STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34A001	A. BUILDING _____ B. WING _____	C 11/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER	932 OLD US 70 HIGHWAY BLACK MOUNTAIN, NC 28711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the Complaint Investigation. Event ID #TGM511.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to submit the 24-Hour Initial Report within twenty-four hours to the Health Care Personnel Registry (HCPR) and failed to report the findings of the investigation in the 5-Day Working Report to the HCPR for a resident with an injury of unknown origin for 1 of 4 sampled residents. (Resident #11). The findings are: Resident #11 was re-admitted to the facility on 06/05/09 with diagnoses including osteoporosis and cerebral palsy with paralysis of all extremities. A review of the most recent quarterly Minimum Data Set (MDS) dated 09/27/12 indicated impairment in short and long term memory and severe impairment in cognition for daily decision making. The MDS further indicated Resident #11 was totally dependent on staff for transfers and activities of daily living and had impairment with	F 226	On 10/7/12 when clinical findings indicated a significant injury to resident #11, BMNTC sent resident to ER for optimal care of fracture. Though a delay occurred in notification of Advocacy and initiation of 24 hr. report, this resident received excellent medical care and follow up. When Advocate did receive notification of incident 10/10/12, Advocate immediately initiated inquiry of significant injury of unknown origin and soon processed information gathered concluding no substantiation of any type of abuse occurring that may have caused injury. On Monday 11/8/12 Black Mountain Neuro-Medical Treatment Center's Administrative "Shift Report Team" (Assistant Director, Program Director, Advocate, Director of Nursing, Quality Assurance Director) began formally meeting as group for am "shift report" where group discusses all incidents involving residents, injuries, concerns, plans, etc., from the previous day, weekend, or holiday. This group will meet every working day at 8:30am in the QA Director's office. Group will review Unit shift reports, discuss documented concerns on shift report &/or SAO report, or any other relevant information shared by group members. To prevent any delay in reporting, any concerns related to significant injuries of unknown injury reported from shift reports, SAO reports, calls to DON, Advocacy, or Administrative staff will be discussed in detail and a 24 hour report made to the Health Care Registry by Director or designee. Advocacy will then immediately initiate an inquiry/investigation.	10/10/12 11/8/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Hollingsworth — TITLE: Facility Director — (X6) DATE: 11/28/12

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

Black Mountain NEURO Received NOV 28 2012 by: MMH

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F 226	Continued From page 1 range of motion in both her upper and lower extremities. A review of medical progress notes dated 10/07/12 indicated Resident #11 had bruising of her left (L) upper arm due to a questionable spontaneous rupture of a blood vessel or possible bruising while changing the resident's position and manipulation of the resident or an upper extremity blood clot but would suspect the injury was due to the first two possibilities. The notes indicated they were awaiting x-ray results and doubt there was a fracture. An addendum to the medical progress notes dated 10/07/12 revealed the x-ray results came back and Resident #11 had a fracture of her (L) humerus (bone in upper arm) and it was minimally displaced. The notes revealed Resident #11 was transferred to the hospital emergency room and a cast was applied to her (L) arm. During an interview on 10/30/12 at 11:21 AM Nurse #1 explained Resident #11 had a bed bath on 10/07/12 between 7:45 AM and 8:00 AM. She stated nurse aides checked on Resident #11 around 9:00 AM and called her to the resident's room because Resident #11 had swelling and bruising to her (L) arm above and below her elbow. She stated she assessed the resident, applied an ice pack, called the physician and an x-ray was ordered. She explained the x-ray results showed a fracture of Resident #11's arm but they did not know how it happened because the resident required total care and did not turn herself in bed or move her arms. She further stated she filled out an incident report and turned	F 226	Policy #133B "Protecting Residents from Rights Infringements" will be revised to include Nurse contacting both SAO and Advocacy regarding significant injuries of unknown origin or allegations of abuse (if Advocate not available Nurse is to leave message on Advocacy's voice mail). Staff training (Nursing, SAO) on policy revisions will take place. Quality Assurance Director will begin tracking Shift Report meeting attendance each day, if Advocacy is unable to be present in report, Quality Assurance Director will ensure message has been left alerting them of any incidents of concern/injuries of unknown origin. A Quality Assurance Objective will be initiated with goal that 100% of the time, reports being made will meet standards of Health Care Registry for 24 hr. and 5 day reports. Objective will be reviewed at least quarterly with Quality Assurance Committee.	11/30/12 11/26/12

