STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345203	A. BUILDING _____ B. WING _____	07/27/2012

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LIFE CARE CENTER OF BANNER ELK	186 NORWOOD HOLLOW ROAD PO BOX 2199 BANNER ELK, NC 28604

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F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews facility staff failed to obtain a physician's order for oxygen in one (1) of three (3) residents on oxygen therapy. (Resident # 22). The findings are: A review of a facility document titled "Oxygen Use, General" with a revised date 02/11 indicated "Oxygen therapy is administered to the resident only upon the written order of a licensed physician." Resident #22 was admitted with diagnoses including chronic airway obstruction, asthma and heart disease. The most recent significant change Minimum Data Set (MDS) dated 6/15/12 indicated impairment in short and long term memory and severe impairment in cognition for daily decision making. The MDS also indicated Resident #22 required extensive assistance from staff for activities of daily living (ADL's). A review of the monthly physician's orders dated 7/1/12 through 7/31/12 indicated there were no physician's orders for oxygen for Resident #22. A review of the monthly Medication Administration	F 281	**Plan of Correction for Survey 08/14/2012** **This plan of correction in response to the Statement of Deficiencies demonstrates our good faith and desire to improve the quality of care and services rendered to our residents. By submitting this plan of correction, the facility does not, however, admit that any deficiency actually existed at the time of the survey. This plan of correction constitutes a written allegation of substantial compliance.** **F281 483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS** **A. Resident found to be affected by alleged deficient practice:** On 7/27/12, MD was notified about failure to obtain a physician order for oxygen for resident #22. Physician order was obtained and transcribed to Medication MAR.	08/20/12

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

LNHA, Senior Executive Director — 8-16-12

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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F 281	Continued From page 1 Record (MAR) dated 7/1/12 through 7/31/12 indicated there was no documentation for oxygen for Resident #22. A review of a care plan dated 7/2/12 indicated a problem statement for potential for upper respiratory infection due to a history of upper respiratory infections. The approaches indicated to administer oxygen as ordered by the physician. During an observation on 7/26/12 at 8:07 AM Resident #22 was lying in bed after her bath and Nursing Assistant (NA) #1 placed a nasal cannula in Resident #22's nose that was connected to an oxygen concentrator and was on at two (2) liters per minute. During an observation on 7/27/12 at 8:30 AM Resident #22 was lying in bed with oxygen on at two (2) liters per minute through a nasal cannula connected to an oxygen concentrator next to her bed. During an interview on 7/27/12 at 9:26 AM Licensed Nurse (LN) #1 stated Resident #22 went to the hospital because of heart problems several months ago and when she came back from the hospital she thought Resident #22 had oxygen. LN #1 stated a physician's order was required when a resident received oxygen therapy. During an Interview on 7/27/12 at 9:34 AM with LN # 2 she verified there were no physician's orders for Resident #22 to receive oxygen and oxygen was not documented on the monthly MAR. She stated Resident #22 routinely used oxygen but she was not sure why there was no	F 281	**B. Residents have the potential to be affected:** All residents have potential to be affected. The Director of Nursing/Assistant Director of Nursing/or Staff Development Coordinator will provide education to all nurses on documenting O2 use on the Medication MARS to include continuous and PRN use to be completed by 08/20/12. The Director of Nursing and Assistant Director of Nursing will complete 100% audit of all O2 use to ensure complete order and transcription of order documented through visual inspection of all residents and chart review completed on 08/17/2012. The Director of Nursing/Assistant Director of Nursing/or Staff Development Coordinator will provide education to all nurses on the Medication Reconciliation Procedure when the resident is re-admitted from outside inpatient setting to be completed by 08/20/2012. **C. Systematic changes to assure alleged deficient practices will not occur:** Medication Reconciliation Procedure is completed when all residents are re-admitted from outside inpatient setting by chart review and review in the daily clinical meeting. Ensure O2 use documentation daily by Medication MAR review daily in the clinical meeting.	

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F 281	Continued From page 2 physician's order and it must have been overlooked. She explained a physician's order was required for a resident to receive oxygen and oxygen therapy was always documented on the resident's MAR. During an Interview on 7/27/12 at 9:40 AM the Director of Nursing (DON) explained a physician's order was required for oxygen therapy because it was considered the same as a medication. The DON verified Resident #22 did not have a physician's order for oxygen and stated it was her expectation for residents who received oxygen to have a physicians order in their medical record. During a telephone interview on 7/27/12 at 10:22 AM with Resident #22's physician he stated he was aware Resident #22 received oxygen and she needed it because of her heart problems. He explained Resident #22 had oxygen since she came back from the hospital in January 2012 and he thought the nurses put it on her because her oxygen saturation percentages had dropped. He stated nursing staff were supposed to have a physician's order to administer oxygen but he didn't know why Resident #22 didn't have an order and thought they must have forgotten to write one.	F 281	**D. Monitoring process:** Audit of Medication Reconciliation Procedure is completed when all residents are re-admitted from outside inpatient setting by chart review and review in the daily clinical meeting by DON/ADON/ or designee. Initiated 08/14/2012 and all findings will be reported to the Performance Improvement Meeting monthly for three months. Audit of O2 use documentation daily by Medication Mar Review daily in the clinical meeting by DON/ADON/or designee. Initiated 08/14/2012 and all findings will be reported to the Performance Improvement Meeting monthly for three months. The next continuous Quality Performance Improvement Meeting is scheduled for 8/22/2012.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**F371 483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY** **A. Resident found to be affected by alleged deficient practice:** No residents were affected.	08/20/12

