STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL018018	A. BUILDING: _____ B. WING _____	R 05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE OF CONOVER	3430 LESTER STREET CONOVER, NC 28613

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Catawba County Department of Social Services conducted an annual and follow-up survey, and a complaint investigation on 05/14/18 and 05/15/18. The county initiated the complaint investigation on 04/30/18.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure the home was maintained free of all obstructions and hazards as related to portable oxygen cylinders stored in an unsafe manner. The findings are: Observation of oxygen storage room on 05/14/18 at 2:51pm revealed: -The oxygen storage closet was located in a community bathroom. -There were 3 full midsize (E) portable oxygen tanks in 3 midsize (E) portable rolling carts.	D 079		

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D 079	Continued From page 1 -There were 6 small M7 portable oxygen tanks out of the safety containers and stored on the floor. Interview with a personal care aide (PCA) on 05/14/18 at 2:35pm revealed: -All portable oxygen tanks were stored in a closet in one of the community bathrooms. -The portable tanks were not used and were full. -She could not remember how long the portable tanks were in there but that it was a least a year. -There was not another place to store the portable oxygen tanks. -She did not know how to safely store the portable oxygen tanks. Interview with a medication aide (MA) on 05/14/18 at 2:54pm revealed: -The portable tanks in the closet belonged to a resident. -The portable oxygen tanks were never used just stored. -She did not even know who to call for pick up or exchange. -She "stored the tanks standing up". -She did not know the portable oxygen tanks were to be stored, upright in a container that would prevent them rom falling. Interview with the maintenance director on 05/14/18 at 3:15pm revealed: -All of the tanks in the storage room belonged to a resident. -There was no ID plate on the tanks that tell what durable medical equipment company they belonged to. -The tanks were "safe" in the closet. -He was not aware of a policy for the safe storage of portable oxygen tanks.	D 079		

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D 079	Continued From page 2 Telephone interview with an oxygen supply representative on 05/14/18 at 4:05pm revealed: -The tanks were not stored in a safe manner. -All portable oxygen tanks were to be stored in stand or crate in an upright manner. -Portable oxygen tanks were not to be stored as "stand alone" because if they tipped over the tanks could become a "missile". Interview with the Administrator on 05/15/18 at 4:12pm revealed: -He was not aware of the portable oxygen tanks were stored in the closet without the safety crate. -Portable oxygen tanks were dangerous if they fell over so they must be stored in a crate. _____ The failure of the facility to be maintained free of hazards by improperly stored and unsecured portable oxygen tanks which puts residents at risk for injury and was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/14/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH JUNE 29, 2018.	D 079		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to refer and follow up with follow up with the physician and durable medical equipment company, to ensure the acute health care needs were met for 2 of 5 sampled residents (Resident #2) with physician orders for continuous oxygen at 2L/M and (Resident #4) with a physician order for portable oxygen at 2L/M during activity.

The findings are:

1. Review of Resident #2's current FL2 dated 04/10/18 revealed:
-Diagnoses included physical deconditioning, generalized weakness and neuropathy.
-An order for oxygen at 2L/M via nasal cannula (NC) continuously.

Review of a Resident #2's Cardiologist's order dated 04/03/18 revealed oxygen at 2L/M via NC continuously for hypoxia.

a. Review of Resident #2's Cardiology visit notes dated 04/03/18 revealed:
-Diagnoses included diastolic dysfunction (mild to moderate), coronary artery disease (CAD), myocardium infarction (MI), coronary artery bypass graft (CABG), pulmonary hypertension, peripheral vascular disease (PAD), chronic obstructive pulmonary disease (COPD), asthma, physical deconditioning and a pacemaker.
-Resident #2's heart ejection fraction was documented at "25-30 %" as of 10/17/16.
-The assessment diagnoses was documented as

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chronic systolic heart failure (Heart failure with reduced ejection fraction (HFrEF), also called systolic failure: The left ventricle loses its ability to contract normally. The heart can't pump with enough force to push enough blood into circulation) and hypoxia (a dangerous condition that happens when your body doesn't get enough oxygen).
-Resident #2's assessment included an oxygen saturation at rest of 93-96 % on room air however when Resident #2 ambulated in the room her oxygen saturation dropped to 79-83% on room air.
-Resident #2 was given oxygen via NC at 2L/M, walked again in the room and Resident #2's oxygen saturation stayed above 90% the whole time.

Review of Resident #2's nurse's notes revealed:
-There were only 3 entries for 2018.
-There were no entries related to oxygen.

Interview with Resident #2 on 05/14/18 at 10:25am revealed:
-She was to be on 2L/M via NC of oxygen continuously.
-She could not wear oxygen all of the time because she did not have portable tanks.
-She would become short of breath when she took off her oxygen and walked around.
-She liked to go outside and sit on the porch but could not because of not having portable oxygen.
-She walked to and from meals every day three times a day without oxygen and it was hard to breathe even before she would get out of the dining room.
-She "did not even have oxygen to go to activities and to the doctor".

Observation of Resident #2 on 05/14/18 from

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12:23pm to 12:45pm revealed:
-Resident #2 walked approximately 50 feet to the dining room without her oxygen on.
-She sat down and was short of breath.
-She rested before she could eat.
-At 12:45pm she walked back to her room without oxygen on and became very short of breath.
-After informing the medication aide (MA), Resident #2's oxygen saturation level was checked using an oxygen pulse oximeter.
-Resident #2's oxygen saturation was 85% on room air.
-The MA put Resident #2 on the oxygen concentrator at 2L/M via NC in Resident #2's room and left the room.

Interview with Resident #2 on 05/14/18 at 12:45pm revealed:
-It was hard for her to breathe walking back after meals without oxygen.
-She was confined to her room and if she left her room, it was without oxygen and she always became short of breath.

Observation of Resident #2 on 05/14/18 at 2:30pm revealed:
-Resident #2 walked approximately 100 feet from the front porch to her room without her oxygen on.
-She sat down and was short of breath.
-After informing the personal care aide (PCA), Resident #2's oxygen saturation level was checked using an oxygen pulse oximeter.
-Resident #2's oxygen saturation was 80% on room air.
-The PCA put Resident #2 on the oxygen concentrator at 2L/M via NC in Resident #2's room and left the room.