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F 226	Continued From page 2 it in to her supervisor. During an interview on 11/01/12 at 2:10 PM Nurse Aide #1 explained it was the usual process when an injury occurred to get the nurse, notify the Senior Administrative Officer (SAO), notify their supervisor and an Advocate right away and a report had to be turned in so it could be investigated. She stated Resident #11 had a sponge bath early in the morning on 10/07/12 and she checked Resident 11's oxygen and saw no swelling or bruising of the resident's (L) arm. She stated around 9:00 AM nurse aides went in to check and change Resident #11 and they called the nurse into the room because Resident 11's (L) arm was swollen and she went with the nurse into the resident's room. During an interview on 11/02/12 at 9:48 AM an Advocate explained the Advocate should always be notified and an inquiry started to determine if an investigation needed to be done. The Advocate stated the incident occurred on 10/07/12 but she was not notified of Resident #11's fractured arm until 10/10/12 and then started an inquiry. She verified there was a delay in their system in getting the incident report but once she got the report she talked with staff who worked on 10/07/12 and a physician who thought the injury occurred because Resident #11 had brittle bones. She stated there was no 24 hour report submitted to the HCPR and the findings of their investigation was not submitted on the 5-Working Day report to the HCPR. During an interview on 11/02/12 at 11:35 AM the facility administrator explained when injuries of unknown origin occurred staff that discovered the	F 226		

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F 226	Continued From page 3 injury was expected to complete an incident report immediately or by the end of their shift. He stated the report then went to the office assistant on the unit for entry into their risk management system and was forwarded to the Unit Manager and they should look at it by the next business day. He explained the information was also recorded on a 24 hour report that was reviewed each morning by the Quality Assurance Director, the Advocate and the Director of Nurses and an advocacy report was generated from the prior day's incidents for the Advocate to begin an inquiry to determine if an investigation needed to be done. He stated the SAO was always available and was expected to determine if immediate advocacy was warranted. He verified the SAO was contacted on 10/07/12 and stated the Advocate should have been in the morning meeting on 10/08/12. He stated the Advocate should have started an inquiry but verified it was not started until 10/10/12. He stated it was his expectation for the Advocate to do the follow up they needed to do and submit the 24 hour and 5-Working Day reports to the HCPR within the required time limits.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility used modified disposable	F 241	Staff on G1 Unit stopped using any disposable cups in place of adaptive dining equipment during meals as soon as deficiency noted on 11/2/12. Will discontinue use of all disposable cups and utensils on all resident units during meals unless used for emergencies, if needed for snacks, medication administration or resident preference. If resident prefers use of disposable cup, documentation of preference will be made in resident's care plan.	11/2/12 11/26/12

