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 07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER	932 OLD US HIGHWAY 70 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 223 SS=G	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews facility staff failed to protect 1 of 3 residents from physical abuse (Resident #1) and 2 of 3 residents from emotional abuse (Resident #1 and #2) for residents sampled for abuse. The findings included: 1. Resident #1 was admitted on 06/13/13 with diagnoses including progressive dementia. A quarterly Minimum Data Set (MDS) dated on 05/21/14 revealed Resident #1 was able to make himself understood, had short and long-term memory problems, and severely impaired cognitive skills for daily decision making. The quarterly MDS noted Resident #1 required extensive assistance for most activities of daily living. Review of a 24-Hour Initial Report faxed to the Health Care Personnel Registry (HCPR) on 06/01/14 alleged on 06/01/14 Nurse Aide (NA) #1 had referred to Resident #1 as a "p....." and stated he would like to suffocate the life out of him. It was also alleged he dragged Resident #1 across the bathroom floor.	F 223	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Per review of investigations regarding both Resident #1 and Resident #2 completed during Complaint survey June 30-July 1, 2014, it was explained by both surveyors (Karen Roquemore, RN and Sonya Fleming, RN) that BMNTC had correctly followed every step of ADM Policy 133B "Protecting Residents from Rights Infringements" in the immediacy of reporting the incident, protection of resident, removal of staff alleged to have been abusive and quickly placed on investigatory leave, full investigation followed, emotional and verbal abuse were substantiated and both staff dismissed from BMNTC. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: On June 9, 2014, Lauri Hollingsworth, Facility Director began an all staff in depth training series emphasizing the importance of Black Mountain Neuro-Medical Treatment Center's 'Code of Conduct' (Attachment A) and how a "fair and just culture" recognizes 'human error' (i.e., resident misses snack), at-risk behavior (i.e., forgetting to put up a wet floor sign), and 'reckless behavior' (i.e., anything less than providing respectful and safe care for our residents). Reckless behavior will not be tolerated and management's response will be disciplinary action up to and including dismissal. Without breaking HIPAA or Confidentiality, Lauri debriefed recent abuse investigation pointing out the lack of immediate intervention, timeliness of reporting, discussed appropriate staff conduct with residents and dismissal of employees resulting from substantiated abuse of identified residents. Summary Statement of Deficiencies arrived at BMNTC on July 22, 2014, was immediately reviewed by Facility Administrative Staff who then sought and obtained, via phone conversation on July 23, 2014, clarification from the Division of Health Service Regulation regarding the nature of deficiency.	June 30, 2014 - July 1, 2014 June 24, 2014 and ongoing July 23, 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lauri Hollingsworth | TITLE: Director | (X6) DATE: 8.4.14

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.

