STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING _____ B. WING _____	C 06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 157 SS=G	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 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 review and resident and staff interviews the facility failed to notify the resident's physician and responsible party when a resident	F 157	F157 This plan of correction is the facility's credible allegation of compliance.	7/7/14

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

Electronically Signed | 06/27/2014

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F 157	Continued From page 1 experienced a physical change in condition which required hospitalization for one of one resident reviewed for a change in condition. (Resident #1) The findings included: Resident #1 was admitted to the facility on 02/27/13 diabetes, hypertension, and congestive heart failure. The most recent Minimum Data Set (MDS) dated 04/23/14 assessed Resident #1 as being cognitively intact. The MDS further indicated Resident #1 required oxygen therapy. Nurses' notes dated 05/18/14 at 7:08 AM written by Nurse #1 revealed Resident #1 was coughing up bloody mucous phlegm. Resident was crying stating she "was going to die if she didn't get to the hospital." Resident called RP (responsible party) in. EMS (emergency medical services) notified to send the emergency room for evaluation per RP request. Review of hospital Discharge Summary dated 05/27/14 revealed Resident #1 was admitted to the hospital 05/18/14 and discharged 05/28/14 with diagnoses which included pneumonia, acute exacerbation of chronic obstructive pulmonary disease, respiratory failure and urinary tract infection. On 06/09/14 at 2:42 PM an interview was conducted with Resident #1. Resident #1 stated when she went to the hospital on the morning of 05/18/14 she was coughing up blood and was very short of breath. She stated she "felt as if she was going to die." She reported to Nurse #1 she felt like she was going to die if she did not get to	F 157	**"Resident #1 was sent to hospital on May 18, 2014 by ambulance, family aware and Medical Doctor notified. **"100% audit of current residents with change in condition in facility was completed by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 6/10/14 to ensure resident□s physician and responsible party were notified. Audit revealed family and physician notifications were done on current residents with change of condition. **"All Licensed Nurses will be educated on Changes in Condition Reporting/ Documentation Guidelines, SBAR(Situation, Background, Assessment, and Request) Communication Tool,notification of resident, resident's physician, and if known, the resident's legal representative or interested family member when there is a resident change of condition. The Director of Nursing, Assistant Director of Nursing, or Administrator will be notified after hours and on weekends of resident change of condition. This in-service will be completed by Director of Nursing/Assistant Director of Nursing by July 1. 2014. All Certified Nursing Assistants will be educated on the Stop/Watch Tool and nurse notification for noted resident change of condition. This will be completed by the Director of Nursing/Assistant Director of Nursing by July 1, 2014.	

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F 157	Continued From page 2 the hospital. She told the nurse she was short of breath and coughing up blood at around 5:00 to 5:30 AM. Resident #1 stated Nurse #1 did nothing to help her and told her she would have to wait until after breakfast before she could be sent to the hospital. Resident #1 stated the nurse did not call her doctor or family regarding her change in condition. Resident #1 stated she called her family member with the help of Nursing Assistant #1. Resident #1 stated she told her family member she was dying and needed to get to the hospital. Resident #1 further stated her family member came to the facility and insisted she go to the hospital. On 06/09/14 at 3:23 PM a telephone interview was conducted with Nurse #1. Nurse #1 stated the resident was coughing up blood when she went in to assess her on the morning of 05/18/14. Nurse #1 stated she told the resident to call her daughter because when you can't get a doctor at night you can call a family member to send her to the hospital. Nurse #1 stated Resident #1 started to complain of coughing up blood at around 5:00 AM. Nurse #1 confirmed she did not provide medical intervention for the resident when she was coughing up blood including contacting the physician. On 06/09/14 at 3:38 PM an interview was conducted with Nurse #2. Nurse #2 stated she came into work around 6:40 AM the morning of 05/18/14. Nurse #2 stated she saw Resident #1's family member in the parking lot. She stated the family member asked her what was going on with Resident #1. Nurse #2 went to get Nurse #1 who told her the resident's oxygen saturation levels had been in the 80's. Nurse #2 stated the family wanted Resident #1 sent to the hospital. Nurse	F 157	All New Hire Nurses and Certified Nursing Assistants will be educated on Family/Physician Notification for resident change of condition, use of Condition Reporting/Documentation guidelines, SBAR and Communication. Stop/Watch Tool in General Employee Orientation by Assistant Director of Nursing or Director of Nursing beginning next scheduled orientation. Certified Nursing Assistants will use Stop/Watch Tool with nurse notification on change of resident condition. Nurse will use Change of Condition Guidelines, SBAR as well as information from Stop/Watch to perform resident observation/assessment. Nurse to notify family and physician of changes as well as documenting on twenty four hour report to ensure reporting to oncoming shift and will document nurses notes. The Nurse will evaluate the resident when notified of change in status. The nurse will notify the M.D. and family member or responsible party of the change in status. The change in medical status wil be documented in the medical record along with notification to the MD and family of any orders received. Director of Nursing or Assistant Director of Nursing will audit twenty four reports, use of Stop/Watch, and documentation in Nurses's notes of change of condition as well as family/physician notification	