Interview with a PCA on 05/14/18 at 2:35pm

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revealed:
-She worked there for more than 2 years.
-Resident #2 had orders for continuous oxygen.
-She checked Resident #2's oxygen saturations when the resident was short of breath.
-She let the MA know of any issues with the residents and breathing difficulties.
-It was the responsibility of the MA to notify the physician about Resident #2's oxygen saturation and shortness of breath.

Interview with a MA on 05/14/18 at 2:54pm revealed:
-Resident #2's oxygen saturation was checked as needed.
-She did not notify anyone about Resident #2's oxygen saturation dropping because she would just put Resident #2 back on her concentrator and it was "all good".

Interview with the Resident Care Coordinator (RCC) on 05/14/18 at 4:05pm revealed she did not notify the physician Resident #2's portable oxygen was not available or that Resident #2's oxygen saturations dropped down to the 70s-80s.

Telephone interview with Resident #2's Primary Care Physician's Assistant (PA) on 05/15/18 at 8:21am revealed:
-She did not know Resident #2 had episodes of being short of breath or Resident #1 was having decreases in her oxygen saturations during daily activity.
-The facility staff did not call her and let her know Resident #2 was experiencing frequent drops in her oxygen saturation with minimal exertion.
-She considered this serious to Resident #2 because the lack of oxygen would lead to shortness of breath, and increase workload on the heart and lungs could lead to respiratory

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D 273	Continued From page 7 distress/failure and or an MI. Telephone interview with Resident #2's Cardiologist on 05/14/18 at 2:00pm and 05/15/18 at 10:18am revealed: -On 04/03/18 she ordered oxygen at 2L/M via NC for Resident #2 because of Resident #2's drop in oxygen saturation into the low 70's-80 causing hypoxemia. -Resident #2's oxygen saturation would drop into the 70's just from walking around in the room. -The facility did not notify her of Resident #2's low oxygen saturations. -Resident #2's heart ejection fraction was only operating at 25%, therefore not getting enough oxygen through Resident #2's system. -She was not notified of Resident #2 not having oxygen continuously or Resident #2's oxygen levels dropping. -Because of Resident #2's cardiac history with the heart pump not working effectively, having a pacemaker to make the heart pump the best it could, COPD, PAD, CABG, and the hypoxia, Resident #2's body required the supplemental oxygen continuously to get sufficient amounts of oxygen to the brain and heart. -With Resident #2's pulmonary hypertension, the hypoxia could lead to ischemia of the heart (decreased blood flow and oxygen to the heart muscle causing muscle death, a Myocardial Infarction (heart attack)) because of the decrease in Resident #2's oxygen. -Resident #2 could suffer an altered mental status from the decrease in oxygen saturation. -If the facility did not follow the orders as written Resident #2 could end up with life threatening issues that could be serious to Resident #2. Interview with the RCC on 05/15/18 at 9:00am revealed:	D 273		

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-When Resident #2 was short of breath the staff would take Resident #2 to her room and put her on oxygen.
-Resident #2 was not sent out to the emergency room or the physician was not notified because Resident #2's oxygen levels "came back up in 3-5 minutes".

Refer to interview with the LHPS Nurse on 05/14/17 at 3:40pm.

Refer to interview with the Administrator on 05/14/18 at 4:00pm.

b. Review of Resident #2's Care Plan dated 04/10/18 revealed a respiratory assessment documented as "oxygen at 2L/M via NC continuously".

Review of Resident #2's nurse's notes revealed:
-There were only 3 entries for 2018.
-There were no entries related to oxygen.

Interview with Resident #2 on 05/14/18 at 10:25am revealed:
-She was to be on 2L/M via NC of oxygen continuously.
-She could not wear oxygen all of the time because she did not have portable tanks.
-She would be short of breath if she took off her oxygen and walked around.
-She liked to go outside and sit on the porch but could not because of not having portable oxygen.
-She walked to and from meals every day three times a day without oxygen and it was hard to breathe even before she would get out of the dining room.
-She "did not even have oxygen to go to activities and to the doctor".

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D 273	Continued From page 9 Observation of Resident #2 on 05/14/18 from 12:23pm to 12:45pm revealed: -Resident #1 walked approximately 50 feet to the dining room without her oxygen on. -She sat down and was short of breath. -She rested before she could eat. -At 12:45pm she walked back to her room without oxygen on and became very short of breath. -After informing the medication aide (MA), Resident #2's oxygen saturation level was checked using an oxygen pulse oximeter. -Resident #2's oxygen saturation was 85% on room air. -The MA put Resident #2 on the oxygen concentrator at 2L/M via NC in Resident #2's room and left the room. Interview with Resident #2 on 05/14/18 at 12:45pm revealed: -It was hard for her to breathe walking back after meals without oxygen. -She was confined to her room and if she left her room, it was without oxygen and she always became short of breath. Observation of Resident #2 on 05/14/18 at 2:30pm revealed: -Resident #2 walked approximately 100 feet from the front porch to her room without her oxygen on. -She sat down and was short of breath. -After informing the personal care aide (PCA), Resident #2's oxygen saturation level was checked using an oxygen pulse oximeter. -Resident #2's oxygen saturation was 80% on room air. -The PCA put Resident #2 on the oxygen concentrator at 2L/M via NC in Resident #2's room and left the room.	D 273		

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D 273	Continued From page 10 Interview with a PCA on 05/14/18 at 2:35pm revealed: -Resident #2 had orders for continuous oxygen. -Resident #2 did not have portable tanks. -She did not know where portable tanks were stored and one other resident had some portable tanks. -She never put a resident on a portable oxygen tank before. Interview with a MA on 05/14/18 at 2:54pm revealed: -Resident #2 did not have portable oxygen tanks, only a concentrator. -A resident was to have an order for portable oxygen in order to get the portable oxygen other than the concentrator. -Resident #2 would go to all meals, activities, and out of the facility without oxygen because Resident #2 did not have portable tanks. -She did not notify the physician, RCC or durable medical equipment provider about not having portable oxygen because she would just put Resident #2 back on her concentrator and it was "all good". Interview with the Administrator on 05/14/18 at 4:00pm revealed: -Resident #2 was on oxygen. -He did not know Resident #2 was not on oxygen continuously as ordered. -He expected the staff to notify the physician and the durable medical equipment company about issues with the oxygen. Interview with the Resident Care Coordinator (RCC) on 05/14/18 at 4:05pm revealed: -She was responsible for all orders, labs X-rays and physician appointments and made sure those were all documented and carried out.	D 273		

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-Resident #2 was on oxygen at 2L/M via NC, continuously.
-Resident #2 did not have an order for "portable oxygen" therefore the facility could not get portable oxygen for Resident #2.
-She did not call the physician to get an order for portable oxygen.
-She did not call the durable medical equipment company to find out what was needed to get the portable oxygen.