DHSR Black Mountain WRO Received AUG 04 2014 By: SKH

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 07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER	932 OLD US HIGHWAY 70 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 223	Continued From page 1 An interview with Advocate #2 on 06/30/14 at 2:00 PM revealed she contacted by the Senior Administrative Officer (SAO) on 06/01/14 regarding alleged emotional and physical abuse of Resident #1 by NA #1. Advocate #2 stated she and the SAO came in to the facility immediately on 06/01/14 to start the facility's investigation and interviewed NA #1, NA #2, and NA #3. Advocate #2 stated NA #1 had been removed from the resident care area by the Health Care Supervisor (HCS) on duty that weekend. The interview further revealed Advocate #2 substantiated the allegations of emotional and physical abuse based on interviews and the definition of abuse. Advocate #2 further stated she completed the 24-Hour Initial Report and the SAO faxed it to the HCPR. Advocate #2 further stated Resident #1 was assessed by a nurse again on 06/02/14 with no injuries noted to his lower back, buttocks, under his arms, or on his arms. The interview further revealed additional interviews were conducted after 06/01/14 and a summary of the advocacy report was given to the management team for review on 06/04/14. An interview was conducted with NA #3 on 06/30/14 at 2:37 PM. NA #3 stated Resident #1 had indicated he needed to sit on the toilet during the 1:00 PM check and change rounds on 06/01/14 and he was assisted on the toilet in the central bath. NA #3 explained while she monitored Resident #1 NA #1 came into the central bath and started talking about Resident #1 and another resident. NA #1 told NA #3 he thought Resident #1 and the other resident were "p....." and he would like to choke the life out of them. NA #1 indicated he provided these residents with the care they needed but did not	F 223	On July 23, 2014, Lauri Hollingsworth, Facility Director sent an e-mail (Attachment B) to all staff at BMNTC summing up the deficiency describing it as "very serious" and pointing out expectations and accountability of all staff with the care of our residents. She highlighted the following : -"All staff are accountable to change our own behavior to ensure residents are treated respectfully at all times". -"All staff are accountable to correct another staff when they are not being respectful". -"All staff are accountable to report any incident to supervisors if there is the slightest hint that resident was not being treated respectfully". -"It is imperative if a staff member is saying things to another staff that feels a bit "out of line", they must report this to a supervisor". Within e-mail note was a mandate that all supervisors would review e-mail with each employee, and that the employee was to sign e-mail demonstrating understanding. Supervisors were to also review 'Code of Conduct' with their employees and have them sign this form and return both signed e-mail and 'Code of Conduct' forms to Administration by August 1, 2014. Will continue to collect reviewed forms from staff on vacation or out on leave at this time. On July 25, 2014 BMNTC Executive Committee (Director, Assistant Director, Medical Director, Director of Nursing, Psychology Director, Quality Assurance Director, Quality Assurance Specialist II, Chief Advocate, Business Director, Budget Officer, Staff Development Director, Human Resources Director) met and conducted a review of events that led to deficiency. The Executive Committee began process of identifying long term and systemic changes to prevent abuse which will include training of concrete examples of abuse or disrespect, when and how to intervene in a disrespectful or potentially abusive situation in any setting, barriers to report concerns, who and how to report concerns to, dealing with diverse populations, managing emotions, etc.	July 23, 2014 July 25, 2014 and ongoing

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 07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER	932 OLD US HIGHWAY 70 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 223	Continued From page 2 feel any love for them. NA #3 stated Resident #1 was on the other side of the privacy curtain in the central bath and she did not know if he heard what NA #1 said. NA #3 explained she told NA #1 to calm down and he stopped the discussion. NA #3 stated she had never heard NA #1 talk like this before and had not ever observed him mistreating a resident. NA #3 left for her break and NA #2 came in the central bath. The interview further revealed NA #3 informed Nurse #1 and the HCS what NA #1 told her in the central bath. During an interview on 06/30/14 at 3:01 PM the Assistant Director stated NA #1 was sent home on administrative leave with pay after the incident on 06/01/14. The management team reviewed the summary of the advocacy report on the 5th working day (06/04/14) and determined substantiation of the allegations. The Assistant Director further stated NA #1 admitted to the verbal abuse or Resident #1 and while he did not admit to the physical abuse management determined NA #1's physical actions were not at the standard of care and felt he had other options while caring for Resident #1 on 06/01/14. Management met with NA #1 on 06/16/14 for a disciplinary pre-conference and discussed grounds for dismissal related to his job performance and substantiated allegations of abuse. NA #1 was dismissed on 06/18/14. A telephone interview with Nurse #1 on 06/30/14 at 3:14 PM revealed he was called in to the central bathroom by NA #1 on 06/01/14 and NA #1 asked him what he should do because Resident #1 had been sitting on the toilet for a long time. Nurse #1 instructed NA #1 to let Resident #1 stay on the toilet. Nurse #1 stated	F 223	Staff Development staff and Advocacy Chief met on July 28, 2914 and began developing a plan for revisions to current training regarding abuse/disrespect of residents. Training will include concrete examples, scenarios, and role plays focused on current deficient practices regarding abuse/disrespect of residents. Resident Unit Manager meeting on July 28, 2014 included a discussion about ideas for getting systematic long term improvement at Unit level. Ideas included debriefing all incidents of abuse/disrespect after they occur with Unit staff (while maintaining HIPAA and Confidentiality mandates), to review stressors or triggers in incident, evaluate intervention strategies and reporting issues. The incident debriefing will be utilized to continually educate and raise awareness of staff responsibilities in addressing abuse/disrespect and treating residents with respect and dignity. Other ideas included having meetings for staff with a focus on stress reduction. These ideas are being implemented as incidents occur and through regularly scheduled meetings. Pre-training questionnaire on abuse, interventions, and reporting (Attachment C) sent to all Senior Staff on July 29, 2014 with instructions to work with each of their employees in answering the questions regarding abuse, interventions, and reporting. Questionnaires to be completed and turned in to Administration Office. As information comes in from questionnaire, it will be shared with Staff Development to enhance additional training on abuse/disrespect. Facility Director, Assistant Director and Supervisory Council (CNA and Nursing Supervisors) conducted root cause analysis referencing deficiencies related to staff involved with Resident #1 & #2 for the purpose of identifying roadblocks that occurred and to address staff performance. Results to be shared with Staff Development to enhance additional training on abuse/disrespect. BMNTC policy ADM060 "DHHS Work Performance Plan" (Attachment D) revised to include BMNTC 'Code of Conduct' integrated into every staff member's 'Strengthening Workforce Responsibilities'- ("Adheres to standards set forth in Code of Conduct") and will be reviewed with staff during work performance reviews and supervisory meetings.	July 28, 2014 and ongoing July 28, 2014 and ongoing July 29, 2014 and ongoing July 30, 2014 July 30, 2014

