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 04/03/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 000	**" Preparation and/or execution of this plan 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."**	
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (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	F 157	F 157 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	5/7/12

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

TITLE: Administrator

(X6) DATE: 4/25/12

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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resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
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 who was attempting to get out of bed (Resident #2). This was evident in 2 of 5 residents with tracheotomies.

Immediate jeopardy began on 03/16/12 for Resident #1 when the resident removed her trach and resulted in a critical oxygen saturation rate. The administrator was notified of the immediate jeopardy on 04/01/12 at 12:13 pm. The immediate jeopardy is present and ongoing. Example 2 (Resident #2 lack of physician notification) 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:

Review of the policy titled, "Ventilator (vent)

F 157 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 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

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Patient with Agitation", which was not dated, indicated
"Identify: Pulling at equipment, uncontrolled moving, 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."

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.

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. She was totally dependant on staff for all of her activities of daily living. She was

F 157 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. On April 12, 2012 the facility modified its policy titled "Status Changes: Notification of ". The modification explicitly adds the following situations when the physician is to be notified: (a) Resident attempting to remove or successfully removing tracheostomy tube, (b) resident attempting to or actually turning off ventilator, (c) new, worsening or change in behavior or mental status, (d) attempts at or risk of harm to

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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

F 157 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 off-going 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.

F 157 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

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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,

F 157 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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revealed Resident #1 was still on artificial ventilation at 12:37 am (since 5:50 pm on 03/16/12). The oxygen saturation rate at that time was 98%. The trach became disconnected 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

F 157 Weekly the Administrator will report progress on the corrective action plan including any issues identified in the reviews with achieving or sustaining compliance to the governing board of the 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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been on the sheet. It was not on the sheet. I got report from (Nurse #4)." 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.

On 03/30/12 at 9:48 am, Nurse #2 was interviewed. The nurse said she worked during the 3 pm -11 pm shift on 03/17/12 as the team leader. She reported that she was not aware that Resident #1 had decannulated herself on 03/16/12. Nurse #2 said no one told her that Resident #1 had disconnected herself 9 times earlier that morning. Respiratory therapists did not report to the supervisors unless it was something such as decannulation.

The respiratory note (written by RT #3) dated 03/18/12, revealed Resident #1 was still on artificial ventilation and her oxygen saturation rate was 98% at 1:42 am. The tracheostomy became disconnected from the ventilator at 4:10 am, 6:00 am and 6:05 am. 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%.

On 03/30/12 at 4:02 pm RT #3 was interviewed. RT #3 worked with Resident #1 on 03/18/12 from 6:30pm until 7 am. 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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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."

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. 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."

On 03/30/12 at 3:15 pm Nurse #7 was interviewed. Nurse #7 stated she worked on 03/18/12 on the 3pm-11pm shift as a team leader (term used when nurse supervisor is a licensed practical nurse as opposed to registered nurse). 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 the respiratory note dated 03/19/12, revealed Resident #1 was on ATC at 1:50 am and oxygen saturation rate was 97%. Bilateral breath sounds were recorded as diminished. 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

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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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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 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 (referring to the 9 disconnections on 3/17/12). My expectation was if a patient had a significant change of behavior then I should be notified."

2. Resident # 2 was admitted to the facility on 01/17/12, with cumulative diagnoses of chronic respiratory failure, obstructive sleep apnea, chronic obstructive pulmonary disease, ischemic cardiomyopathy, dementia, and chronic kidney disease.

The most recent Minimum Data Set (MDS) dated 3/16/12, revealed Resident #2 was moderately cognitively impaired, had no behaviors, required extensive physical assistance of 2 persons with toileting and was totally dependent on staff for activity of daily living, including transferring and bed mobility. He required oxygen and artificial ventilation through a tracheostomy (trach) (a surgically created hole through the front of the neck and into the windpipe).

Review of the last available respiratory note dated 03/27/12, indicated Resident #2 was put on aerosol tracheostomy collar (ATC) at 2:45 pm in an attempt to begin weaning him from artificial ventilation. At 9:25 pm, the resident's oxygen

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saturation rate was 86% on the ATC. The resident was returned to artificial ventilation and 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 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.

