Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0107	A. BUILDING: _____ B. WING _____	C 04/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKS-HOWELL HOME	266 MERRIMON AVENUE ASHEVILLE, NC 28801

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L 035	.2207 PATIENT RIGHTS 10A-13D.2207 (a) The facility shall enforce the Nursing Facility Patient's Bill of Rights as described in G.S. 131E-115 through G.S. 131E-127. (b) In matters of patient abuse, neglect or misappropriation the definitions shall have the meaning defined in Rule .2001 of this Subchapter. This Rule is not met as evidenced by: Based on observations, record reviews, resident and staff interviews the facility failed to promote dignity and respect for 1 of 3 residents by removing food from the resident's private refrigerator without his knowledge or approval (Resident #3). The findings included: Resident #3 was admitted to the facility on 03/04/14 with diagnoses that included chronic pain syndrome and diabetes mellitus. Review of Resident #3's weekly nursing summary dated 04/11/17 noted him to be alert and oriented. On 04/12/17 at 1:30 PM during an interview with Resident #3, he stated that on the evening of 04/11/17 he went to his refrigerator to get a salad that he was going to eat as a snack as he did every evening and the salads were not there. He stated that they were there the last time he looked in his refrigerator which was the morning of 04/11/17 before he left his room to go to lunch. Resident #3 stated that not all the salads were dated but had his own system to keep them rotated and knew which one to eat first. Resident	L 035	A. Resident #3 was educated on procedure for labeling and discarding food at expiration date while he is present in his room. Nurse #2 was educated 4/12/17 by Director of Nursing Services on Resident Rights and process for removing food from resident's refrigerator. B. All residents with refrigerators who were A&O were reeducated on the process by 4/25/17. An in-service was conducted on 4/17/2017 to all nursing staff on Resident Rights. C. Dietary staff will provide a food label for any food to be taken back to the resident's personal refrigerators with the date issued and the expiration date. The Dietary Manager or designee will monitor this on a daily basis to ensure compliance by staff. Food will be discarded after the expiration date with the resident's knowledge and offer another option to replace the food if requested. D. Audits will be performed by interviewing A&O residents who have personal refrigerators in their rooms and observing staff members who are removing items from refrigerators 3x/wk for 4 weeks, 2x/wk for 4 weeks, then monthly x4 weeks by Director of Clinical Services or designee. Audits will also be conducted on resident rights by Director of Clinical Services or designee 3x/wk for 4 weeks, 2x/wk for 4 weeks, then monthly for 2 months. This will be reviewed by QA committee to determine compliance and need for continuation of monitoring.	5/25/17

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L 035	Continued From page 1 #3 stated that he felt violated and did not think he could trust the staff to stay out of his room when he was not in there. He further stated that the facility should have asked his permission first before they took it upon themselves to take his food. Resident #3 stated he reported it to the Administrator. During an interview with Nurse #2 on 04/12/17 at 2:50 PM she stated that she was told that Resident #3 had old food in the refrigerator in his room so while Resident #3 was out of his room for lunch on 04/11/17, she went into Resident #3's room and removed two undated vegetable plates that were gelled and watery, from his refrigerator. Nurse #2 stated that she did it without his knowledge because she knew that if she had asked Resident #3 before she removed the food that he would be angry and not let her remove the food and she did not want to him to get sick. After thinking about it, Nurse #2 stated that she should have asked Resident #3's permission before she removed the food from his refrigerator. Interview with the Administrator on 04/12/17 at 3:45 PM revealed she was aware that someone removed food from Resident #3's refrigerator without his knowledge or approval and that she was disappointed about it. The Administrator stated that the staff should have asked Resident #3's permission first.	L 035		
L 039	.2208(E) SAFETY 10A-13D.2208 (e) The facility shall ensure that: (1) the patients' environment remains as free of accident hazards as possible; and	L 039		