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 07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER	932 OLD US HIGHWAY 70 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 223	Continued From page 3 he was called back to the central bath approximately 10 minutes later and Resident #1 was sitting on the floor several feet from the toilet. NA #1 indicated to Nurse #1 he had eased Resident #1 to the floor. Nurse #1 and NA #1 assisted Resident #1 off the floor, cleaned him up, and assisted him into his wheel chair. Nurse #1 stated Resident #1 was agitated but he did not note any injuries when he assessed him in the central bath. The interview further revealed NA #2 and NA #3 came to him after the incident in the central bath and told him NA #1 had forced Resident #1 off the toilet and also called him a "p.....". Nurse #1 recalled NA #2 and NA #3 went straight to their HCS to report their concerns. A telephone interview was conducted with NA #1 on 06/30/14 at 4:02 PM. NA #1 stated NA #3 was in the central bath with him at first and then NA #2 was there with him. NA #1 further stated when he assisted Resident #1 off the toilet on 06/01/14 he became unsteady and NA #1 eased him to the floor. NA #1 explained Resident #1 was near the bathroom door and he wanted to move him so he stood behind him and pulled him from under his arms approximately 4 feet to the center of the bathroom. Nurse #1 returned to the central bath and assisted NA #1 to get Resident #1 off the floor and cleaned up. NA #1 stated he did not think he was rough with the resident. When asked about referring to Resident #1 as a p..... and stating he would like to suffocate the life out of a p..... NA #1 stated he should not have said these things and regretted having done so. During an interview on 06/30/14 at 3:39 PM the SAO stated she was contacted by the HCS on 06/01/14 regarding alleged emotional and	F 223	All BMNTC staff will be trained in abuse with focus on interventions and reporting. Any staff on leave will be trained on return to work before returning to work. Address what measures will be put into place, or what systematic changes you will make to ensure that the deficient practice does not recur: All classes involving Resident Rights and Protections in New Employee Orientation (NEO), New Employee Curriculum (NEC), and Annual Staff Training will be revised to include a focus on the 'Code of Conduct' as well as scenarios modified from past investigations of abuse and will include demonstration of learning for all new and long term employees. During abuse investigations, BMNTC Quality Assurance Specialist II will seek information regarding interventions by staff and any obstacles to reporting. Interview responses regarding staff interventions in protecting residents will be documented on 'Management Report' (Attachment E) which will also identify accommodation for best practice or corrective action to assure timely interventions and accurate reporting All cases of substantiated abuse will be debriefed with staff (de-identified per Confidentiality/HIPAA mandates) on all residential units within seven working days of substantiation. Staff improvement suggestions will be documented on meeting minutes/roster and turned into Quality Assurance Director. The agenda for regularly scheduled Senior Staff meetings has been revised to include a review of substantiated cases of abuse and ideas of improvement in any area throughout BMNTC. Senior Staff members will then facilitate conversations regarding substantiated abuse incidents with employees in staff meetings (de-identified per Confidentiality/HIPAA mandates). Meeting minutes will be submitted to the Quality Assurance Director. Will modify interviewing practices with applicants applying for positions throughout BMNTC to include review of BMNTC 'Code of Conduct'. Agenda for the first day of employment was revised to include review of 'Code of Conduct' and signed by all new employees	August 5, 2014 August 4, 2014 and ongoing August 4, 2014 and ongoing August 4, 2014 and ongoing July 30, 2014 and ongoing August 1, 2014 and ongoing August 1, 2014 and ongoing