Nurses' notes, dated 03/28/12 at 1:55 am, indicated Resident #2 had increased agitation with several attempts to get out of bed. Ativan (an antianxiety medication) 0.5mg was given at 12:00 midnight. The resident was attempting to get out of bed at 2:45 am. The supervisor was notified and a sitter was placed in the room with the resident.

Review of the medication administration record (MAR) on 03/28/12, indicated the resident was given Ativan 0.5mg at 12:00 midnight and 12:00 noon for agitation. There was no documentation of the effectiveness of the medication.

A physician's order dated 03/28/12 at 3:35 am read:
"1.Give Ativan 0.5mg po (by mouth) now x1 (1 time).
2.Call physician (named) after 7 am 03/28/12 for patient evaluation follow up.
3.Ok for patient to have one on one (1:1) sitter for safety."

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

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indicated the family was made aware of Resident #2's agitation.

Nurses' notes, dated 03/28/12 at 9:40 am, indicated the resident was incontinent and required assistance with feeding. At 12:00 noon, the family was at the bedside, voicing concerns of Resident #2's increased lethargy and agitation. The physician was called and gave an order for Risperdal (antipsychotic medication) and a consult with behavioral medicine. Family requested to send Resident #2 to the hospital emergency room for evaluation. The physician was telephone for an order and the resident was transported to the hospital by Emergency Medical Services.

During a telephone interview on 04/03/12 at 7:18 am, Nurse #10 said she worked the day shift on 03/28/12 starting at 7 am. She indicated Resident #2 was on a trach collar, on the day he went out. Nurse #10 said he had to be sent out because he was having confusion. Nurse #10 said, "The nurse who worked the 11pm -7am indicated to me he required one-on-one." Nurse #10 said there was no body sitting with the resident when she came to work on the 7 am- 3 pm shift. Resident #2 was asleep. Nurse #10 said "His family came in that afternoon and they were upset that he had no sitter, they were told he had a sitter." The family wanted the resident to go to the hospital. EMS was called. Nurse #10 indicated that a resident needed one-on-one supervision when they tried to get out of bed, were anxious and agitated, and the prn (as needed) medications didn't work. Nurse #10 said, "Then she would tell the supervisor that she needed someone to do one-on-one supervision.

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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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F 157	Continued From page 14 medical director indicated, the nursing staff "should contact me, when (Resident #1) exhibited a different pattern or a significant change in behavior. My expectation was if a patient had a significant change of behavior then I should be notified. He indicated he should be more specific in the physicians order how long 1:1 should take place."	F 157		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 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 (trach) residents (Resident #1 and #2) who both had agitation. Resident #1 removed her tracheostomy and died. Resident #2 was sent to the hospital for increased agitation and shortness of breath. Immediate jeopardy began on 03/16/12 for Resident #1 when the resident removed her trach and resulted in a critical oxygen saturation rate. The administrator was notified of the immediate jeopardy on 04/01/12 at 12:13 pm. The immediate jeopardy is present and ongoing.	F 323	F 323 1. 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	5/7/12

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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 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.

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 nurse would then complete an SBAR (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 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

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

1. 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

F 323 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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Therapist may replace tracheostomy tube routinely and /or emergently for dislocation, plugging or inadvertent decannulation."

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. She was totally dependant on staff for all of her activities of daily living.

The Care plan dated 1/19/12 indicated the resident had inappropriate disruptive behavior, was attempting multiple times to throw feet out of bed, and was trying to get out of bed even after redirection. The interventions included:
Monitor for increased anxiety and restlessness, notify the nurse, determine the need for PRN (as needed medications), administer (medications) per order, monitor for effectiveness of the medication.
Assess behavior, attempt to redirect and educate resident.
Keep resident safe. Notify family, MD (physician) and Psych (psychiatry) service of changes in behavior. 2 /27/12 Enrichment program day/evening as tolerated.

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 (her trach tube was removed from the stoma). RT (respiratory therapist) was called to the resident's room. The trach was reinserted and the resident was bagged. Family

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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.
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

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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.

F 323 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" 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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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. 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."

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. Resident #1 decannulated herself 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.

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

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 implemented to provide additional opportunity for close communication between nursing and respiratory teams regarding the care and treatment of tracheostomy residents. The stand down meeting will be conducted to discuss the MSU residents' conditions, follow-up on the completion status of the action items identified by the IDT during morning meeting and to ensure that information regarding "at risk" behaviors is clearly communicated to the nursing and 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

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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.