Telephone interview with Resident #2's Primary Care Physician's Assistant (PA) on 05/15/18 at 8:21am revealed:
-She did not know Resident #2 was on continuous oxygen because it was ordered by the Cardiologist.
-The facility was to put all "specialist office visit notes" in a notebook for review by her to approve and to make sure she was aware of any changes in the resident's condition or medication changes.
-She did not see that note on Resident #2.
-She did not know Resident #2 did not have access to portable oxygen.
-If they would have notified her, she would have made sure the facility staff was using the portable oxygen tanks so Resident #2 could walk to and from meals without shortness of breath and could come out of the room to participate in activities.
-On 05/15/18 she immediately contacted the facility and ordered them to obtain portable oxygen.
-She expected the facility staff to follow all orders written and to notify her with any issues or concerns.
-She considered this serious to Resident #2 because the lack of oxygen would lead to shortness of breath, and increase workload on the heart and lungs could lead to respiratory distress/failure and or an MI.

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D 273	Continued From page 12 Telephone interview with a representative from the oxygen supply company on 05/15/18 at 10:30am and 11:47am revealed: -Services were offered for any resident requiring oxygen. -They needed to have an order from a physician and then they processed the insurance qualification sheet. -The process qualification sheet contained the basic information about the resident, i.e., name, date of birth, order and insurance information. -Once that information was received (about 10 minutes) the delivery for supplies was put in the system for an emergency delivery or next day. -We could not deliver just "portable" oxygen because the insurance would not cover it so the order must be for complete service. -The complete services include a concentrator and portable tanks depending on the amount of oxygen supplied to each resident (2L/M, 4L/M) and a request from the facility for the complete package, because "we do not know what the resident already paid for, (they may already have portable tanks or a concentrator)." -A client could not order just "portable oxygen services". It has to be all of the system and then let us know what of that the resident needed. -We started delivery for Resident #2 on 04/03/18 with an oxygen concentrator only. -The facility never requested portable oxygen system for Resident #2. -On 05/14/18 we received a call from the facility to deliver portable tanks for Resident #2 and #4. -That was the first call to deliver portable oxygen for Resident #2. Telephone interview with Resident #2's Cardiologist on 05/14/18 at 2:00pm and 05/15/18 at 10:18am revealed:	D 273		

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-On 04/03/18 she ordered oxygen at 2L/M via NC for Resident #2 because of Resident #2's drop in oxygen saturation into the low 70s-80 causing hypoxemia.
-She was not notified of Resident #2 not having oxygen continuously or Resident #2's oxygen levels dropping.
-Because of Resident #2's cardiac history with the heart pump not working effectively, having a pacemaker to make the heart pump the best it can, COPD, PAD, CABG, and the hypoxia, Resident #2's body required the supplemental oxygen continuously to get sufficient amounts of oxygen to the brain and heart.
-The facility staff did not call her and request an order for "portable oxygen"

Observation of Resident #2 on 05/15/18 at 1:15pm revealed she was sitting in the dining room with portable oxygen at 2L/M via NC.

Interview with Resident #2 on 05/15/18 at 1:15pm revealed:
-She felt a lot better because she was breathing easier.
-She could walk from the dining with oxygen on and felt a lot better.
-She was able to have oxygen while she was in the dining room with her meals and was easier to eat and breathe at the same time.
-She could now go to bingo and outside because of the portable oxygen instead of being confined to her room.

Review of Resident #2's oxygen delivery receipts revealed 4 E-Cylinders (used for back up and or portable oxygen delivery) with post valves and a chrome care (used to store oxygen cylinders upright), delivered on 05/14/18 at 4:30pm.

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Interview with the LHPS Nurse on 05/14/17 at 3:40pm revealed:
-The MAs were responsible for applying and removing nasal cannula's, replacing empty tanks with full ones and adjusting oxygen flow according to doctor's orders.
-She did not know Resident #2 did not have portable tanks to use.

Refer to interview with the Administrator on 05/14/18 at 4:00pm.

2. Review of Resident #4's current FL2 dated 12/04/17 revealed:
-Diagnoses included COPD, encephalopathy, shortness of breath, altered mental status and hypertension.
-An order for oxygen at 2L/M via nasal cannula (NC) during the hours of sleep.

Review of Resident #4's subsequent physician's orders revealed an order dated 05/09/18 for portable oxygen via NC at 2L/M with activity. Diagnoses: hypoxemia, COPD, and an oxygen saturation while walking in the room of 85% on room air.

a. Review of Resident #4's Care Plan dated 12/04/17 revealed a respiratory assessment documented as "oxygen and shortness of breath".

Review of Resident #4's March 2018 Treatment Administration Record (TAR) revealed:
-An entry for oxygen at 2L/M via NC documented as administered at bedtime only (8:00pm).
-An entry for a pulse oximeter check every shift, documented as obtained at 7:00am - 3:00pm, 3:00pm - 11:00pm and 11:00pm - 7:00am.
-There were 93 entries documented with oxygen

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saturation results,43 entries were documented as 90% or less, 21 entries were documented as 85% or less and 2 entries were documented as refused.

Review of Resident #4's April 2018 Treatment Administration Record (TAR) revealed:
-An entry for oxygen at 2L/M via NC documented as administered at bedtime only (8:00pm).
-An entry for a pulse oximeter check every shift, documented as obtained at 7:00am - 3:00pm, 3:00pm - 11:00pm and 11:00pm - 7:00am.
-There were 90 entries documented with oxygen saturation results, 27 entries were documented as 90% or less, and 5 entries were documented as 85% or less.

Review of Resident #4's May 2018 Treatment Administration Record (TAR) revealed:
-An entry for oxygen at 2L/M via NC documented as administered at bedtime only (8:00pm).
-An entry for a pulse oximeter check every shift, documented as obtained at 7:00am - 3:00pm, 3:00pm - 11:00pm and 11:00pm - 7:00am.
-There were 42 entries documented with oxygen saturation results 05/01/18 - 05/14/18, 17 entries were documented as 90% or less, 2 entries were documented as 85% or less and 1 of the entries was documented as refused.