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F 241	Continued From page 4 paper cups instead of an adaptive drinking cup for 1 of 4 sampled residents observed during dining (Resident #13). The findings included: Resident #13 was admitted to the facility on 03/30/05 with diagnoses including mental and behavioral problems, severe mental retardation and pervasive developmental disorders/autistic disorder. The most current quarterly Minimum Data Set (MDS) dated 09/18/12 coded the Resident as severely impaired for daily decision making. The MDS further revealed the resident received a mechanically altered therapeutic diet, with adaptive equipment, and was assessed for extensive assistance with 1 person physical assist for eating. A review of Resident #13's care plan dated 10/08/12 under nutrition indicated the resident received extensive to total assistance for feeding activities daily for safe consumption of food and drink. The care plan further revealed the resident required adaptive equipment as indicated in the dining guidelines dated 09/21/12. A review of Resident #13's individual dining guidelines dated 09/21/12 included in the adaptive equipment and materials column to use medium sized (4 oz.) nosey cup (cup with a cut-away brim for the nose to allow safe swallowing without tilting the head back) for fluids provided. Resident #13 was observed on 10/30/12 at 12:54 PM during the lunch meal. The resident was seated in a wheelchair in front of a tray set-up which included a paper cup with the brim torn-out approximately 2 inches down the cup in a shape	F 241	All adaptive eating and drinking adaptive cups will be clearly marked with individual Unit # to assure Dietary returns them to correct Unit and appropriate adaptive dinner ware will be available for resident use. Dietary began sending non-disposable tumblers to Units at each meal service. Additional non-disposable cups ("tumblers" and "nosey cups") will be ordered by Dietary and available on units for resident use at each meal to assure multiple fluids offered will be served in individual non-disposable cups. Nurses will also maintain a separate "emergency" supply of non-disposable drinking cups in Nurses office to assure availability. All resident guidelines will be revised by OT to include only use of adaptive equipment. All staff will be inserviced on guideline changes and discontinuation of disposable cups. As part of the ongoing BMNTC Quality Assurance process, RCAs will iniate a new objective that 100% of the time (except for snacks, medications, resident personal preference) non-disposable eating and drinking adaptive and standard equipment will be utlizied during resident meals. RCAs will observe resident meals daily and monitor for use of adaptive dining equipment only, unless resident preference is documented in care plan. Observations will be documented on "Adaptive Equipment Checkoff List" form and turned in weekly. Any instances when disposable cups are being used (if not for snacks, medications, or personal preference), observations will be reported to Unit Management where corrective action will be put in place. Data will be reviewed at least quarterly with Quality Assurance Director and reported to Quality Assurance Committee.	11/26/12 11/26/12 11/26/12 11/20/12 11/30/12 11/30/12

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F 241	Continued From page 5 to look like a nosey cup. Nurse Aide (NA) #2 was observed feeding the resident. She used the cut away paper cup to give the resident water. During the lunch seating on 10/30/12 at 12:59 PM Nurse Aide supervisor (NAS) #1 toured the dining room kitchen and storage area with the surveyor and showed the cupboard where some of the adaptive devices were stored including several nosey cups in the cabinet. An interview with the NAS #1 revealed that most of the adaptive devices came from the kitchen on the tray but if any item was missing they could get them from the cabinet. Resident #13 was observed on 10/31/12 at 9:07 AM during the breakfast meal. The resident was seated in a wheelchair in front of a tray set-up which included a paper cup with the brim torn-out approximately 2 inches down the cup in a shape to look like a nosey cup , as well as a medium sized (4 ounce) nosey cup. She used the paper cup to give the resident orange juice and the Nosey cup to give the resident water. During the breakfast seating on 10/31/12 at 9:07 AM the NA #2 was interviewed and stated that when multiple fluids were present she used disposable paper cups cut to look like nosey cups and had been using disposable nosey cups all the time for all meals. A continued interview with the NAS #1 on 10/31/12 at 9:19 AM stated that she used disposable paper cups cut to look like nosey cups for Resident #13 per dining guidelines and stated that she was allowed to use disposable paper cups.	F 241		

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F 241	Continued From page 6 The speech therapist was not available for interview and an interview with the occupational therapist on 11/01/12 at 1:38 PM reported that there was plenty of stock of nosey cups available and nursing staff was able to obtain them at a short notice when needed. The interview revealed that it was not desirable to modify the disposable paper cups to be used as nosey cups except in emergency situations and further stated that this should not be a regular practice and should not have happened consecutively. The occupational therapist was able to show several nosey cups in different sizes in the stock. An interview with the Director of Nursing on 11/02/12 at 9:35 AM revealed that she was not aware of the situation and stated that using disposable paper cups all the time was not acceptable.	F 241		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to follow physician orders accurately and obtain clarification orders for administration of Calcium supplements with Vitamin D for 2 of 10 sampled residents reviewed for unnecessary medications. (Resident #4 and #152) The findings include:	F 281	Upon review of deficiency noted during Survey exit, order for Calcium 500mg po TID x duration for supplement for resident #4 was written on 7/5/11. At that time, Pharmacy dispensed their stock Calcium medication (Calcium Citrate + Vitamin D) without clarifying physician order. Nursing administered Calcium Citrate + Vitamin D TID. On 8/3/11 the "Monthly Physicians Order Update" listed the correct order to correlate with medication being given (Calcium Citrate + Vitamin D), with both Physician and Nursing documenting that orders were up to date and the orders matched exactly wtih medications being sent from Pharmacy. All successive "Monthly Physicians Order Updates" since 8/4/11 have been correct with the order being exactly the medication given.	11/26/12