F 323 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 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

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During an interview with nurse #4 on 03/30/12 at 11:30 am, she said she was assigned to Resident #1 on 03/16/12 on the 11 pm - 7 am shift. Nurse #4 said she was not made aware of the decannulation on 03/16/12. Nurse #4 said she found out about the decannulation on 03/20/12 when the resident decannulated herself again and died.

Review of staffing for the Medical Speciality Unit (MSU) for 03/16/12 revealed staffing was 4.59 hours per patient per day (PPD) and there was no Registered Nurse coverage for that day. This did not meet the State Licensure requirement of 5.5 PPD and having a Registered Nurse on staff at all time.

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 6:30 pm 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 RT said when there were that many disconnections, usually it was because the resident was taking it off. Residents disconnected the vent instead of using the call bell to get the nurse. It was used for attention. The nurse was aware of the disconnections. Many of the nurses know how to reconnect circuit. I felt like the resident was agitated. This (behavior) was not 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

F 323 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 implement one-to-one supervision, or Resident Monitoring and notify the attending physician or the Medical Director of the change in the ventilator dependent resident's condition and obtain orders for the intervention implemented by the charge nurse and any other intervention the physician or Medical Director deems necessary.
Newly admitted residents to the MSU will routinely be placed on Resident Monitoring for the 1st week of their admission and will be reviewed by the IDT. If at any time during the 1st week of admission an "at risk" behavior is identified, the physician will be notified and the level of supervision may be increased. The Nursing and Respiratory assessments will determine an appropriate level of ongoing supervision, based on available information. Care plans will be reviewed by the IDT and updated as needed to reflect the residents' current care needs.
Respiratory therapist working on MSU are CPR certified.

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

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ventilation at 12:37 am (since 5:50 pm on 03/16/12). The trach became disconnected 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.

An interview with nurse #13 (RN supervisor) on 03/30/12 at 11:54 am, revealed the nurse worked 11 pm -7am on 03/16/12. The nurse said that nurse #4 has called her and told her that Resident #1 was agitated. Nurse #13 said she did not recall being told that Resident #1 decannulated herself prior to the RN supervisor's arrival at the facility on 03/16/12. The nurse on the second shift would write it on the supervisor sheet and then pass it on to the supervisor. While on duty as a shift supervisor, the information would be documented on the supervisor's 24-hour note. Nurse # 13 said she was told that Resident #1 had been medicated around 11 pm or 12 am and then she slept. Nurse #13 said "I wasn't aware of any problem during the night. I was not aware of the multiple disconnections that occurred during the early morning hours of 3/17/12." Nurse #13 said that one-to-one supervision was required "if a patient disconnects from the vent, or is agitated (ie pulling at tubing, climbing out of the bed), we (the supervisor or team leader) have to assign the patient to an aide or a nurse to sit in the room with the patient. Then the supervisor will call the doctor to get an order. Someone has to stay with the patient." Nurse #13 said, "If she (Resident #1) disconnected even once, I would have someone sitting with her." Nurse #13 again denied she was aware of any

F 323 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 9, 2012 will not be permitted to work until

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disconnections during her shift. If she knew she would absolutely call the doctor.

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 7 pm (after the resident decannulated herself and disconnected herself from the vent). Nurse #3 stated "I was assigned to (Resident #1). She was on the trach collar. 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 been on the sheet. It was not on the sheet. I got report from (nurse #4). She told me that (Resident #1) was trying to get out of bed during the night and that was why she was in the geri chair. 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."

On 03/30/12 at 9:48 am, nurse #2 was interviewed. The nurse said she worked during the 3 pm -11 pm shift on 03/17/12 as the team leader. She reported that she was not aware that Resident #1 had decannulated herself on 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

F 323 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.

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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

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shift (7:00am-3:00pm) and 2nd shift (3pm-11pm). While sitting in a recliner chair at 10:30 am she was attempting to get out of the recliner because she was incontinent of a large amount of stool, resulting in the resident falling to the floor. The physician and family were notified.

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. I asked her if she was tired and I asked her if she wanted to go on the oxygen mask and she said 'No.' 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 (oximeter) to notify staff when they (residents) are getting a low (oxygen) saturation rate."

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."