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 07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER	932 OLD US HIGHWAY 70 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 223	Continued From page 4 physical abuse of Resident #1 by NA #1. The SAO assisted with the interviews and at the conclusion gave NA #1 a letter informing him he was on administrative leave with pay. An interview was conducted with NA #2 on 07/01/14 at 9:58 AM. NA #2 stated she went to the central bath after her break on 06/01/14 at approximately 2:18 PM. NA #2 recalled Resident #1 was sitting on the toilet behind the privacy curtain and NA #1 was leaning against the sink. NA #1 indicated Resident #1 was not finished using the toilet. NA #2 stated she asked Resident #1 if he was ready to get off the toilet and Resident #1 told her he was ready to get up. NA #2 stated when she turned around after getting supplies she observed NA #1 pulling on Resident #1's arms and telling him to stand up. NA #2 further stated Resident #1 fell to the floor on his left side and the back of his head was in front of the central bath door. The interview further revealed NA #2 put her foot in front of the bathroom door to stop it from being opened completely. NA #1 then dragged Resident #1 several feet by his lower arms and moved him in to the middle of the bathroom floor. About that time NA #4 stuck her head in to the bathroom and went to get Nurse #1. NA #2 further explained when she and NA #3 wheeled Resident #1 out of the central bath he was kicking and hitting at them and told his family staff were beating him. NA #2 then reported her observations to Nurse #1 and the HCS. An interview with NA #4 on 07/01/14 at 10:35 AM revealed she took Resident #1 to the central bath because he indicated he needed to have a bowel movement. NA #4 stated Resident #1 was able to stand with assist and use the rail to pivot to the	F 223	Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. The facility must develop a plan for ensuring correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility. BMNTC has an Operational Plan that directs Executive Committee in overall management and planning for the facility. The following Quality Assurance Objectives will be added to the Operational Plan to ensure corrections related to abuse are achieved and sustained through action plans developed by the Executive Committee as data indicates. Quality Assurance data &/or Action Plans will be reviewed and disseminated to all facility staff. The Executive Committee (EC) will review the QA objectives at all regularly scheduled meetings and minimally every month. Staff Development will conduct follow up testing with employees at three and six months after NEC training to evaluate retention of training regarding abuse/disrespect. QA Objective will be that 90% of staff completing training questionnaires on abuse/disrespect will demonstrate retention regarding abuse/disrespect training. Any evidence of difficulties individual staff have in assimilating understanding of training and staff responsibilities will result in follow-up with management to provide coaching &/or retraining. Quality Assurance Specialist II will report information gained from staff interviews, numbers of interventions that did or did not occur and will report to the Executive Committee. QA objective will be that staff will intervene in incidents of potential abuse or disrespect situations 100% of the time. Quality Assurance objective developed regarding Unit staff debriefing of abuse incidents will occur within 7 working days of substantiation 100% of the time as evidenced by meeting minutes/roster. Quality Assurance objective developed that Senior Staff will conduct debriefing of substantiated incident of abuse with departmental staff at regularly scheduled meetings 100% of the time.	July 30, 2014 and ongoing July 30, 2014 and ongoing July 30, 2014 and ongoing July 30, 2014 and ongoing Augst 4, 2014 and ongoing Augst 4, 2014 and ongoing

