STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345558	A. BUILDING _____ B. WING _____	C 04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS HOME-BLACK MOUNTAIN	62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711

(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 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care	F 328		5/26/17

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

Electronically Signed | 05/25/2017

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

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F 328	Continued From page 1 and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to properly store a portable oxygen tank for 1 of 2 sampled residents receiving continuous oxygen (Resident #8). The findings included: The facility's policy Oxygen Safety and Storage last revised on 11/05/2015 under Procedure included: a. Safety: #3. "Tanks in use must either be installed on a stable, wheeled dolly or on an oxygen tank stand." b. Storage: #3. "Oxygen tanks that are considered 'in use' (regulator attached) should be stored in a rack or carrier in an upright position with the regulator off. Oxygen tanks should never be stored lying down." Resident #8 was admitted to the facility on 04/20/17 with diagnoses including chronic	F 328	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?	

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F 328	Continued From page 2 obstructive pulmonary disease and acute bronchitis. Physician orders on admission on 04/20/17 and current included continuous oxygen at 2 liters per minute. Observations made on 04/27/17 at 9:10 AM revealed Resident #8 was in bed receiving oxygen via an oxygen concentrator. A portable oxygen tank with the tubing still connected to the regulator was located lying on its side on a square table as you entered the room. This portable oxygen tank was not secured in any fashion on the table. The portable oxygen tank remained on the table unsecured on 04/27/17 at 11:16 AM. On 04/27/17 at 11:24 AM, Nurse Aide (NA) #1 was observed in the room assisting Resident #8 get up for the day. The portable oxygen tank had been moved to the back of Resident #8's wheelchair in the appropriate sleeve. An interview with NA #1 at this time revealed he had retrieved the wheelchair from the bathroom and secured the portable oxygen tank from the table into the sleeve on the back of the wheelchair. He stated he just noticed the portable oxygen tank on the table and had not seen it there this morning. He stated he had not put the tank on the table and stated it should be kept on the back of the wheelchair. Interview with NA #2 on 04/27/17 at 12:28 AM revealed she had served Resident #8 breakfast this morning and noticed the oxygen tank lying on the table and intended to move it to the secured location on the back of Resident #8's wheelchair but forgot about it. She stated the oxygen tank	F 328	The oxygen tank was immediately removed from resident #8□s room per policy and returned to the proper storage area. No adverse conditions to resident were noted to resident #8 at that time. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1.An audit was performed on 4/28/17 all residents on receiving oxygen for proper storage on of oxygen tanks. 2.An audit was performed on 4/28/17 all oxygen storage areas on in the facility. 3.New residents admitted with oxygen usage will be assessed and monitored for proper storage per policy What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? 1.Education was provided by the Clinical Competency Coordinator and RN supervisors on 4/28/17 to all licensed and unlicensed clinical nursing staff. Education involved discussion and review of the facility policy on oxygen safety and storage. 2.Education regarding oxygen use and safety will be assigned to all licensed and unlicensed clinical nursing staff during orientation and ongoing, including	

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F 328	Continued From page 3 should not have been lying on the table and thought that the previous shift must have left it there. NA #3 was interviewed via phone on 04/27/17 at 6:46 PM. He related that he worked side by side with NA #4 last night and neither he nor NA #4 left the oxygen tank on the table in Resident #8's room. He stated the oxygen tank needed to be secured and not lying on its side. Attempts to interview NA #4 were unsuccessful. On 04/28/17 at 9:59 AM, Nurse #1 was interviewed and stated she had also worked on day shift on 04/27/17 and had given Resident #8 several morning medications, including checking his blood sugar and administering a breathing treatment, prior to him getting up. She stated she had not noticed the oxygen tank lying on the table as you entered the room. She stated that the oxygen tank should have been secured and the staff recently had an inservice on storage and transporting oxygen tanks. The Administrator stated during interview on 04/28/17 at 11:30 AM that his expectation was that portable oxygen tanks should be kept on the sleeve on the back of a resident's wheelchair or transported and secured in the designated oxygen room.	F 328	unlicensed staff in all departments via Pruitt University. 3.New residents admitted with oxygen usage will be assessed and monitored for proper storage per policy. 4.Rounds will be performed by the Nursing Supervisor and/or licensed staff every shift for compliance. Rounds will be performed and documented per the following schedule: once daily for one week, twice weekly for four weeks, then once weekly for 90 days thereafter. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The Director of Health Services and nursing supervisors will monitor for compliance and discuss with the IDT team during daily rounds, weekly Clinical Meetings, and monthly QAPI meetings.	