Review of Resident #4's physician's notes revealed:
-A note dated 04/11/18 documented Resident #4 was complaining of chest pain and assessed as being shortness of breath with exertion, COPD, no cough and hypoxemia at times. Resident #4 was sent to the emergency room for evaluation.
-A noted dated 05/09/18 documented Resident #4 being short of breath with exertion and low oxygen saturation of 83% on room air reported by

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physical therapy (PT) on 05/04/18. Resident #4 was assessed as being short of breath with exertion and diagnosed with hypoxemia and was sent out to the emergency room for evaluation.

Review of emergency room chest X-ray reports dated 04/11/18 and 05/09/18 revealed chronic lung disease and no acute findings.

Review of Resident #4's PT notes revealed:
-A note dated 04/04/18 documented a drop in oxygen saturation to 85% during ambulation for 12 minutes.
-A note dated 05/04/18 documented a drop in oxygen saturation to 88% after 8 minutes of ambulation.

Review of Resident #4's nurses' notes revealed:
-A note dated 05/04/18 by PT documenting Resident #4 "desats to 83%" with ambulation and without oxygen.
-A note dated 05/12/18 by PT documenting Resident #4 "continued to have issues with oxygen saturations dropping with minimal exertion".

Observation of Resident #4 on 05/14/18 1:00pm revealed:
-Resident #4 walked approximately 100 feet to his room without his oxygen on.
-He sat down on his bed and was short of breath.
-After informing the personal care aide (PCA), Resident #4's oxygen saturation level was checked using an oxygen pulse oximeter.
-Resident #4's oxygen saturation was 80% on room air.
-The PCA put Resident #4 on the oxygen concentrator at 2L/M via NC in Resident #4's room and left the room.

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Interview with a PCA on 05/14/18 at 2:35pm revealed:
-She worked there for more than 2 years.
-Resident #4 had orders for continuous oxygen.
-She checked Resident #4's oxygen saturations when the resident was short of breath.
-Resident #4 became short of breath 2-3 times a day and the oxygen saturation fell below 80%.
-She would then put Resident #4 back on his oxygen concentrator and the oxygen level would increase to 90% after "2 minutes".
-She let the MA know of any issues with the residents and breathing difficulties.

Interview with a MA on 05/14/18 at 2:54pm revealed:
-Resident #4's oxygen saturation was checked every shift and as needed.
-She did not notify anyone about a drop in oxygen saturation because she would just put Resident #4 back on his concentrator and it was "all good".

Observation of Resident #4 on 05/14/18 at 3:30pm revealed:
-He returned to his room short of breath without oxygen on.
-A PCA checked his oxygen saturation level and it was 82% on room air.

Interview with Resident #4 on 05/14/18 at 3:30pm reveled:
-He was short of breath and asked the PCA to check his oxygen level.
-He put his oxygen on himself after the PCA checked his oxygen level.

Telephone interview with Resident #4's physician assistant (PA) on 05/15/18 at 8:21am revealed:
-On 04/11/18 Resident #4 became short of breath and had chest pains. Resident #4 was sent to the

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emergency room for evaluation.
-On 05/04/18, it was reported to her by the Physical Therapist, Resident #4 became short of breath and had a decrease in oxygen saturation on exertion during this PT visit and on 6 other visits as well.
-The Physical Therapist reported the oxygen saturation was in the low 70s to 80s during activity.
-On 05/09/18 she saw Resident #4 in the facility.
-She diagnosed Resident #4 with shortness of breath during exertion and hypoxemia because of Resident #4 having desaturations in oxygen during exertion.
-She did not know Resident #4 was having issues with low oxygen levels or desaturations since 05/09/18.
-She expected the facility staff to follow her orders and to call with decreased oxygen saturations.
-Resident #4's drop in oxygen saturation could lead to decreased oxygen profusion to Resident #4's heart and brain leading to respiratory distress, MI and or brain damage and she considered it serious for Resident #4.

Interview with the Resident Care Coordinator (RCC) on 05/15/18 at 9:00am revealed:
-Resident #4 was to wear his oxygen during activity.
-When Resident #4 was short of breath the staff would take him to his room and put him on his oxygen.
-Resident #4 was not sent out to the emergency room because his oxygen levels "came back up in 3-5 minutes".
-She did not notify Resident #4's physician about low oxygen saturations because the oxygen saturations would come back up after he was placed back on oxygen at 2L/M via NC.

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D 273	Continued From page 19 Interview with Resident #4's Physical Therapist on 05/15/18 at 3:30pm revealed: -Resident #4's PT started on 03/08/18. -Resident #4 had good and bad days because of his breathing and his oxygen saturations dropping. -According to her notes, she reported "major drops" in Resident #4's oxygen saturations on 3/12/18, 03/19/18, 04/25/18, 05/08/18, and 05/12/18 reported to the shift MA's. -On 05/04/18, a PT re-evaluation was performed to requalify him and the plan of care changed because of Resident #4's increase in oxygen desaturations. -The facility staff reported to her their concerns about Resident #4's issues with the decrease in oxygen saturation on 05/04/18. -She reported her concerns to Resident #4's PA on 05/04/18. -On 05/12/18 Resident #4 became dizzy and his oxygen saturation dropped into the 70s. The staff was notified at the facility. -Today (05/15/18) Resident #4 had a much easier time with PT visit on 2L/M via NC while participating in his PT plan without a drop in his oxygen saturation. Refer to interview with the LHPS Nurse on 05/14/17 at 3:40pm. Refer to interview with the Administrator on 05/14/18 at 4:00pm. b. Review of Resident #4's PT notes revealed: -A PT assessment dated 05/04/18 documented Resident #4 "may need to use supplemental oxygen during ambulation". -A plan was documented as contacting Resident #4's physician regarding the use of supplemental	D 273		

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D 273	Continued From page 20 oxygen during ambulation. Observation of Resident #4 on 05/14/18 1:00pm revealed: -Resident #4 walked approximately 100 feet to his room without his oxygen on. -He sat down on his bed and was short of breath. -After informing the PCA, Resident #4's oxygen saturation level was checked using an oxygen pulse oximeter. -Resident #4's oxygen saturation was 80% on room air. -The PCA put Resident #4 on the oxygen concentrator at 2L/M via NC in Resident #4's room and left the room. Interview with a personal care aide (PCA) on 05/14/18 at 2:35pm revealed: -Resident #4 was on continuous oxygen. -Resident #4 did not have portable tanks. -She did not know where portable tanks were stored and one other resident had some portable tanks. -She never put a resident on a portable oxygen tank before. Interview with a MA on 05/14/18 at 2:54pm revealed: -Resident #4 did not have a portable oxygen tanks, only a concentrator. -A resident was to have an order for portable oxygen in order to get the portable oxygen other than the concentrator. -Resident #4 would go to all meals, activities, and out of the facility without oxygen because Resident #4 did not have portable tanks. -She did not notify the Resident #4's physician or the durable medical equipment company about not having portable oxygen because she would just put Resident #4 back on his concentrator and	D 273		