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F 281	Continued From page 7 1. Resident #4 was admitted to the facility on 06/13/00. The admitting diagnoses included hypothyroidism, risk for falls, herniated lumbar disk, vitamin B12 deficiency and depression. A review of the physician orders for Resident #4 dated 07/15/11 included an order to administer 'Calcium 500 mg three times daily' . A review of the 'Monthly Physician Order Update' listed the medication as: Calcium Citrate plus Vitamin D (Citrocal D). A continued review of several previous monthly physician order sheets and the Medication Administration Records (MAR's) revealed that Resident #4 received stock medication of Citrocal-D containing 630 mg (milligram) Calcium with 400 International Units (IU) of Vitamin D and the nurse confirmed using this stock medication. Further review of the physician order did not reveal any clarification to that effect. An interview with Nurse #2 on 10/31/12 at 3:11 PM revealed that all physician orders were faxed to the pharmacy and the monthly physician order sheets and the MAR's were printed by the pharmacy. The interview revealed that it was the responsibility of the nurse administering the medications to compare the original physician orders for accuracy and obtain clarification when needed. At the beginning of each month when MAR's and monthly physician orders were printed, an assigned 3rd shift nurse always checked for accuracy of the physician orders. Nurse #2 also stated that a clarification order should have been obtained for Resident #4 related to Calcium with Vitamin D. An interview with the pharmacist on 11/01/12 at	F 281	Upon review of deficiency noted during Survey exit, order for Caltrate 600mg po BID was written on Admission orders for for resident #152 on 6/26/12. At that time, Pharmacy dispensed their stock Calcium medication (Calcium + D 600mg) without clarifying physician order. Nursing administered Calcium + D 600mg BID. On 7/26/12 the "Monthly Physicians Order Update" listed the correct to correlate with medication being given (Calcium + D 600), with both Physician and Nursing documenting that orders were up to date and the orders matched exactly with medications being sent from Pharmacy. All successive "Monthly Physicians Order Updates" since 7/26/12 have been correct with the order being exactly the medication given. Pharmacy will review all residents taking Calcium/Vitamin D supplements to assure that physician orders are written specifically for the medication being administered. Pharmacy will obtain clarifying orders for any discrepancies noted. Pharmacist will notify physicians/PAC if any medication ordered does not correlate with medication available in pharmacy. Nurses will immediately initiate medication error process if medication order on MAR is not exactly the same medication as ordered or supplied by Pharmacy. This information will be entered into the Quantros Reporting system. Medical Policy # 46 "Processing Physician Orders" will be revised to clarify specific process Nursing and Pharmacy will initiate if medication or medication label does not exactly match the physician's order. All Nurses and Pharmacy staff will review policy revision.	11/26/12 11/26/12 11/2/12 11/2/12 11/30/12

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F 281	Continued From page 8 2:09 PM revealed that the Calcium tablet was coded as Calcium plus D stock medication in the pharmacy documentation. The floor stock medications included both Calcium 500 mg and Calcium 500 mg with Vitamin D. The pharmacist interview revealed that the entry of the order with Vitamin D was an error and the nurse or the pharmacist should have obtained a clarification. An interview with the physician on 11/02/12 at 9:24 AM stated that any orders with doubt had to be clarified and he did not recall any clarification order written for Calcium 500 mg order for Resident #4. An interview with the Director of Nursing (DON) on 11/02/12 at 9:35 AM confirmed that it was the responsibility of the 3rd shift assigned nurse to check for all order accuracy. The DON also stated that it was the responsibility of the nurse and the pharmacist to check for accuracy of all the orders entered to the system by the pharmacy and sent from the pharmacy. 2. Resident #152 was admitted to the facility on 06/26/12. The admitting diagnoses included hypothyroidism, Alzheimer's dementia and depression. A review of the physician orders dated 06/26/12 included an order for 'Caltrate 600 mg (milligram) po (per oral) BID (two times daily)' . A review of the Medication Administration Record (MAR) and the 'monthly physician order update' listed the medication as: 'Calcium + D 600 mg (Caltrate 600 Plus) take 1 tablet (s) (600 mg) orally twice daily for supplement' .	F 281	Medical Policy #43, "Medication Administration" specifies proper sequence of steps (Best Practive Standards for Medication Administration) Nurses take prior to and during administration of medication. All nurses will review standards. A Quality Assurance Objective will be initiated by the Medical Department (to include the DON and Pharmacy) that medication errors involving discrepancy between physician order and medication dispensed will be less than 5% as identified by mediction error reports. A Nursing supervisor will also do random monitoring of MARs and medications administered to assure physician orders reflect actual medication administration. The DON and Quality Assurance Director will review objective at least quarterly and report findings to the BMNTC Quality Assurance Committee.	11/30/12 11/30/12