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L 039	Continued From page 2 (2) each patient receives adequate supervision and assistance to prevent accidents. This Rule is not met as evidenced by: Based on record reviews and staff interviews the facility failed to have two staff members present for a mechanical lift transfer which resulted in the resident falling to the floor for 1 of 5 sampled residents reviewed for accidents (Resident #8). The findings included: An undated facility policy titled "Transferring a Resident Using a Mechanical Lift" stated in part: "Mechanical lifts are used to transfer residents who cannot help themselves to chairs, stretchers, toilets, tubs, and cars. At least two staff members are needed." Review of the medical record revealed Resident #8 was admitted on 07/03/09 with diagnoses including left artificial hip and knee, chronic kidney disease, and polyneuropathy. Review of an incident report dated 02/04/17 at 12:05 PM revealed Nurse Aide (NA) #1 told Nurse #1 she was transferring Resident #8 from her chair to the bed using the mechanical lift and one of the straps became dislodged and Resident #8 fell to the floor and hit her head. Resident #8 denied pain or discomfort and no injuries were noted. Nurse #1 documented neurological checks and vital signs were negative. Nurse #1 advised NA #1 to ask for assistance when transferring a resident using the mechanical lift. Review of the post incident actions revealed NA	L 039	A. Nurse Aide #1 was reeducated on lift/transfer policy that requires x2 assist for mechanical lifts on 4/15/17. B. New hires in nursing will receive lift and transfer training during orientation and all nursing staff members will receive training annually. A new hire orientation check list for each new nursing employee will be given to the Director of Clinical Services or designee for review. This process will be overseen by the Director of Nursing or designee to ensure compliance. C. Lift/transfer assessments will be performed for every resident by 5/25/17 and for all new admissions. A fall and incidents committee was started on 3/15/2017 and is held daily to discuss all incidents. Interventions are put into place at the time of an incident by nursing and during the fall/incidents committee. D. The Director of Clinical Services or designee will observe transfers randomly by nursing staff members 3x/wk for 4 weeks, 2x/wk for 4 weeks, then monthly for 2 months for compliance with lift/transfer policy/procedure. This will be reviewed by QA committee to determine compliance and need for continuation of monitoring.	5/25/17

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L 039	Continued From page 3 #1 received training regarding safe transfers which included using 2 staff members with all mechanical lift transfers. Review of a hospice note dated 02/04/17 at 1:00 PM revealed the hospice nurse assessed Resident #8 and noted her range of motion and neurological checks were within normal limits and level of consciousness was at baseline. The hospice nurse also documented Resident #8 denied pain and no apparent injuries were noted. Review of a nurse's note dated 02/04/17 at 1:38 PM revealed Nurse #1 documented Resident #8 had a fall from the mechanical lift to the floor while being transferred from her chair to bed by NA #1. NA #1 indicated the strap on the mechanical lift came off mid air and Resident #8 had fallen to the floor landing on her back and hit the back of her head on the floor. Nurse #1 noted Resident #8 moved all her extremities equally, denied pain, and her vital signs were within normal limits. Neurological checks were started at the time of the fall at 12:00 PM. Nurse #1 also documented the physician, a family member, and hospice were all notified of the fall. Review of a written disciplinary action dated 02/06/17 completed by the facility's Director of Nursing (DON) at the time of the incident revealed NA #1 did not get another staff member to assist her with transferring Resident #8 to bed using a mechanical lift on 02/04/17. Resident #8 fell from the sling to the floor during the transfer. The DON noted this was a safety issue and all mechanical lift transfers were to completed with two staff members present at all times for the residents safety and per the facility's policy. It was noted NA #1 was sent home after the DON was notified per the facility policy pending an	L 039		

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L 039	Continued From page 4	L 039		

investigation. The form was signed by the DON and NA #1 on 02/06/17.

Review of a care plan dated 03/15/17 revealed Resident #8 had self care deficits related to cognitive deficits, weakness, impaired mobility, and end of life care. Interventions included: total assistance of two staff members with activities of daily living and two person assistance with total lift transfers.

Review of a weekly nursing summary dated 04/10/17 revealed Resident #8 was alert to self only but was able to make basic needs known. The summary noted Resident #8 was totally dependent on staff for all her care and required two person assistance with mechanical lift transfers.

During an interview on 04/11/17 at 1:30 PM Nurse #1 recalled on 02/04/17 she asked NA #1 to take Resident #8 back to her room because she was yelling out in the common area when lunch was finishing up. Nurse #1 stated she did not ask NA #1 to put Resident #8 back to bed because she knew it was time for NA #1 to take her lunch break. Nurse #1 indicated when NA #1 reported Resident #8 had fallen from the sling to the floor she reminded NA #1 it was facility protocol to have two staff members present for all mechanical lift transfers. Nurse #1 further stated she assessed Resident #8 for injuries, started neurological checks, and contacted the supervisor on call, the physician, hospice, and a family member.

An interview with NA #2 on 04/12/17 at 10:30 AM revealed she had been employed by the facility for four months and cared for Resident #8 frequently. NA #2 stated Resident #8 was a

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L 039	Continued From page 5 mechanical lift transfer and the NAs always had two staff members present when transferring a resident using the mechanical lift. Attempts to contact NA #1 during the investigation were not successful. An interview was conducted with the Administrator on 04/12/17 at 10:55 AM after she reviewed the incident report for Resident #8's fall on 02/04/17, the facility policy for transferring residents using a mechanical lift, and the written disciplinary action completed with NA #1 02/06/17. The Administrator stated she did not know when the policy for transferring residents using a mechanical lift was developed but she expected two staff members to assist with mechanical lift transfers for the safety of the residents. The Administrator indicated the DON who investigated Resident #8's fall was no longer employed by the facility and she was not sure what the DON's findings were for her investigation or what measures were taken for residents' safety after Resident #8's fall.	L 039		
L 049	.2210(A) REPORTING, INVESTIGATING ABUSE, NEGLECT 10A-13D.2210 (a) A facility shall take measures to prevent patient abuse, patient neglect, or misappropriation of patient property, including orientation and instruction of facility staff on patients' rights and the screening of and requesting of references for all prospective employees.	L 049		