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 07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER	932 OLD US HIGHWAY 70 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 223	Continued From page 5 toilet. NA #4 explained it was time for her break and Resident #1 told her he was not ready to get off the toilet and NA #1 came in the bathroom and offered to watch Resident #1. NA #4 stated Resident #1 was standing by the time she got back in to the central bath and he seemed upset. NA #4 further stated she was assigned to monitor Resident #1's visit with his family immediately after the incident in the bathroom and when his family asked him what was wrong he did not answer them. The interview further revealed NA #4 observed the visit for approximately 30 minutes and stated Resident #1 seemed calm after a few minutes with his family. An interview was conducted with the Staff Development Coordinator (SDC) on 07/01/14 at 3:20 PM. The SDC stated all employees received training regarding abuse and neglect during their initial orientation to the facility presented by the advocacy department. The SDC reviewed facility documents and confirmed NA #1 attended a mandatory staff annual update on 03/24/14 which included a review of information regarding client's rights, abuse, neglect, exploitation, rights infringements, and reporting incidents. During an interview on 07/01/14 at 4:03 PM the Program Director stated physical and emotional abuse were substantiated for Resident #1 because the physical evidence from the investigation did not support all of NA #1's statement. 2. Resident #2 was admitted on 10/18/2010 with diagnosis which included anemia, hypertension, diabetes mellitus, seizure disorder and other	F 223	The Patient Safety Organization (PSO) Core Group is a subset of the EC to include the Director, Assistant Director, Medical Director, Director of Nursing, Quality Assurance Director, QA Specialist II, Director of Psychology and Program Director. The PSO Core Group meets every workday morning for the purpose of reviewing events of past 24 hours (or weekend, holiday) and discusses any calls received from Advocate on Call or Senior Administrator on Call regarding possible resident rights infringment. Based on information received each morning, the PSO Core group will determine any additional actions (coaching, training, etc.) required to resolve issues beyond protections of resident put in place by Advocacy/SAO when a potential abuse situation was reported. Trends identified during daily PSO Core Group meeting will be presented to Executive Committee at all regularly scheduled meetings or minimally every month. Continuous improvement in the intervention and reporting of incidents of abuse/disrespect will occur as additional issues arise. Through the Quality Improvement Performance Improvement process with Root Cause Analysis, BMNTC will work diligently to identify causal and significant causal factors, root cause and latent conditions that attributed to concerns regarding abuse/respect and non-compliance with the 'Code of Conduct'.	July 30, 2014 July 30, 2014 and ongoing August 1, 2014 and ongoing

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 07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER	932 OLD US HIGHWAY 70 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 223	Continued From page 6	F 223		

specified mental retardation/moderate intellectual disabilities.

The most recent annual Minimum Data Set (MDS) dated 01/16/14 indicated Resident #2 required extensive assistance with bed mobility, transfer, and locomotion on and off unit, dressing, toilet use and personal hygiene. Resident #2 was occasionally incontinent of bowel and bladder. The MDS further indicated Resident #2 had problems with short term and long term memory.

During an interview on 06/30/14 at 2:09 PM, Advocate #2 stated an incident had occurred with Resident #2 on 02/07/14. Advocate #2 continued by stating near the end of first shift on 02/07/14, NA #7 reported she had witnessed NA #9 in Resident #2's room purposefully withholding her doll and would not give it back to Resident #2 despite her repeated requests to have the doll back. Resident #2 became visibly upset using a whiny voice to indicate she was sad, upset and spitting. NA #7 then entered Resident #2's room and took the resident to the bathroom.

During an interview on 07/01/14 at 11:05 AM, NA #7 discussed reporting an incident she had witnessed on 02/07/14. NA #7 stated she saw NA #9 taunting and emotionally abusing Resident #2 and purposefully withholding her doll. NA #9 reportedly held Resident #2's doll and said, "I have your doll" and would not give it back to Resident #2 after the resident asked NA #9 several times. NA #9 was also reported to be laughing at the resident.