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F 157	Continued From page 3 #2 stated she communicated with the resident's doctor to notify him they were sending Resident #1 to the hospital. Nurse #2 wrote the order for the Resident to be sent to the hospital per RP (responsible party) request and then called EMS. On 06/09/14 at 4:28 PM a telephone interview was conducted with Nursing Assistant (NA) #1. NA #1 stated during the morning of 05/18/14 Resident #1 was short of breath and coughing up blood. NA #1 stated the resident's bleeding had gotten worse during the night and there were a number of bloody tissues on her over bed table. NA #1 stated Nurse #1 had already been into see Resident #1 but she went to get her again around 6:00 AM. NA #1 stated sometime later she went back into the resident's room and Resident #1 asked her to call her family member so she dialed the number. She stated Resident #1 was hysterical and upset because she was having difficulty breathing and was unable to get to the hospital. On 06/10/14 at 11:12 AM an interview was conducted with the Director of Nursing (DON). The DON stated she was unaware Nurse #1 told Resident #1 to call her family on 05/18/14 when she voiced concerns about her condition to the nurse. The DON stated it was her expectation for Nurse #1 to have called the family and the resident's doctor because Resident #1 was coughing up blood which was a change in her condition.	F 157	Monday through Friday and will use audit tool for weekends for follow up on Monday. Any discrepancy identified will be addressed with certified nursing assistant and /or nurse 1:1 by Director of Nursing or Assistant Director of Nursing with appropriate counseling as deemed necessary. Audits will be conducted Monday-Sunday times 4 weeks, then weekly times two months by the Director of Nursing or Assistant Director of Nursing. **The Director of Nursing or Assistant Director of Nursing will prepare a summary of the monitoring and present to QA Committee monthly x 3 months at which time the Committee review with decisions to change if necessary. 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 conclusion set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely because it is required by provisions of state and federal law.	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		7/7/14

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F 309	Continued From page 4 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to implement medical intervention and initiate emergency medical service for a resident who was coughing up blood and was short of breath for 1 of 1 resident reviewed for change in condition. (Resident #1) The findings included: The facility's policy entitled "Change in Resident Medical Status/Condition" dated 06/2011 read in part, "The Nurse will evaluate the resident when notified of any change in status. The nurse will immediately notify the M.D. (Medical Doctor) and family member or responsible party of the change in status." Resident #1 was admitted to the facility on 02/27/13 with diagnoses which included chronic obstructive pulmonary disease, hypertension, diabetes and congestive heart failure. The most recent Minimum Data Set (MDS) dated 04/23/14 assessed Resident #1 as being cognitively intact. The MDS further indicated Resident #1 required oxygen therapy. A nurse's note dated 05/18/14 at 7:08 AM written by Nurse #1 indicated the resident had been coughing up bloody mucous phlegm. The	F 309	F309 This plan of correction is the facility's credible allegation of compliance. *Resident #1 was sent to hospital on May 18, 2014 by ambulance. Family aware and MD notified by Licensed nurse. *100% audit of current resident in facility with change of condition was completed by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 6/10/14 to ensure that medical intervention and/or emergency medical service was initiated as necessary. Audit revealed medical interventions per M.D. orders were initiated and emergency medical services initiated as necessary. * All Licensed Nurses will be educated on Changes in Condition Reporting/ Documentation Guidelines, SBAR(Situation, Background, Assessment, and Request) Communication Tool ,notification of resident, resident□s physician, and if known, the resident□s legal representative or interested family member when there is a resident change of condition and Stop/Watch Tool as well as initiating medical intervention and/or	