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

F 323 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.
Weekly the Administrator will report progress on the corrective action plan including any issues identified in the reviews with achieving or sustaining compliance to the governing board of the facility. The board will take any other actions they deem necessary based on the 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.

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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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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.

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 3:20 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 am.

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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chair. She didn't sleep well in bed."

During a telephone interview on 03/31/12 at 5:39 am, NA #2 said she worked on 03/19/12 on the 11 pm -7 am shift. The NA stated, "We had been told to watch her closely. When we watch her closer, we actually go into the room. We got to her room (Resident #1) on rounds about 11:30 (pm)-12 (midnight). The nurse was on the hall passing medications. She gave (Resident #1) something to calm her down. Then the next time we went in was about 1 am. Her trach was in place, she was asleep. I was sure she was alive, she moved her feet. We made our next set of rounds and started on the 100 hall, then to the 200 hall. We were also doing vital signs. I went to (Resident #1) room around 3:20 am and she didn't look right to me. I looked at her face and her tongue was not pink. She usually slept with her mouth open. She was in the recliner with her feet up. The trach collar was in the right place. Then I tapped her on the face, she didn't respond to her name. Her head flopped back and that is when I realized the trach was entirely out. The trach with the straps was in her left hand near her left leg. I ran to get the nurse. (Nurse #1) came back with me, the respiratory therapist (RT #1) came and he put the trach back in and bagged her, we picked her up and put her on the bed on the board. Then I got out of the way, while they coded her."

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. Resident #1 had a fall 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

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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

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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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there are no alarms to alert staff. It takes about 3-5 minutes without oxygen for a resident to die."

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.

Review of staffing for the Medical Speciality Unit (MSU) for 03/19/12 revealed 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 Resident #1 messed with her trach all the time. She would try to pour water over it. She would pull at it quite a bit. She would alert the nurse and tell respiratory (therapist).

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

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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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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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up if I have to add a sitter."

2. Resident # 2 was admitted to the facility on 01/17/12, with cumulative diagnoses of chronic respiratory failure, obstructive sleep apnea, chronic obstructive pulmonary disease, ischemic cardiomyopathy, dementia, and chronic kidney disease.

The most recent Minimum Data Set (MDS) dated 3/16/12; revealed Resident #2 was moderately cognitively impaired, had no behaviors, required extensive physical assistance of 2 persons with toileting and was totally dependent on staff for activity of daily living, including transferring and bed mobility. He required oxygen and artificial ventilation through a tracheostomy (trach) (a surgically created hole through the front of the neck and into the windpipe).

Review of the last available respiratory note dated 03/27/12, indicated Resident #2 was put on aerosol tracheostomy collar (ATC) at 2:45 pm in an attempt to begin weaning him from artificial ventilation. At 9:25 pm, the resident's oxygen saturation rate was 86% on the ATC. The resident was returned to artificial ventilation and 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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with several attempts to get out of bed. Ativan (an antianxiety medication) 0.5mg was given at 12:00 midnight. The resident was attempting to get out of bed at 2:45 am. The supervisor was notified and a sitter was placed in the room with the resident.

Review of the medication administration record (MAR) on 03/28/12, indicated the resident was given Ativan 0.5mg at 12:00 midnight and 12:00 noon for agitation. There was no documentation of the effectiveness of the medication.

A physician's order dated 03/28/12 at 3:35 am read:
" 1.Give Ativan 0.5mg po (by mouth) now x1 (1 time).
2.Call physician (named) after 7 am 03/28/12 for patient evaluation follow up.
3.Ok for patient to have one on one (1:1) sitter for safety. "

Nurses' notes, dated 03/28/12 at 7:15 am, indicated the family was made aware of Resident #2 agitation.

Nurses' notes, dated 03/28/12 at 9:40 am, indicated the resident was incontinent and required assistance with feeding. AT 12:00 noon, the family was at the bedside, voicing concerns of Resident #2's increased lethargy and agitation. The physician was called and gave an order for Risperdal (antipsychotic medication) and a consult with behavioral medicine. Family requested to send Resident #2 to the hospital emergency room for evaluation. The physician was telephone for an order and the resident was transported to the hospital by Emergency Medical

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Services.

Review of hospital history and physical dated 3/28/2012 indicated the resident went to the hospital "agitated and short of breath," and returned 3/30/12. Medication changed recommended by psychiatry.

