rented or loaned will follow the same procedure for training and auditing. 5) The results of the audits, trending and analysis will be presented to the QA committee monthly for 3 months and then quarterly thereafter. Validation of the Credible Allegation of Compliance began on 1-6-12 between the hours of 3 PM and 4:45 PM with nurses and nursing assistants on the MSU and Respiratory Therapists that indicated the staff had received in-service training. Interviews with the nursing staff and Respiratory Therapists indicated they were aware of turning on low pressure alarms, checking low pressure alarms, notification of respiratory staff if alarms are not on, and the location of low pressure alarms. Staff interviewed were also able to report on symptoms of agitation for MSU residents, i.e. what to look for, what to do and who to notify. Care Plans for ventilator dependent were reviewed for agitation as deemed appropriate. Tours were made of the Secondary Low Pressure Alarms on the MSU to determine the alarms were turned on. Audit tools and In-service records were reviewed. The Immediate Jeopardy was lifted on 1-6-12 at 5 PM.	F 328		