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F 309	Continued From page 5 resident had stated she was going to die if she did not get to the hospital. Resident #1 called her responsible party. EMS (Emergency Management Services) was notified to send the ER (Emergency Department) per responsible party's request. The EMS report dated 05/18/14 indicated Resident #1 was experiencing severe shortness of breath with bloody sputum. The EMS indicated they reached the facility at 7:15 AM and had resident at the hospital at 7:30 AM. The hospital History and Physical dated 05/18/14 indicated Resident #1 had blood tinged sputum which started that morning and was extremely short of breath with oxygen saturations were in the 70's by the time she arrived at the emergency room. The hospital Discharge Summary dated 05/27/14 revealed Resident #1 presented to the hospital with severe shortness of breath. Resident #1 was evaluated and found to have pneumonia associated with acute exacerbation of chronic obstructive pulmonary disease. It further described Resident #1 as being in acute respiratory failure. Resident #1 was treated with the following antibiotics, Zosyn, Levaquin and Vancomycin. Resident #1 was readmitted to the facility on 05/28/14 with diagnoses which included pneumonia, acute exacerbation of chronic obstructive pulmonary disease and acute respiratory failure. On 06/09/14 at 2:42 PM an interview was conducted with Resident #1. Resident #1 stated	F 309	emergency medical services as necessary by July 1st 2014 by Director of Nursing and Assistant Director of Nursing. All Certified Nursing Assistants will be educated on the Stop/Watch Tool and nurse notification for noted resident change of condition. This will be completed by the Director of Nursing/Assistant Director of Nursing by July 1, 2014. All New Hire Nurses and certified Nursing Assistants will be educated in General Orientation by the Director of Nursing/Assistant Director of Nursing on family /physician notification for resident change of condition, use of Condition Reporting/Documentation guidelines, SBAR communication, Stop.Watch Tool, and to initiate medical intervention and/or emergency medical services per Medical Doctor orders and as necessary. To Begin at next scheduled orientation date. Certified Nursing Assistants will use Stop/Watch Tool with nurse notification on any change of resident condition. Nurse will use Change of Condition Guidelines, SBAR as well as information from Stop/Watch to perform resident observation/assessment. Nurse to notify family and physician of changes as well as documenting on twenty four hour report to ensure reporting to oncoming shift and will document nurses notes. The Nurse will evaluate the resident when notified of change in status. The nurse will notify the M.D. and family member or responsible party of the change in status.	