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F 371	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure staff dated two (2) opened food items placed back in the walk in freezer and failed to remove dented cans of Ensure from one (1) of two (2) nourishment refrigerators. The findings are: 1. An initial tour of the kitchen was conducted on 7/24/12 at 8:20 AM with the Dietary Manger. During observations in the walk in freezer there were two (2) plastic bags that were approximately one-half (1/2) full with no date on the outside and the bags were sitting on two (2) separate shelves between cardboard boxes of frozen food. Both bags were closed and the Dietary Manager identified one of the bags contained frozen cheddar biscuits and the second bag contained frozen shrimp. During an interview on 7/24/12 at 8:36 AM the Dietary Manager stated staff had been instructed to write the date on the outside of the bag when they opened frozen food and before they placed it back into the walk in freezer. She stated someone was probably in a hurry and forgot to write the date on the outside of the bags. During a follow-up interview on 7/27/12 at 8:46 AM the Dietary Manager verified the frozen cheddar biscuits and the frozen shrimp was ordered on 7/18/12, delivered to the facility on	F 371	**B. Resident having potential to be affected:** All residents have the potential to be affected by frozen food not properly labeled when opened and stored in freezer and potential consumption of dented ensure can. **C. Systematic changes to assure alleged deficient practices will not occur:** The Dietary Manager will provide education to all dietary staff on proper labeling of all food items to be completed by 08/20/2012. The Dietary Manager and the Director of Nursing will provide education to all dietary and nursing staff to ensure all dented Ensure cans are discarded and will be completed by 08/20/2012. **D. Monitoring process:** Audit for proper labeling of all food items to be completed three times per week for three months by Dietary Manager/ED/or Designee. Audit for monitoring Ensure cans to be completed three times per week for three months by Dietary Manager/ED/or Designee. Initiated 8/15/12 and all findings will be reported to the Performance Improvement Meeting monthly for three months. The next Continuous Quality Performance Improvement Meeting is scheduled for 8/22/12.	

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F 371	Continued From page 4 7/19/20 and was served on 7/20/12. She explained they might have been used as an alternative on the menu but they probably would not have been served until the next menu cycle which would be in four (4) weeks. The Dietary Manager stated it was her expectation all frozen foods should be dated when it was opened and before staff placed it back into the walk in freezer. 2. During an observation on 7/24/12 at 4:00 PM of an upright refrigerator in the Day Room there were five (5) cans of Ensure sitting on a shelf inside the door of the refrigerator and available for use. Three (3) of the five (5) cans had dents under the rims at the top of each can. During an observation on 7/25/12 at 2:47 PM of an upright refrigerator in the Day Room there were five (5) cans of Ensure sitting on a shelf inside the door of the refrigerator and available for use. Three (3) of the five (5) cans had dents under the rims at the top of each can. During an observation on 7/26/12 at 10:00 AM of an upright refrigerator in the Day Room there were five (5) cans of Ensure sitting on a shelf inside the door of the refrigerator and available for use. Three (3) of the five (5) cans had dents under the rims at the top of each can. During an interview on 7/27/12 at 8:56 AM the Dietary Manager stated the dietary department ordered Ensure for residents who liked it but they didn't order it very often. She stated they put it in the upright refrigerator in the Day Room so it would be readily available for resident use. She explained if the cans were dented they should be removed by dietary staff when they stocked the	F 371		

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F 371	Continued From page 5 refrigerator or if nursing saw a dented can they should take it back to dietary for replacement. During an observation on 7/27/12 at 9:03 AM the Dietary Manager verified there were two (2) cans of Ensure sitting on a shelf inside the door of the refrigerator and one (1) of the cans of Ensure was dented under the rim at the top of the can. During an interview on 7/27/12 at 9:04 AM the Dietary Manager stated she was not aware there were dented cans of Ensure in the refrigerator and she was not sure how it was dented but it should have been discarded. During an interview on 7/27/12 at 12:14 PM the Director of Nursing (DON) explained she had talked with a nurse who worked last night and she reported she gave one (1) can of Ensure to a resident last night and remembered the can was not dented. The DON further explained she could not verify what happened to the other two (2) cans of Ensure with the dented rims but it was her expectation that dented cans of Ensure should be removed and should not be available for resident use.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441	**F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** **A. Residents found to be affected by alleged deficient practice:** The Staff Development Coordinator provided one on one education on infection control with the C.N.A.'s scheduled on the hall on 7/26/12 and was completed on 7/26/12.	08/20/12