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L 049	Continued From page 6 This Rule is not met as evidenced by: Based on policy review, record reviews and staff interviews, the facility failed to obtain references and/or screen licensing and/or registry boards prior to employing 4 of 5 staff reviewed (Nurse #3 and Nurse Aides (NA) #1, #2 and #3). The findings included: Review of the facility's undated policy related to Hiring Process included: *"After a decision has been made to hire a particular candidate, all licensing and certifications will be verified. Once verification is complete, an offer will be made to that individual contingent on satisfactory completion of reference checks and criminal background checks." 1. NA #3 was hired on 02/01/17. Review of the personnel record revealed there was no evidence that the Health Care Personnel Investigations (HCPI) was checked to ensure she was currently on the registry with no findings of neglect or abuse against her and that her references were checked. The Human Resources Director was interviewed on 04/11/17 at 1:56 PM. She related that the department heads were responsible for checking references and the HCPI. She verified she did not receive any verification for either of these items from the department head, who was no longer employed. On 04/11/17 at 2:23 PM, the Administrator stated during interview she was not aware of the system breakdown in checking for licensing/registries or	L 049	A. All current nursing staff member's licensure and certification was checked on 4/11/17. B. The Director of Nursing or designee will maintain a spreadsheet with current licensure and certification dates of all nursing staff and will check licensure and certification beginning one month prior to expiration until verification of renewal. The new licensure or certification renewal will be given to the Human Resources Director for the employee file. C. Prior to a position being offered; a background check, reference checks and a drug screen will be obtained by the Human Resources Director as well as a licensure or certification validation. Once these items have been cleared by Human Resources, the position can be offered by the Department Director to the potential employee. D. The Human Resources Director will randomly run licensure checks monthly x3 months and present to the QA committee for further evaluation.	5/25/17

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L 049	Continued From page 7 evidence of reference checks not being documented. 2. Nurse #3 was hired on 01/17/17. Review of her personnel record revealed no evidence that her references were checked prior to hire. The Human Resources Director was interviewed on 04/11/17 at 1:56 PM. She related that the department heads were responsible for checking references. She verified she did not receive any verification of reference checks from the department head, who was no longer employed. On 04/11/17 at 2:23 PM, the Administrator stated during interview she was not aware of the system breakdown in checking for licensing/registries or evidence of reference checks not being documented. 3. NA #2 was hired on 12/20/16. Review of her personnel record revealed no evidence that the Health Care Personnel Investigations (HCPI) was checked to ensure she was currently on the registry with no findings of neglect or abuse against her. The Human Resources Director was interviewed on 04/11/17 at 1:56 PM. She related that the department heads were responsible for checking the HCPI. She verified she did not receive any verification of the HCPI check from the department head, who was no longer employed. On 04/11/17 at 2:23 PM, the Administrator stated during interview she was not aware of the system breakdown in checking for licensing/registries or evidence of reference checks not being documented.	L 049		

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L 049	Continued From page 8 4. NA #1 was hired on 01/06/15. Review of her personnel record revealed no evidence that the Health Care Personnel Investigations (HCPI) was checked to ensure she was currently on the registry with no findings of neglect or abuse against her and that her references were checked. The Human Resources Director was interviewed on 04/11/17 at 1:56 PM. She related that the department heads were responsible for checking references and the HCPI. She verified she did not receive any verification for either of these items from the department head, who was no longer employed. On 04/11/17 at 2:23 PM, the Administrator stated during interview she was not aware of the system breakdown in checking for licensing/registries or evidence of reference checks not being documented.	L 049		
L 166	.2701(O) PROVISION OF NUTRITION & DIETETIC SVCS 10A-13D.2701 (o) Food services shall comply with Rules Governing the Sanitation of Restaurants and Other Foodhandling Establishments (15A NCAC 18A .1300) as promulgated by the Commission for Public Health which are incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food under sanitary conditions. Copies of these Rules can be accessed online at http://www.deh.enr.state.nc.us/rules.htm.	L 166		