During a telephone interview on 04/03/12 at 7:18 am, nurse #10 said she worked the day shift on 03/28/12 starting at 7 am. She indicated Resident #2 was on a trach collar, on the day he went out. Nurse #10 said he had to be sent out because he was having confusion. Nurse #10 said, "The nurse who worked the 11pm -7am indicated to me he required one-on-one." Nurse #10 said there was no body sitting with the resident when she came to work on the 7 am- 3 pm shift. Resident #2 was asleep. Nurse #10 said "His family came in that afternoon and they were upset that he had no sitter, they were told he had a sitter." The family wanted the resident to go to the hospital. EMS was called. Nurse # 10 indicated that a resident needed one-on-one supervision when they tried to get out of bed, were anxious and agitated, and the prn (as needed) medications didn't work. Nurse # 10 said, "Then she would tell the supervisor that she needed someone to do one-on-one supervision. 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,

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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 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) 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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-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 up if I have to add a sitter.:
During an interview on 04/03/12 at 12:25 pm, the administrator indicated, "A RN was on every shift. I don't know what the ratio for the MSU unit. This was my first unit of this type. They should bring someone in who is off duty to cover a one-on-one. Right now they are using light duty nurses." The administrator said that in "an emergent one-on-one, the resident can be pulled to the nurses station. When a physician had ordered a one-on-one, we should have individual people to sit with each individual resident. I do not expect an aide to be pulled off from another unit to cover the MSU unit."

During an interview on 04/03/12 at 9:27 am, the director of nursing (DON) indicated that she did not know what the staffing ratio for the MSU (Medical Specialty Unit) should be and referred all questions to the staffing coordinator. The DON stated she used light duty staff for one-on-one supervision. There was no sign off sheet, and no documentation to show 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 supervision had been put into place.

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The nurses make the determination when to discontinue the one-on-one. The doctor was not notified when we discontinued the one-on-one."

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 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).

Immediate jeopardy began on 03/16/12 when Resident #1 removed her trach resulting in a critical oxygen saturation rate. The administrator was notified of the immediate jeopardy on 04/01/12 at 12:13 pm. The immediate jeopardy is present and ongoing. Findings include:

Review of the policy titled "Ventilator (vent)

F 323

F 328

F 328
1. 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 change in the resident's condition on the 24 hour report and the one-to-one supervision being provided, (e) the 24 hour

5/7/12

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BLUE RIDGE HEALTH CARE CENTER	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

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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 "Protocol 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."

F 328 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,

F 328 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.

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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	F 328	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 /or 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

F 328 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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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.

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

F 328 implemented to provide additional opportunity for close communication between nursing and respiratory teams regarding the care and treatment of tracheostomy residents. The stand down meeting will be conducted to discuss the MSU residents' conditions, follow-up on the completion status of the action items identified by the IDT during morning meeting and to ensure that information regarding "at risk" behaviors is clearly communicated to the nursing and 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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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

F 328 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 implement one-to-one supervision, or Resident Monitoring and notify the

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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. There is a protocol to go by; I used the vent setting she was on previously."

RT #6 was interviewed at 12:11 pm on 03/30/12. RT #6 said Resident #1 had anxiety problems and her oxygen saturation rate was in the nineties. 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 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 (increased) she would get anxious."

Review of staffing for the Medical Speciality Unit (MSU) for 03/16/12 revealed staffing was 4.59 hours per patient per day (PPD) and there was no Registered Nurse coverage for that day. 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 respiratory note dated 03/17/12, revealed Resident #1 was still on artificial ventilation at 12:37 am (since 5:50 pm on 03/16/12). The oxygen saturation rate at that time was 98%. The trach became disconnected 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. The