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D 273	Continued From page 21 it was "all good". Interview with Resident #4 on 05/14/18 at 3:30pm reveled: -He did not have portable oxygen for walking down the hall. -His oxygen was set at 2L/M via NC from a concentrator. -His Physical Therapist told him that he needed a portable tank with activity so he would not get so short of breath. Interview with the Administrator on 05/14/18 at 4:00pm revealed: -Resident #4 was on oxygen. -He did not know Resident #4 was not on oxygen continuously as ordered. -He expected the RCC and MA to notify the physician if they could not fulfill the order for oxygen. Telephone interview with Resident #4's PA on 05/15/18 at 8:21am revealed: -On 12/04/17, an order was written for oxygen at 2L/M via NC during the night for Resident #4. -No one from the facility notified her they could not get portable oxygen. -No one from the facility requested and order for portable oxygen. -On 05/09/18, she wrote an order for portable oxygen for Resident #4 based on the Physical Therapist's observations and her assessment. -On 05/09/18, she sent an order to the durable medical equipment company for Resident #4 to have portable oxygen at 2L/M via NC. -She did not know Resident #4 did not have portable oxygen since 05/09/18. -Resident #4 not having portable oxygen during activity could lead to a drop in Resident #4's oxygen saturation, thus it could lead to decreased	D 273		

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oxygen profusion to Resident #4's heart and brain leading to respiratory distress, MI and or brain damage and she considered it serious for Resident #4.

A second interview with the RCC on 05/15/18 at 12:39pm revealed:
-She did know about the order written by Resident #4's PA for portable oxygen on 05/09/18.
-The durable medical equipment company called her on 05/10/18 to let her know Resident #4 was discharged from their company in 01/2018.
-She was told by the durable equipment company which company was listed as Resident #4's supplier.
-She called the other durable equipment company on 05/11/18 and was told Resident #4 was not listed as their client either.
-She was not able to locate a durable equipment company that supplied Resident #4 with oxygen.
-She did not notify the PA she was unable to obtain portable oxygen as ordered.

Review of Resident #4's physician order form dated 05/15/18 revealed:
-This form was to requalify Resident #4 for durable medical equipment.
-An order for oxygen therapy consisted of; portable oxygen at 2L/M via NC, a conservation device (a type of cannula that conserves oxygen) at 2L/M via NC and an overnight pulse oximetry.
-The orders were signed by Resident #4's PA.

Interview with Resident #4 on 05/15/18 at 3:20pm revealed:
-He had issues with breathing while walking because he became very short of breath.
-While he did PT, he became short of breath even with just walking in the room without oxygen

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on.
-His Physical Therapist called his PA to let her know he needed portable oxygen.
-He just received his portable tank 2 hours ago and his PT visit was a lot easier on him because of the portable oxygen tank.

Interview with Resident #4's Physical Therapist on 05/15/18 at 3:30pm revealed on 03/26/18 she put him on his concentrator in his room to do the bicycle exercise and Resident #4's oxygen saturations stayed above 90% with 2L/M via NC.

Telephone interview with a representative from the oxygen supply company on 05/15/18 at 10:30am and 11:47am revealed:
-Services were offered for any resident requiring oxygen.
-They needed to have an order from a physician and then they processed the insurance qualification sheet.
-The process qualification sheet contained the basic information about the resident, i.e., name, date of birth, order and insurance information.
-Once that information was received (about 10 minutes) the delivery for supplies was put in the system for an emergency delivery or next day.
-We could not deliver just "portable" oxygen because the insurance would not cover it so the order must be for complete service.
-The complete services include a concentrator and portable tanks depending on the amount of oxygen supplied to each resident (2L/M, 4L/M) and a request from the facility for the complete package, because "we do not know what the resident already paid for, (they may already have portable tanks or a concentrator)."
-On 05/09/18 we received an order for "portable oxygen" for Resident #4 via fax.
-On 5/10/18 the facility called about the order for

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portable oxygen and was told that Resident #4 was not in our system.
-On 05/11/18 we called the facility and informed them that Resident #4 was a client of another durable medical equipment company.
-On 05/11/18 one of our representatives called that company and was told Resident #4 was not their client as noted in the database for services.
-That representative called the facility and informed the facility Resident #4 was not a client at any durable medical equipment company.
-No new orders, or a recertification was received.
-On 05/15/18 a representative went to the facility and initiated a recertification by filling out the paperwork and calling the physician for a new order for oxygen.
-The concentrator Resident #4 had was from an unknown company. There was no sticker on the concentrator and it was not theirs.

Interview with the LHPS Nurse on 05/14/17 at 3:40pm revealed:
-The MAs were responsible for applying and removing nasal cannula's, replacing empty tanks with full ones and adjusting oxygen flow according to doctor's orders.
-She did not know Resident #4 did not have portable tanks to use.

Interview with the Administrator on 05/14/18 at 4:00pm revealed:
-The RCC was responsible for making sure all orders received on all residents were carried out as ordered.
-He expected the staff to carry out all orders as written and to call the physician with any issues or clarifications.
-There were Policies and Procedures in place for reporting resident changes (MA to the physicians

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D 273	Continued From page 25 and staff to staff). -Some examples were; a shift to shift report, care given that day to the oncoming shift, immediate notification to the supervisor with any changes in a residents condition or concerns, and observe residents functional status and report concerns(PCAs to MA, then MAs to RCC and RCC to physician). -All MAs were to fill out a shift report sheet. -He was not able to provide the shift report sheets. -The orders were put in place by the physician to meet the residents' needs and if there were any concerns or issues the physician should be notified. The facility failed to provide services necessary to maintain the physical heath of two residents who required portable oxygen continuously while outside of their room which resulted numerous occasions of Resident #2's and #4's oxygen saturation levels dropping below 90% and then not notifying the physician which put the residents at substantial risk of serious injury and this constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/14/18 for this violation. DATE OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 8, 2018.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record:	D 276		