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F 441	Continued From page 6 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews facility staff placed soiled linens on top of clean linens and failed to obtain a clean nasal cannula before placing it in the resident's nose after it had been laying on the floor in one (1) of one (1) resident's observed during incontinence care. (Resident #22).	F 441	**B. Residents having the potential to be affected:** All residents have potential to be affected. The Director of Nursing/Assistant Director of Nursing/or Staff Development Coordinator will provide education on infection control with all nurses and C.N.A.'s initiated on 7/26/12 and will be completed by 8/20/12. **C. Systematic changes to assure alleged deficient practice will not occur:** Visual inspections during resident care to ensure soiled lines are placed into plastic bags not on clean surfaces, clean linen, or on the floor and to ensure a clean nasal cannula is placed on the resident. **D. Monitoring Process:** Audit tool for visual inspections during resident care to be completed three times a week on all shifts for three months to ensure proper technique are followed by DON/ADON/ or designee. Initiated 8/14/12 and all findings will be reported to the Performance Improvement Meeting monthly for three months. The next Continuous Quality Performance Improvement Meeting is scheduled for 8/22/12.	

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F 441	Continued From page 7 The findings are: A review of a facility document titled "Standard Precautions" with a revised date of 7/18/11 indicated in part that soiled linen is handled as little as possible, and waste is bagged in bags that cannot be penetrated by water or drainage. A review of a facility document titled "Use of oxygen" with a revised date of 5/21/04 indicated to keep oxygen tubing off the floor. During continuous observations on 7/26/12 from 8:07 AM until 9:29 AM Resident #22 was lying in bed flat on her back and her oxygen tubing and nasal cannula was lying on the floor next to her bed and the oxygen concentrator was turned on at two (2) liters per minute. The floor of Resident #22's room was not cleaned by housekeeping staff during this time. During an observation of incontinence care on 7/26/12 at 9:29 AM Nursing Assistant (NA) #1 washed her hands, put on gloves and removed the bed spread from Resident #22's bed and placed it in a large upholstered chair next to her bed. NA #1 then provided incontinence care to Resident #22 and removed two (2) large pads that were positioned under the resident's buttocks that were saturated with urine and placed them in the chair on top of the resident's bedspread and against the back of the fabric on the chair. Oxygen tubing with the nasal cannula attached to it were laying in the floor next to the resident's bed and the bottom of NA #1's left (L) shoe touched the tubing. NA #1 placed soiled towels and washcloths on top of the pads in the chair. She then pulled the bed spread out from under	F 441		

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F 441	Continued From page 8	F 441		

the soiled linens and the soiled linens slid down the back of the chair and touched the fabric on the back and seat of the chair. NA #1 placed the bedspread on the resident's bed and picked the oxygen tubing and nasal cannula off the floor and put the cannula in Resident #22's nose.

During an interview on 7/27/12 at 9:49 AM with NA #1 she stated she had been told she should not put soiled linen on the floor but did not recall any other specific instructions about where to place soiled linen or whether to bag it during incontinence care. NA #1 verified she placed the soiled linen in the chair on top of the resident's bedspread, picked up the oxygen tubing off the floor and put the cannula in the resident's nose.

During an Interview on 7/27/12 at 12:49 PM the Infection Control Nurse explained nursing staff received in-service education in infection control when they were hired and periodically throughout the year. She stated they reviewed hand washing and use of gloves during resident care. She explained soiled linen should always be placed in a plastic bag and tied off before it was taken to the soiled linen barrels. She stated oxygen tubing should not be left on the floor and if a nasal cannula was in the floor the NA should notify the nurse so they could get a clean one for the resident.

During a follow up interview on 7/26/12 at 12:55 PM with NA #1 she stated she was very nervous this morning during Resident #22's care and she realized she should not have put the soiled linen in the residents chair on top of her bedspread. She stated she realized she should not have put the nasal cannula in the resident's nose after it

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F 441	Continued From page 9 had been on the floor. During an Interview on 7/27/12 at 1:17 PM the Director of Nursing (DON) stated it was her expectation if a nasal cannula was found on the floor in the resident's room it should be thrown away immediately and a clean one obtained for the resident. She explained soiled linen should never be placed on clean chairs or bedspreads and soiled linens should always be placed in plastic bags, tied off and disposed in soiled linen barrels.	F 441		