During an interview on 07/01/14 at 11:23 AM, NA #8 stated she was walking in Resident #2's room on 02/07/14 when she saw NA#7 trying to take

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 07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER	932 OLD US HIGHWAY 70 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 223	Continued From page 7 the resident to the bathroom. Resident #2 was being resistive because NA#9 would not give her doll back. Resident #2 said several times she wanted her doll back. NA#7 took Resident #2 to the bathroom. On 07/01/14 at 11:48 AM an attempt was made to contact NA#7 which was unsuccessful. During an interview on 07/01/14 at 3:32 PM, Program Director and Senior Advocate #1 stated the facility had conducted an investigation and determined this case to be substantiated as emotional abuse.	F 223		

Attachment A

BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER
CODE OF CONDUCT

In order to fulfill our mission and create a positive working culture, each employee is personally committed to continually enforcing and adopting the following attitudes and behaviors:

- **I will take responsibility for my actions and behaviors.** If events happen that are unfavorable, I will look to see where I can improve or change to prevent those events from happening again.

- **I will work at developing a culture of trust and respect.** I will acknowledge my co-workers by listening to their ideas and concerns, recognizing their efforts and contributions, by keeping my agreements and promises, and by showing support of team members to other team members.

- **I will be an active participant at team meetings.** I will listen, acknowledge, and contribute to the best of my ability so the meetings will be productive and proactive.

- **I will be genuinely concerned about each team member's personal welfare.** I will do what I can to help others succeed and share in the excitement of their accomplishments.

- **I will communicate in a manner so others will know they can believe, depend, and count on me.** I will be frank, tactful, open, and honest with my co-workers. If I have a problem with a team member I will only discuss the problem with that person to resolve it and refrain from talking negatively about them with others.

- **My behaviors will be proactive, not reactive.** I will avoid taking statements too personally. When I have a concern about a statement, I will ask for clarification to understand, rather than reacting to what I feel at the time.

- **I will conduct myself in a professional manner.** I will discuss my personal life/problems outside of BMNTC. I will not discuss other co-workers or residents with or in front of residents. I will not use profanity or sexually provocative language or behavior with or in front of residents. I will not discuss or post photographs of BMNTC property, staff, or residents on Facebook, Twitter, SnapChat or any other type of social media mechanism.

- **I will demonstrate pride and a sense of ownership in my role at Black Mountain Neuro-Medical Treatment Center**. I will work with all my team members to show we are committed to Black Mountain Neuro-Medical Treatment Center's mission and supportive of its core priorities.

- **I will work as part of a holistic team.** I recognize all departments need to work together in order to achieve Black Mountain Neuro-Medical Treatment Center's mission. My job focus will be on achieving success throughout Black Mountain Neuro-Medical Treatment Center and not just in my department.

I understand that the Code of Conduct serves as a supplement, not a replacement to all approved policies and procedures. The purpose of the Code of Conduct is to provide guidance to improve interpersonal relationships between staff and residents and supports the provision of respectful, individualized, compassionate and quality care. I agree to continuously strive to uphold this Code of Conduct to the best of my ability.

_____ **Employee Signature/Date**

On this date, I _____ **as your supervisor reviewed this information with you.**

Attachment B(1)

Barker, Anne

From: Hollingsworth, Lauri
Sent: Wednesday, July 23, 2014 11:22 AM
To: BMNTC All
Subject: IMMEDIATE ATTENTION REQUIRED
Importance: High
Attachments: Copy (1) of BMNTC Code of Conduct.doc

We have received the results of the survey of two weeks ago. The regulations state: "The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion."

BMNTC did not meet this requirement based on three investigations that were reviewed by the survey team. BMNTC failed to protect 1 of these residents from physical abuse and 2 of these residents from verbal abuse.

This is a very serious deficiency for the facility. This is not the way we treat our residents. This is not what we should overlook or allow at BMNTC.