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F 309	Continued From page 6 when she went to the hospital on the morning of 05/18/14 she was coughing up blood and was very short of breath. She stated she "felt as if she was going to die." She reported to Nurse #1 she felt like she was going to die if she did not get to the hospital. She told the nurse she was short of breath and coughing up blood at around 5:00 to 5:30 AM. Resident #1 stated Nurse #1 did nothing to help her and told her she would have to wait until after breakfast before she could be sent to the hospital. Resident #1 stated the nurse did not call her doctor or family regarding her change in condition. Resident #1 stated she called her family member with the help of Nursing Assistant #1. Resident #1 stated she told her family member she was dying and needed to get to the hospital. Resident #1 further stated her family member came to the facility and insisted she go to the hospital. On 06/09/14 at 3:00 PM an interview was conducted with the Director of Nursing (DON). The DON stated during the morning of 05/18/14 Resident #1 was coughing up blood and she had a change in condition. She stated Nurse #1 should have assessed the resident and notified the physician of the resident's condition. On 06/09/14 at 3:23 PM a telephone interview was conducted with Nurse #1. Nurse #1 stated the resident was coughing up blood when she went in to assess her on the morning of 05/18/14. Nurse #1 stated she told the resident to call her daughter because when you can't get a doctor at night you can call a family member to send her to the hospital. Nurse #1 stated Resident #1 started to complain of coughing up blood at around 5:00 AM. Nurse #1 confirmed she did not provide medical intervention for the resident when she	F 309	The change in medical status will be documented in the medical record along with notification to the MD and any orders received. Change in medical status will be documented on the 24 hour report and in the nurses notes. Family and M.D notification will be documented in the medical record/ and medical intervention implemented or emergency medical services initiated as necessary by Licensed Nurse per Physician order. **Director of Nursing or Assistant Director of Nursing will audit twenty four reports, use of Stop/Watch, and documentation in Nurses' Notes of change of condition, family, M.D. notification, implementation or medical interventions and/or initiating emergency medical services to assure that medical interventions and/or emergency service initiated as necessary. Any discrepancy identified will be addressed with certified nursing assistant and /or nurse 1:1 by Director of Nursing or Assistant Director of Nursing with appropriate counseling. Audits will be conducted Monday-Sunday x 4 weeks, then weekly x2 months by the Director of Nursing or Assistant Director of Nursing. **The Director of Nursing or Assistant Director of Nursing will prepare a summary of the monitoring and present to QA Committee monthly x 3 months at which time the Committee review with decisions to change as necessary.	

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F 309	Continued From page 7	F 309		

was coughing up blood including contacting the physician.

On 06/09/14 at 3:38 PM an interview was conducted with Nurse #2. Nurse #2 stated she came into work around 6:40 AM the morning of 05/18/14. Nurse #2 stated she saw Resident #1's family member in the parking lot. She stated the family member asked her what was going on with Resident #1. Nurse #2 went to get Nurse #1 who told her the resident's oxygen saturation levels had been in the 80's. Nurse #2 stated the family wanted Resident #1 sent to the hospital. Nurse #2 stated she communicated with the resident's doctor to notify him they were sending Resident #1 to the hospital. Nurse #2 wrote the order for the Resident to be sent to the hospital per RP (responsible party) request and then called EMS.

On 06/09/14 at 4:28 PM a telephone interview was conducted with Nursing Assistant (NA) #1. NA #1 stated during the morning of 05/18/14 Resident #1 was short of breath and coughing up blood. NA #1 stated the resident's bleeding had gotten worse during the night and there were a number of bloody tissues on her over bed table. NA #1 stated Nurse #1 had already been into see Resident #1 but she went to get her again around 6:00 AM. NA #1 stated sometime later she went back into the resident's room and Resident #1 asked her to call her family member so she dialed the number. She stated Resident #1 was hysterical and upset because she was having difficulty breathing and was unable to get to the hospital.

On 06/10/14 at 11:12 AM an interview was conducted with the Director of Nursing (DON). The DON stated she was unaware Nurse #1 told

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F 309	Continued From page 8 Resident #1 to call her family on 05/18/14 when she voiced concerns about her condition to the nurse. The DON stated it was her expectation for Nurse #1 to have called the family and the resident's doctor because Resident #1 was coughing up blood which was a change in her condition.	F 309		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to secure an oxygen tank and provide clean and unclogged oxygen tubing for 2 of 5 residents reviewed for respiratory care. (Residents #2 and #5) The findings included: 1. The facility's policy entitled Oxygen Storage (undated) read in part, "Each tank must be secured by a chain, on a cart or on a stand."	F 328	F328 This plan of correction is the facility's credible allegation of compliance. **Resident #5's empty oxygen tank was removed from the room and secured appropriately in oxygen room by licensed nurse immediately on observation on June 9, 2014. **Resident #2 nasal cannula was changed by licensed nurse immediately on observation on June 9, 2014.	7/7/14