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attending physician or the Medical Director of the change in the ventilator dependent resident's condition and obtain orders for the intervention implemented by the charge nurse and any other intervention the physician or Medical Director deems necessary.
Newly admitted residents to the MSU will routinely be placed on Resident Monitoring for the 1st week of their admission and will be reviewed by the IDT. If at any time during the 1st week of admission an "at risk" behavior is identified, the physician will be notified and the level of supervision may be increased. The Nursing and Respiratory assessments will determine an appropriate level of ongoing supervision, based on available information. Care plans will be reviewed by the IDT and updated as needed to reflect the residents' current care needs.
Respiratory therapist working on MSU are CPR certified.
The facility investigated the tracheostomy collars available on the market to determine if a collar was available that would enhance resident safety and security of the tracheostomy. Respiratory therapists changed all tracheotomy collars to a new collar that is constructed out of a single piece of foam and has only 2 fastening points.
To increase safety for tracheostomy residents that are ventilator dependent, facility RT staff has implemented the use of TrachStay™ anti-disconnect devices for all tracheostomy residents who are ventilator dependent. The TrachStay™ device stabilizes the ventilator connection and aids in the prevention of the disconnection from the ventilator.

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oxygen saturation rate was 94% (at 8:35 am) and the resident required suctioning at 8:35 am, 10:30 am, 11:30 am, 1:40 pm, 2:50 pm, 5:28 pm, 7:25 pm, and 9:30 pm. Tracheostomy care was completed at 11:25 am, 12 noon and 11:45 pm. The oxygen saturation rate was 95% and pulse was 39 at 1:40 pm, and 98% at 7:20 pm. She continued on the ATC until 11:45 pm when she was returned to artificial ventilation.

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 RT said when there were that many disconnections, usually it was because the resident was taking it off. Residents disconnected the vent instead of using the call bell to get the nurse. It was used for attention. Sometimes residents don't sleep, because there is always something going on even in the middle of the night. RT #3 said Resident #1 could be confused at times and other times she wasn't confused. The nurse was aware of the disconnections. Many of the nurses know how to reconnect circuit. I felt like the resident was agitated." During an interview on 3/31/12 at 2 pm, RT #3 indicated on the 17th Resident #1 disconnected and "I shared it with the nurse (Nurse #6). Everyone was aware of the alarm. Medication was discussed with the nursing staff; they determine when the doctor should be called. The respiratory therapist doesn't page the doctor, nursing staff

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:

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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

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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. I 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."

F 328 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 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 in place. (g) 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

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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. 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."

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 respiratory note dated 03/19/12, revealed Resident #1 was on ATC at 1:50 am and oxygen saturation rate was 97%. Bilateral breath 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

F 328 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.
Weekly the Administrator will report progress on the corrective action plan including any issues identified in the reviews with achieving or sustaining compliance to the governing board of the facility. The board will take any other actions they deem necessary based on the 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.

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oxygen saturation rate had increased to 93% and pulse was 58 at that time. The resident was suctioned at 1:20 pm, 1:50 pm, 3:10 pm, 5:30 pm and 8:00 pm. No oxygen saturation rate was recorded at 8:00 pm. Breath sounds were recorded as "coarse" and she was suctioned for blood tinged "mucoid" at 8:00 pm. Tracheostomy care was done at 10:15 am and at 8:10 pm.

Review of the nurses' notes dated 03/19/12, revealed at 8:45 pm, Resident #1 fell from the bed to the floor with no injury. Family and physician were notified. Nurses notes at 9:30 pm revealed, Resident #1 was observed to be anxious and was redirected and responded to 1:1. She fell a second time and was assisted to the recliner.

Review of the medication administration record (MAR) on 3/19/12, revealed acetaminophen 650mg was given at unknown time for pain and restlessness. Zolpidem 5 mg was given at 9:00 pm for insomnia and restlessness. Ativan 0.5mg was given at 9:00 pm for restlessness.

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 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

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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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chair. She didn't sleep well in bed."

During a telephone interview on 03/31/12 at 5:39 am, NA #2 said she worked on 03/19/12 on the 11 pm -7 am shift. The NA stated, "We had been told to watch her more closely. When we watch her closer, we actually go into the room. Earlier that night she had banged on her chair, that was how she got attention. We got to work at 11:00 pm. As soon as we got there we started answering call bells. We got to her room (Resident #1) on rounds about 11:30 (pm)-12 (midnight). The nurse was on the hall passing medications. She gave (Resident #1) something to calm her down. Then the next time we went in was about 1 am. Her trach was in place, she was asleep. I was sure she was alive, she moved her feet. We made our next set of rounds and started on the 100 hall, then to the 200 hall. We were also doing vital signs. I went to (Resident #1) room around 3:20 am and she didn't look right to me. I looked at her face and her tongue was not pink. She usually slept with her mouth open. She was in the recliner with her feet up. The trach collar was in the right place. Then I tapped her on the face, she didn't respond to her name. Her head flopped back and that is when I realized the trach was entirely out. The trach with the straps was in her left hand near her left leg. I ran to get the nurse. (Nurse #1) came back with me, the respiratory therapist (RT #1) came and he put the trach back in and bagged her, we picked her up and put her on the bed on the board. Then I got out of the way, while they coded her. "