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F 281	Continued From page 9 An interview with Nurse #3 on 10/31/12 at 3:02 PM confirmed that she had been administering stock medication Caltrate 600 mg with 400 International Units (IU) of Vitamin D. The interview revealed that Nurse #3 should have obtained a clarification on the strength of Vitamin D as Caltrate comes with several Vitamin D strengths. An interview with the pharmacist on 11/01/12 at 2:09 PM revealed that the Caltrate tablet was wrongly coded as Calcium plus D stock medication and the order should have been clarified as Resident #152 was also receiving 2000 IU Vitamin D as a separated order. An interview with the physician on 11/02/12 at 9:24 AM stated that any orders with doubt had to be clarified and he did not recall any clarification given on the Caltrate order for Resident #152. An interview with the Director of Nursing (DON) on 11/02/12 at 9:35 AM confirmed that it was the responsibility of the 3rd shift assigned nurse to check for all order accuracy. The DON stated that it was the responsibility of the nurse and the pharmacist to check for accuracy of all the orders entered into the system and sent by the pharmacy.	F 281		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		

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F 371	Continued From page 10 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to follow proper sanitation and food handling practices during an observation of obtaining food temperatures prior to serving a meal. The findings are: On 11/01/12 at 11:00 AM an observation was made of dietary staff monitoring the temperatures of hot food on the steam table prior to serving the midday meal. During the observation the staff member placed the probe end of the thermometer into a container of chopped French fries, pushing down until her ungloved hand came into contact with the food. The staff member removed the thermometer from the French fries and placed the probe end of the thermometer into a container of pureed soup. After obtaining the temperature of the pureed soup the staff member placed her clip board on top of the steam table and picked up a wet rag with yellow stains from the top of a metal cart and wiped off the thermometer. The staff member then placed the probe end of the thermometer into a container of chopped meat, pushing down until her ungloved hand came into contact with the meat. Without cleaning the thermometer, the dietary staff member obtained a temperature reading from a container of pureed French fries. All temperatures	F 371	Immediately after deficiency noted, temperature probes were sanitized properly with alcohol/bleach solution between each food tested. Dietary Director discussed proper sanitation procedure with all Dietary staff present during survey. Procedure for placement of thermometer in foods to prevent cross contamination revised to reinforce sanitation standards and proper food handling. All staff reviewed revisions. A Quality Assurance objective will be initiated that temperature probes will be used properly and sanitized between use/different foods 100% of the time as noted during scheduled monitoring by Dietary staff. The Dietary "Food Temp Log" will be revised to include checking that temperature probe is being used properlay and sanitized between use/different food items. Data will be reviewed weekly by Dietary supervisors and at least quarterly with Quality Assurance Director and reported to the BMNTC Quality Assurance Committee.	11/1/12 11/2/12 11/30/12 11/30/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34A001	A. BUILDING _____ B. WING _____	C 11/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 11 were noted to be within the appropriate range. An interview with the dietary staff member on 11/01/12 at 12:15 PM revealed she does not sanitize the thermometer probe while obtaining temperatures of foods on the tray line. The interview also revealed alcohol wipes were not available in the kitchen and gloves should be worn if coming into contact with food. An interview with the dietary manager on 11/01/12 at 12:30 PM revealed staff are expected to glove prior to coming into contact with prepared foods and the thermometer probe should be sanitized between foods, especially between food types. The dietary manager further revealed the thermometer probe should be sanitized with an alcohol pad or bleach solution and not a rag.	F 371		