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F 328	Continued From page 9 On 06/09/14 at 1:17 PM an observation was made of an unsecured oxygen tank sitting on top of Resident #5's dresser. Resident #5 had an empty oxygen caddy on the back of her wheelchair. During this observation Resident #5's roommate was trying to get to the bathroom in her wheelchair and got caught on Resident #5's foot rest. The Roommate was pulling on the handles of the dresser to help herself get by. On 06/09/14 at 1:20 PM an interview was conducted with Nursing Assistant (NA) #2. NA #2 stated the oxygen tank should be on the back of her chair or secured in the oxygen storage area. On 06/09/14 at 1:30 PM an interview was conducted with NA #3 who stated she saw the oxygen tank sitting on top of Resident #5's dresser but she had not put it there. On 06/09/14 at 1:55 PM an interview was conducted with the Director of Nursing (DON). The DON stated the oxygen tank should have been stored on the back of the resident's chair or if it was empty is should have been stored in the oxygen storage room. 2. The facility's policy entitled Oxygen Nasal Cannulas updated 03/2008 read in part, "Change when soiled and PRN " (as needed). Resident #2 was admitted to the facility on 05/09/14 with diagnoses which included pneumonia and chronic airway obstruction. The most current Admission Minimum Data Set dated 05/23/14 assessed Resident #2 as being cognitively intact. Review of physician's orders revealed an order	F 328	**On June 9, 2014, Director of Nurses/Assistant Director of Nursing conducted 100% audit of residents on oxygen. Oxygen cannulas were clean and changed as necessary. Audit of all rooms were completed by Director of Nursing on June 9, 2014 to ensure that tanks were secured by a chain, on a cart, wheel chair caddy, or stand when in use and that empty oxygen tanks were secured in the oxygen room appropriately. No other incidents of unsecured tanks were found. All new hires nurses and certified nursing assistants will be educated in General Orientation by the Director of Nursing/Assistant Director of Nursing on property securing all oxygen tanks and on changing oxygen nasal cannula when soliled and prn. To begin at next scheduled orientation. All licensed nurses and certified nursing assistants will be educated on properly securing all oxygen tanks including empty tanks and to change oxygen nasal cannula when soiled and prn by Director of Nursing and/or Assistant Director of Nursing. Education will be completed by July 1, 2014. Licenses nurses to check nasal cannula daily for need of changing with documentation on TAR with changes completed as necessary. Director of Nurses and Assistant Director of Nurses will audit resident's nasal oxygen cannula three times weekly as well as TAR for	

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LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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	Continued From page 10 dated 05/09/14 for oxygen at 4 liters per nasal cannula at all times. On 06/09/14 at 10:32 AM an observation was made of Resident #2's oxygen nasal cannula having dark debris in the nasal prong of the tubing. Resident #2 removed the tubing from his nose and stated "there is something wrong with this tubing." On 06/09/14 at 1:55 PM an interview was conducted with the Director of Nursing (DON). The DON stated Resident #2's oxygen tubing was dirty and the nasal prong was clogged. The DON further stated the tubing should have been changed.	F 328	compliance. Any discrepancy will be provided 1:1 by Director of Nurses and/or Assistant Director of Nurses with additional education or counseling as deemed necessary. Environment Services/Director of Nurses/Assistant Direotor of Nursing will do daily audits for unsecured oxygen tanks Monday-Friday with charge nurses completing audit Saturday and Sunday. This audit will be completed daily x 4 weeks, then weekly then 4 weeks, and monthly x 1 month. Any unsecured oxygen tanks will be secured immediately when found. Environmental Services or Director of Nurses or Assistant Director of Nurses will prepare a summary of monitoring for presentation during the monthly QA Committee Meeting x 3 month at which time the QA Committee will review with decisions to change if necessary. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of th facts alleged or conclusion set forth in thestatement of deficiencies. The plan of correctionis prepare and/or executed solely because it is required by provisions of state and federal law.	