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. 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 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

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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 revealed 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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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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	345517	A. BUILDING _____ B. WING _____	C 04/03/2012

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BLUE RIDGE HEALTH CARE CENTER	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

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F 328 Continued From page 59

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-to-one. We keep the PPD at 4.39 for the MSU but it will go below it and it may go up if I have to add a sitter."

F 353 SS=J 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

Except when waived under paragraph (c) of this section, licensed nurses and other nursing

F 328

F 353

1. 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

5-7-12

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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.

This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews with facility staff, the physician, and respiratory therapists, the facility failed to provide adequate staffing to monitor and supervise tracheostomy residents with agitation. Resident #1 decannulated herself and expired. The facility failed to provide one-on-one supervision as ordered by the physician for Resident #2 who was agitated and trying to get out of bed. This was evident in 2 of 5 residents (Resident #1 and 2).

Immediate jeopardy began on 03/16/12 when Resident #1 removed her trach resulting in a critical oxygen saturation rate. The administrator was notified of the immediate jeopardy on 04/01/12 at 12:13 pm. The immediate jeopardy is present and ongoing. Findings include:

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 who was attempting to get out of bed (Resident

nurse complete an SBAR (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 continues at this time.

2. Residents on the Medical Specialty Unit (MSU) have the potential to be affected by the same alleged deficient practice based on a review of the North Carolina nursing home licensing regulations as it relates to ventilator dependent residents and a review of the facility's direct care nursing for the weeks of the incidents identified.

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F 353	Continued From page 61 #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).	F 353	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 non-ventilator 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)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. 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 one-to-one form has been implemented. One-to-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, one-to-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 one-to-one supervision. Any orders for modification or discontinuation or one-to-one 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 non-ventilator 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 resident-specific 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)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

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L 183	.3003(3) VENTILATOR DEPENDENCE 10A-13D.3003 (3) Direct nursing care staffing shall be in accordance with Rule. 3005 of this Section. This Rule is not met as evidenced by: 10A-13D.3005 Direct care nursing personnel staffing ratios established in Rule .2303 of this Subchapter shall not be applied to nursing services for patients who require brain injury long-term care. The minimum direct care nursing staff shall be 5.5 hours per patient day, allocated on a per shift basis as the facility chooses, to appropriately meet the patients' needs. It is also required that regardless of how low the patient census, the direct care nursing staff shall not fall below a registered nurse and a nurse aide I at any time during a 24-hour period. Based on observation, record reviews and staff interviews, the facility failed to ensure sufficient nursing staff was assigned to the medical specialty unit MSU (Ventilator Unit) on 4 of 4 days audited and lacked 24 hour Registered Nurse coverage 3 of 4 days audited. Review of the staffing time sheet and schedule on the MSU (vent unit) dated 3/16/12 through 3/19/12 revealed: No Registered Nurse worked on the MSU unit 3/16/12, Shift 1st shift, 2nd shift and 3rd shift. No Registered Nurse worked on the MSU unit 3/17/12, 7:00am-7:00pm. No Registered Nurse worked on the MSU unit 3/18/12, 7:00am-3:00pm. No Registered Nurse worked on the MSU unit 3/19/12 4:00pm-7:00am. The patient census/PPD (per patient day) was as	L 183	1.No resident was named in this citation. 5/7/12 2. Residents on the Medical Specialty Unit (MSU) have the potential to be affected by the same alleged deficient practice based on a review of the North Carolina nursing home licensing regulations as it relates to ventilator dependent residents and a review of the facility's direct care nursing for the weeks of the incidents identified. 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 non-ventilator 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	