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D 276	Continued From page 26 (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement physician orders for 2 of 5 sampled residents with physician orders for oxygen administration (Resident #2 and #4). The findings are: 1. Review of Resident #2's current FL2 dated 04/10/18 revealed: -Diagnoses included physical deconditioning, generalized weakness and neuropathy. -An order for oxygen at 2L/M via nasal cannula (NC) continuously. Review of a Resident #2's Cardiologist's order dated 04/03/18 revealed an order for oxygen at 2L/M via NC continuously for hypoxia. Review of Resident #2's Care Plan dated 04/10/18 revealed a respiratory assessment documented as "oxygen at 2L/M via NC continuously". Observation of Resident #2 on 05/14/18 from 12:23pm to 12:45pm revealed: -Resident #2 walked approximately 50 feet to the dining room without her oxygen on.	D 276		

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-She sat down and was short of breath.
-She rested before she could eat.
-At 12:45pm she walked back to her room without oxygen on and became very short of breath.
-After informing the medication aide (MA), Resident #2's oxygen saturation level was checked using an oxygen pulse oximeter.
-Resident #2's oxygen saturation was 85% on room air.
-The MA put Resident #2 on the oxygen concentrator at 2L/M via NC in Resident #2's room and left the room.
-After informing the medication aide (MA), Resident #2's oxygen saturation level was checked using an oxygen pulse oximeter.
-Resident #2's oxygen saturation was 85% on room air.
-The MA put Resident #2 on the oxygen concentrator at 2L/M via NC in Resident #2's room and left the room.

Observation of Resident #2 on 05/14/18 at 2:30pm revealed:
-Resident #2 walked approximately 100 feet from the front porch to her room without her oxygen on.
-She sat down and was short of breath.
-After informing the personal care aide (PCA), Resident #2's oxygen saturation level was checked using an oxygen pulse oximeter.
-Resident #2's oxygen saturation was 80% on room air.
-The PCA put Resident #2 on the oxygen concentrator at 2L/M via NC in Resident #2's room and left the room.

Review of Resident #2's Cardiology visit notes dated 04/03/18 revealed:
-Resident #2's assessment included an oxygen saturation at rest of 93-96 % on room air however

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when Resident #1 ambulated in the room that oxygen saturation dropped to 79-83% on room air.
-Resident #2 was given oxygen via NC at 2L/M and walked again in the room and Resident #2's oxygen saturation stayed above 90% the whole time.

Review of Resident #2's April 2018 Treatment Administration Record (TAR) revealed an entry for oxygen at 2L/M via NC at documented as administered at 7am - 3pm shift, 3pm - 11pm shift and 11pm - 7am shift for 74 out of the 83 shifts.

Review of Resident #2's May 2018 TAR revealed an entry for oxygen at 2L/M via NC at documented as administered at 7am - 3pm shift, 3pm - 11pm shift and 11pm - 7am shift for 42 out of the 43 shifts.

Review of Resident #2's nurse's notes revealed:
-There were only 3 entries for 2018.
-There were no entries related to oxygen.

Interview with Resident #2 on 05/14/18 at 10:25am revealed:
-She was to be on 2L/M via NC of oxygen continuously.
-She could not wear oxygen all of the time because she did not have portable tanks.
-She would be short of breath if she took off her oxygen and walked around.
-She liked to go outside and sit on the porch but could not because of not having portable oxygen.
-She walked to and from meals every day three times a day without oxygen and it was hard to breathe even before she would get out of the dining room.
-She "did not even have oxygen to go to activities and to the doctor".

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D 276	Continued From page 29 Interview with Resident #2 on 05/14/18 at 12:45pm revealed: -She wore oxygen only when she was in her room because she did not have portable oxygen tanks. -It was hard for her to breathe walking back after meals without oxygen. -She was confined to her room and if she left her room, it was without oxygen and she always became short of breath. Interview with a PCA on 05/14/18 at 2:35pm revealed: -She worked there for more than 2 years. -Resident #2 had an order for continuous oxygen. -Resident #2 did not have portable tanks. -She never put a resident on a portable oxygen tank before. -Resident #2 was not able to be on oxygen continuously because they had no portable oxygen. Interview with a MA on 05/14/18 at 2:54pm revealed: -Resident #2 did not have portable oxygen tanks only a concentrator. -Resident #2 would go to all meals, activities, and out of the facility without oxygen because Resident #2 did not have portable tanks. Interview with the Resident Care Coordinator (RCC) on 05/14/18 at 4:05pm revealed: -She was responsible for all orders, labs X-rays and physician appointments and made sure those were all documented and carried out. -Resident #2 was on oxygen at 2L/M via NC, continuously. -Resident #2 was unable to have continuous oxygen because they did not have an order for "portable oxygen".	D 276		

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Telephone interview with Resident #2's Primary Care Physician's Assistant (PA) on 05/15/18 at 8:21am revealed:
-If they would have notified her, she would have made sure the facility staff was using the portable oxygen tanks so Resident #2 could walk to and from meals without shortness of breath and could come out of the room to participate in activities.
-She called the facility to have the facility get portable oxygen tanks for Resident #2.
-She expected the facility staff to follow all orders written and to notify her with any issues or concerns.
-She considered this serious to Resident #2 because the lack of oxygen would lead to shortness of breath, and increase workload on the heart and lungs which could lead to respiratory distress/failure and or an MI.

Interview with the RCC on 05/15/18 at 9:00am revealed:
-Resident #2 only had a concentrator for oxygen use and nothing for portable use.
-She did not think to put the concentrator in the dining room with Resident #2 while Resident #2 had her meals.

Observation of Resident #2 on 05/15/18 at 1:15pm revealed she was sitting in the dining room with portable oxygen at 2L/M via NC.

Interview with Resident #2 on 05/15/18 at 1:15pm revealed:
-She felt a lot better because she was breathing easier.
-She could walk from the dining with oxygen on and felt a lot better.
-She was able to have oxygen while she was in the dining room with her meals and was easier to

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eat and breathe at the same time.
-She could now go to bingo and outside because of the portable oxygen instead of being confined to her room.