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L 166	Continued From page 9 This Rule is not met as evidenced by: Based on observations and staff interviews the facility failed to discard nutritional shakes 14 days after the thaw date and remove expired juice and milk cartons from 1 of 2 nutrition pantry refrigerators and failed to monitor the storage of snacks in the cabinets of 1 of 2 nutrition pantries. The findings included: 1. Observations of the CH unit nutrition pantry refrigerator on 04/10/17 at 11:12 AM and 04/11/17 at 8:40 AM revealed the following items available for use: - One (1) 4 ounce strawberry nutritional shake labeled with a discard date of 03/28/17. - Four (4) 4 ounce vanilla nutritional shakes labeled with a discard date of 03/31/17 - Four (4) 4 ounce chocolate nutritional shakes labeled with a discard date of 04/07/17. - One (1) 4 ounce chocolate nutritional shake labeled with a resident's name but no visible thaw or discard date. - Four (4) 4 ounce vanilla nutritional shakes with no visible thaw or discard date. Three of the shakes were labeled with a resident's name. - Six (6) 4 ounce strawberry nutritional shakes labeled with a discard date of 04/07/17. - 1/2 full clear plastic pitcher of juice with an attached label which noted it was grape juice with a discard date of 04/08/17. - Three (3) 4 ounce vanilla nutritional shakes labeled with a discard date of 04/09/17. - Five (5) 1/2 pint cartons of whole milk dated 04/10/17. An interview was conducted with the Dietary Manager (DM) on 04/11/17 at 9:05 AM. The DM stated the nutritional shakes were good for 14	L 166	A. The nutrition pantry refrigerators on both BTU and CHU were checked for correct date labels and all expired products were discarded on 4/11/17. The cleaning product and crackers found in the BTU nutrition pantry was removed and an in-service was completed on 4/11/17 with staff to ensure an understanding of storage procedures. B. The dietary department will ensure that the products in the nutrition pantry refrigerators on both BTU and CHU will be monitored to ensure date labels are visible at all times, and stock will be rotated on a daily basis. This will be accomplished by the following procedures; On 4/11/17 there was an in-service with staff members for labeling correctly, as to not cover up the expiration date with the nutrition label, and removing expired items from the nutrition pantry refrigerators. This included dry items such as bread and cereal. An in-service was completed on 4/11/17 with staff members related to the procedure for the proper storage of chemicals and snacks, keeping chemicals in a separate locked container, and keeping food in the cupboards with proper date labels. C. A designated dietary aid will be responsible for filling the nutrition order and removing expired inventory on a daily basis. The dietary manager or her designee will also follow up on staff by physically checking dates, labels, and appropriate storage of all food items at least 3 days a week.	5/25/17

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L 166	Continued From page 10 days after thaw and were labeled with a thaw date and discard date by dietary staff when they were removed from the freezer. The DM further stated she expected the dietary aides to check the nutrition pantry refrigerators when they made their daily delivery to the units and remove and discard expired foods including milk, juices, and nutritional shakes. On 04/11/17 at 9:17 AM the DM was accompanied to the CH unit for observations of the nutrition pantry refrigerator. The DM stated the pitcher of juice should have been removed on 04/08/17 and the five (5) 1/2 pint cartons of milk should have been removed on 04/10/17. The DM further stated the nutritional shakes should have been removed and discarded according to the dates on the label attached to the carton. The DM thought the nutritional shakes labeled with a resident's name might have the label with the thaw/discard date underneath but confirmed there would be no way for staff to know when to discard the nutritional shakes. The DM stated she had a lot of new staff in the kitchen and would need to do more training. 2. Observations of the BT unit nutrition pantry on 04/10/17 at 11:21 AM and 04/11/17 at 8:54 AM revealed a box of saltine crackers with a use by date of 13/July/16 in a bottom cabinet next to a spray bottle of cleaner/degreaser. On 04/11/17 at 9:11 AM the DM was accompained to the BT unit nutrition pantry and observed the box of saltine crackers in the bottom cabinet next to a spray bottle of cleaner/degreaser. The DM stated the box of saltine crackers did not come from the kitchen and the dietary staff always put snacks in the top cabinets.	L 166	D. A product check list will be put in place as of 5/8/17 to aid in the monitoring of expired food products. The list will consist of the current date, product, product date, loss, and initials of person checking the inventory. The Dietary Manager or her designee will monitor the adherence of the policy weekly x4 weeks, then continue maintenance monitoring for 2-3 days a week continuously thereafter and report to the Quality Assurance Process Improvement (QAPI) committee. The QAPI committee will implement additional interventions as needed to ensure continued compliance.	

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L 166	Continued From page 11 During an interview on 04/11/17 at 3:15 PM the Director of Clinical Services (DCS) stated residents' snacks should be stored in the top cabinets in the nutrition pantries. The DCS further stated staff members were expected to put a name and date on any food items brought in by family members and place them in the top cabinets or refrigerator. The interview further revealed the DCS did not know who had placed the saltine crackers in the bottom cabinet next to the spray bottle of cleaner/degreaser but noted the facility was working with the family members to set up new guidelines for the nutrition pantries.	L 166		