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L 183	Continued From page 1 follows: 3/16/12 30 residents, actual hours of direct care staff: 137.75 = 4.59 PPD 3/17/12 32 residents actual hours of direct care staff: 148.25 = 4.6 PPD 3/18/12 32 residents actual hours of direct care staff: 156.75 = 4.89 PPD 3/19/12 39 residents actual hours of direct care staff: 154 = 4.81 PPD During an interview on 3/31/12 at 5:36 pm, Nurse #11 worked on 3/16/12, from 7:00 pm-11:00 pm, as the team leader she indicated, an LPN (licensed practical nurse) who was assigned and worked as a 24 hour supervisor were referred to as a "team leader" not as a supervisor. During an interview on 4/2/12 at 5:03 pm, the Director of Nursing indicated, the facility calculated the unit manager or the charge nurse as part of the direct care staff. This nurse did not have a direct care assignment. She indicated the nurse may do direct care at some point, and gave the example performing an assessment. During an interview on 4/3/12 at 9:27 am, the Director of Nursing indicated, on MSU (vent unit) the staffing was as follows, 1st shift (7 am-3 pm) had 3 nurses and 4 aides , on 2nd shift (3 pm-11 pm) had 3 nurses and 4 aides, and 3rd shift (11pm-7am) had 2 nurses and 2 aides. Nurses work 8 hours and aides work 7.5 hours. Eight nurses a day work 8 hours and 10 aides a day work 7.5 hours. When asked what was the ratio for the vent unit, she replied, "I do not know, the staffing coordinator does it." During an interview on 4/3/12 at 11:31 am, Staff Coordinator, indicated the staff on the MSU (vent unit) was as follows: 3 nurses (either RN/or LPN) worked 8 hours, and an RN on every shift. Four (4) aides on the 1st shift (7 am-3 pm)	L 183	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)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. 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 one-to-one form has been implemented. One-to-one resident supervision is ordered by the attending physician or the Medical Director to provide continuous supervision	

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L 183	Continued From page 2 worked 7.5 hours. 3 nurses worked 8 hours and 4 aides worked 7.5 hours on the 2nd shift. On the 3rd shift (11pm-7am shift) 2 nurses worked 8 hours and 2 aides worked 7.5 hours. When staff called out (did not come to work) , staff was telephoned to come in. During the week the staffing coordinator replaced staff during 1st shift to fill the absence. The shift supervisor made calls for 2nd and 3rd shifts. The patient per day(PPD) for the MSU unit (vent unit) was 4.39. The staffing program used guided the daily staffing based on the census. She indicated if those staff positions are filled on the spread sheet there was enough people to work. The sitter scheduled was counted as part of the PPD. To provide a sitter a staff who was on duty would be used or would somebody was called and asked to work. Usually we would use someone on who was already on the the hall. On the 11pm-7am shift it was very hard to get a sitter. We would pull from the 400 hall, and that would cause a staff shortage on the 400 hall. If more then one resident needed a sitter then one person would rotate and not stay in the room continuously. Thirty minute in one room :30 minutes in an other. One person from the 400 hall would have to sit with how ever many people need to have 1:1 supervison. When the facility added a sitter it was calculated on the PPD sheet. We keep the PPD at 4.39 for the vent unit, sometimes it was below the 4.39 PPD , if a sitter was added the PPD increased. During an interview on 4/3/12 at 12:25 pm, the Administer indicated the MSU (vent unit) staffing ratio of 3 nurses (RNor LPN) working 8 hours and 4 aides working 7.5 hours During the 1st and 2nd shifts(7am-11pm). During the 3rd shift (11pm-7am) there were 2 nurses working 8 hours (RNor LPN) and 2 aides	L 183	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, one-to-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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0428	A. BUILDING _____ B. WING _____	04/03/2012

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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L 183	Continued From page 3 working 7.5 hours. He expected there was an RN on every shift. He indicated he was not aware of the 5.5 PPD (state licensure) staffing ratio for the (vent unit). During a telephone interview on 4/10/12 at 3:18 pm, the Administrator indicated during the survey period 3/29/12- 4/3/12, the RN coverage was assigned anywhere not necessarily on the MSU (vent unit). There was no Registered Nurse (RN) coverage for the vent unit on 3/16/12 , 1st, 2nd or 3rd shifts and partial RN coverage on 3/17,3/18, and 3/19.	L 183	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 one-to-one supervision. Any orders for	

modification or discontinuation or one-to-one 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 non-ventilator 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 resident-specific 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.