Telephone interview with Resident #2's Cardiologist on 05/14/18 at 2:00pm and 05/15/18 at 10:18am revealed:
-On 04/03/18 she ordered oxygen at 2L/M via NC for Resident #2 because of Resident #2's drop in oxygen saturation into the low 70's-80 causing hypoxemia.
-Resident #2's oxygen saturation would drop into the 70's just from walking around in the room.
-Resident #2's heart ejection fraction was only operating at 25%, therefore not getting enough oxygen through Resident #2's system.
-She was not notified of Resident #2 not having oxygen continuously or Resident #2's oxygen levels dropping.
-Because of Resident #2's cardiac history with the heart pump not working effectively, having a pacemaker to make the heart pump the best it can, COPD, PAD, CABG, and the hypoxia, Resident #2's body required the supplemental oxygen continuously to get sufficient amounts of oxygen to the brain and heart.
-With Resident #2's pulmonary hypertension, the hypoxia could lead to ischemia of the heart (decreased blood flow and oxygen to the heart muscle causing muscle death, a Myocardial Infarction (heart attack)) or her heart to stop because of the decrease in Resident #2's oxygen.
-Resident #2 could suffer an altered mental status from the decrease in oxygen saturation.
-If the facility did not follow the orders as written Resident #2 could end up with life threatening issues that could be serious to Resident #2.

Interview with the Administrator on 05/14/18 at

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4:00pm revealed:
-Resident #2 was on oxygen.
-He did not know Resident #2 was not on oxygen continuously as ordered.
-The RCC informed him on 05/14/18 there was an issue with getting the portable oxygen tanks for Resident #2 and the RCC was working to resolving the problem.
Interview with the Resident Care Coordinator (RCC) on 05/14/18 at 4:05pm revealed:
-She was responsible for all orders, labs X-rays and physician appointments and made sure those were all documented and carried out.
-Resident #2 did not have an order for "portable oxygen" therefore the facility could not get portable oxygen for Resident #2.

Refer to interview with the Administrator on 05/14/18 at 4:00pm.

Refer to interview with the Administrator on 05/15/18 at 4:12pm.

2. Review of Resident #4's current FL2 dated 12/04/17 revealed:
-Diagnoses included COPD, encephalopathy, shortness of breath, altered mental status and hypertension.
-An order for oxygen at 2L/M via nasal cannula (NC) during the hours of sleep.

Review of Resident #4's subsequent physician's orders revealed an order dated 05/09/18 for portable oxygen via NC at 2L/M with activity. Diagnoses: hypoxemia, COPD, and an oxygen saturation while walking in the room of 85% on room air.

Observation of Resident #4 on 05/14/18 1:00pm revealed:

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-Resident #4 walked approximately 100 feet to his room without his oxygen on.
-He sat down on his bed and was short of breath.
-After informing the personal care aide (PCA), Resident #4's oxygen saturation level was checked using an oxygen pulse oximeter.
-Resident #4's oxygen saturation was 80% on room air.
-The PCA put Resident #4 on the oxygen concentrator at 2L/M via NC in Resident #4's room and left the room.

Review of Resident #4's Care Plan dated 12/04/17 revealed a respiratory assessment documented as "oxygen and shortness of breath".

Review of Resident #4's May 2018 Treatment Administration Record (TAR) revealed an entry for oxygen at 2L/M via NC documented as administered at bedtime only (8:00pm).

Review of Resident #4's physician's notes revealed:
-A note dated 04/11/18 documented Resident #4 was complaining of chest pain and assessed as being short of breath with exertion, COPD, no cough and hypoxemia at times. Resident #4 was sent to the emergency room for evaluation.
-A noted dated 05/09/18 documented Resident #4 being short of breath with exertion and low oxygen saturation of 83% on room air reported by physical therapy (PT) on 05/04/18. Resident #4 was assessed as being short of breath with exertion and diagnosed with hypoxemia and was sent out to the emergency room for evaluation.

Review of Resident #4's nurses' notes revealed:
-A note dated 05/04/18 by PT documenting Resident #4 "desats to 83%" with ambulation and

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without oxygen.
-A note dated 05/12/18 by PT documenting Resident #4 "continued to have issues with oxygen saturations dropping with minimal exertion".
-There were no entries related to Resident #4 not having portable oxygen.

Interview with a PCA on 05/14/18 at 2:35pm revealed:
-She worked there for more than 2 years.
-Resident #4 had orders for continuous oxygen.
-Resident #4 did not have portable tanks.
-She never put a resident on a portable oxygen tank before.

Interview with a MA on 05/14/18 at 2:54pm revealed:
-Resident #4 did not have portable oxygen tanks only concentrators.
-Resident #4 would go to all meals, activities, and out of the facility without oxygen because Resident #4 did not have portable tanks.

Observation of Resident #4 on 05/14/18 at 3:30pm revealed:
-He returned to his room short of breath without oxygen on.
-A PCA checked his oxygen saturation level and it was 82% on room air.

Interview with Resident #4 on 05/14/18 at 3:30pm reveled:
-He did not have portable oxygen for walking down the hall.
-His oxygen was set at 2L/M via NC from a concentrator.
-His Physical Therapist told him that he needed a portable tank with activity so he would not get so short of breath.

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D 276	Continued From page 35 Interview with the Resident Care Coordinator (RCC) on 05/15/18 at 9:00am revealed: -Resident #4 was to wear his oxygen during activity. -When Resident #4 was short of breath the staff would take him to his room and put him on his oxygen. -Resident #4 only had a concentrator for oxygen use and nothing for portable use and could not be provided continuous oxygen. -She could not get portable oxygen for Resident #4 as ordered because "no durable medical equipment company was his provider". Interview with RCC on 05/15/18 at 12:39pm revealed she did know about the order written by Resident #4's PA for portable oxygen on 05/09/18. Interview with Resident #4 on 05/15/18 at 3:20pm revealed: -He had issues with breathing while walking because he became very short of breath. -He was on oxygen at night but did not have a portable tank to use while out of his room. -He did not use oxygen continuously. Telephone interview with Resident #4's PA on 05/15/18 at 8:21am revealed: -On 04/11/18, Resident #4 became short of breath and had chest pains. Resident #4 was sent to the emergency room for evaluation. -The Physical Therapist reported on 05/04/18 the oxygen saturation was in the low 70s to 80s during activity. -On 05/09/18 she saw Resident #4 in the facility and diagnosed Resident #4 with shortness of breath during exertion and hypoxemia. -On 05/09/18, she wrote an order for portable	D 276		

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oxygen for Resident #4.
-She did not know Resident #4 did not have portable oxygen since 05/09/18.
-She expected the facility to follow her orders and to call with any issues.
-Resident #4 not having portable oxygen during activity could lead to a drop in Resident #4's oxygen saturation, thus it could lead to decreased oxygen profusion to Resident #4's heart and brain leading to respiratory distress, MI and or brain damage and she considered it serious for Resident #4

Interview with the Administrator on 05/14/18 at 4:00pm revealed:
-Resident #4 was on oxygen.
-He did not know Resident #4 was not on oxygen continuously as ordered.
-There were issues with Resident #4 that he was aware of and the RCC was working on it today (05/14/18).

Refer to interview with the Administrator on 05/14/18 at 4:00pm.

Refer to interview with the Administrator on 05/15/18 at 4:12pm.

Interview with the Administrator on 05/14/18 at 4:00pm revealed:
-The RCC was responsible for making sure all orders received on all residents were carried out as ordered.
-He expected the staff to carry out all orders as written and to call with any issues or clarifications.
-He considered an order for continuous oxygen to be given "all of the time" not just "some of the time".

Interview with the Administrator on 05/15/18 at

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D 276	Continued From page 37 4:12pm revealed the RCC and or MA should have notified the physician's office and the durable medical equipment company to find out what was needed to get the portable tanks that were ordered by the physician. The facility failed to implement physician orders for Resident #2 and #4 related to administration of oxygen as ordered which resulted in 2 emergency room visits for (Resident #4), and constant drops in oxygen saturation. This failure resulted in neglect and a risk for serious physical harm and injury to residents #2 and #4 and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/14/18 for this violation. DATE OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 8, 2018.	D 276		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by:	D 287		

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D 287	Continued From page 38 Based on observations, interviews and record reviews, the facility failed to assure table service included a non-disposable place setting consisting of a knife, fork, and spoon. The findings are: Observation of the dining room on 05/14/18 at 11:25am revealed the place settings on the tables consisted of a fork and spoon folded in a napkin. Observations of the lunch meal service on 05/14/18 between 12:05pm to 12:45pm revealed: -There were 43 residents seated in the dining room. -The meal served to residents included meatloaf with gravy, mashed potatoes, green beans (pre-cut in approximately ¾ inch pieces), canned pears and a dinner roll. Observation of the dining room on 05/14/18 at 5:05pm revealed the place settings on the tables consisted of a fork and spoon folded in a napkin. Observations of the dinner meal service on 05/14/18 between 5:05pm to 5:40pm revealed: -There were 48 residents seated in the dining room. -The meal served to residents included a grilled meat and cheese sandwich, pasta salad, stewed tomatoes (sliced) and a piece of chocolate cake. Interview with a dietary aide on 05/14/18 at 11:26am revealed: -She had been working at the facility for approximately three years. -There had never been a knife as a part of the place setting "for as long as she had worked at the facility". -It was due the "their [residents] mental health	D 287		

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issues".
-"I just do what I am told."

Interview with a medication aide on 05/14/18 at 12:25pm revealed:
-She had been working at the facility for 7-8 years.
-She was trained knives would not be placed at the tables due to the "potential of residents using the knife as a weapon".
-They did not "put out knives so the residents wouldn't take them [knives] or use them to hurt someone".
-It's "always been that way".
-She did not know if a safety assessment had been completed on the residents.

Interview with a resident on 05/14/18 at 5:15pm revealed:
-"Staff will cut up your food if you ask them."
-Staff "do cut-up the food for one resident who has sight issues".
-He had no difficulty cutting the tomatoes (served with the dinner meal) with his fork, they were "soft enough".

Interviews with five residents on 05/15/18 between 7:35am and 7:40am revealed staff will cut their food "if they ask".

Interview with the Business Office Manager on 05/14/18 at 5:35pm revealed:
-She had "been here 10 years".
-It had "always been that way (not placing knives at the tables) due to the residents' mental health diagnoses and for safety reasons".
-She did not know of any safety assessments ever being completed for the residents.
-Staff "will cut up food for the residents".
-If a resident asked for a knife, "staff will bring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL018018	A. BUILDING: _____ B. WING _____	R 05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE OF CONOVER	3430 LESTER STREET CONOVER, NC 28613

(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) COMPLETE DATE
D 287	Continued From page 40	D 287		

one [a knife], the resident would use the knife and then staff would take the knife back to the kitchen".
-The only policy about knives was in the admissions packet.

Interview with the Dietary Manager on 05/15/18 at 1:25pm revealed:
-She had worked at the facility "on and off for 30 years" and had been working in the kitchen for 15 years.
-Knives were removed from the tables because "we had a couple of violent residents who had taken knives off of the tables about 20 years ago".
-They had "just stayed no knives at the tables" since then.
-She locked the sharp knives up in the pantry "every evening".
-They did not have any butter knives stored in the kitchen.
-"We got rid of them [butter knives] about 8 or 9 years ago."
-"I cook the meat tender so it can be cut with a fork."
-Staff would cut up food for the residents when needed or asked.

Interview with the Resident Care Coordinator on 05/15/18 at 8:49am revealed:
-She had worked at the facility for 15 years.
-They "never had a butter knife on the table".
-Staff were "trained" to put a fork and spoon on the table.

Interview with the Administrator on 05/15/18 at 8:45am revealed:
-He had been working at the facility since 04/02/18.
-He was told not having a knife at the tables "had

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D 287	Continued From page 41 always been the case" due to resident safety issues, residents with behavior issues and mental health diagnoses. -He "was not aware there were no knives at the tables until yesterday". -Whenever he was in the dining room the place settings were wrapped up in napkins. -He knew of the full place setting rule. -He did not know of anything in writing about not providing a full place setting. -He did not know of any resident safety assessments.	D 287		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to oxygen treatments and oxygen tank storage. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to follow up with the durable medical equipment company to ensure	D912		

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D912	Continued From page 42 portable oxygen was available, to ensure the acute health care needs were met for 2 of 5 sampled residents (Resident #2) with physician orders for continuous oxygen at 2L/M and (Resident #4) with a physician order for portable oxygen at 2L/M during activity [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to implement physician orders for 2 of 5 sampled residents with physician orders for oxygen administration (Resident #2 and #4). [Refer to Tag D276, 10A NCAC 13F .0902(c)(3-4) Health Care (Type A2 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to assure the home was maintained free of all obstructions and hazards as related to portable oxygen cylinders stored in an unsafe manner. [Refer to Tag D079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)].	D912		