A review of the regulations and the information provided by the surveyors make it clear that each and every one of us MUST pay close attention to our interactions with and around residents. It means that we must speak to our residents respectfully and handle our residents with care. Instances where this is not occurring should be reported immediately to your supervisor.

Many of you have attended the Just Culture training. You know that I am very serious about BMNTC becoming a Just Culture. I need to review some Just Culture beliefs here:

We are all accountable and **that means you are accountable for the care provided at BMNTC.** Just Culture talks about 3 employee behaviors: Human Error (missed snack), At-Risk Behavior (forgetting to put up the wet floor sign), and Reckless Behavior. Anything less than providing respectful care is a **reckless behavior** and within Just Culture the management response is **disciplinary action.**

At a time when a human error or at-risk behavior choice is made, there should never be a moment when a resident is treated disrespectfully.

Each of us is accountable to change our own behavior to insure that each resident is treated respectfully at ALL times.
Each of us is accountable to correct another staff member when they are not being respectful.
Each of us is responsible to report any incident to our supervisor where we have the slightest hint that a resident is not treated respectfully.

And then we need to take things one step further. It is imperative that if a staff member is saying things to another staff member that feels a bit "out-of-line" in terms of the way they feel about the residents of BMNTC that too, must be reported to a supervisor. I know that feels and sounds harsh and hard to monitor. However, even though staff is trained on how to interact with our residents...they may not "get it". We are all accountable to help them understand how we treat our residents. So, those instances must also be reported to your supervisor.

*****Each supervisor is to review this with each employee. Each employee is to sign this e-mail. Each employee is also to sign the attached Code of Conduct, even if you have already signed it. ****

As they are signed, send them to Anne Barker. All should be completed by August 1st. These need to be available to the surveyors.

Attachment B (2)

I can not emphasize enough the seriousness of treating our residents respectfully. If you have any questions about the seriousness of how we treat our residents, Kay will make you an appointment to speak directly with me.

Thank you in advance for your immediate and ongoing attention to this.

Lauri Hollingsworth, MS, NHA
N.C. Department of Health and Human Services
Director, Black Mountain Neuro-Medical Treatment Center
932 Old U.S. 70 Highway
Black Mountain, NC 28711
Phone: 828-259-6702
Fax: 828-669-3177
lauri.hollingsworth@dhhs.nc.gov
http://www.bmcnc.org

Attachment C

BEHAVIOR UNCHALLENGED IS BEHAVIOR UNCHANGED

(Quote from Belinda Croft, UM R2)

Please answer the following questions and turn into your supervisor:

What does the Code of Conduct look like?

What does abuse looks like?

What would prevent you from intervening when you see a staff member disrespecting &/or abusing a resident?

What would stop you from reporting abuse/disrespect of a resident? -

Attachment D(1)

BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER

ADMINISTRATIVE POLICY MANUAL

SUBJECT: DHHS Work Performance Plan **Policy No: ADM060**

Effective Date: 07/30/2014
Supersedes: 04/26/2012
Review: 02/25/2014
07/30/2014

Reference: State Personnel Policy Manual Section 10; DHHS Policies and Procedures (State Personnel Manual

Approved By:

Lauri Hollingsworth, MS, N.H.A.
Director

I. Purpose

To set forth guidelines for the provision of an objective basis for performance evaluation, to improve communication between employees and supervisors, to allow employee's input in the appraisal process, to help departments improve working conditions, to increase productivity in the work force, and to provide a basis for making personnel related management decisions such as disciplinary actions, promotions, to provide information in regard to performance salary increases.

II. Policy

The Department of Health and Human Services (DHHS) and Black Mountain Neuro-Medical Treatment Center (BMNTC) accepts and endorses the commitment of North Carolina State Government to the Performance Management Program. The following "Implementation" procedures were developed in compliance with the policies adopted by the Office of State Personnel (OSP).

All DHHS divisions and facilities shall use the DHHS Work Performance Plan form.

The DHHS policy "Performance Management System" is the policy that all BMNTC employees must adhere to. The DHHS policy will be posted in each unit/departmental area. The DHHS policy will be available on the BMNTC InfoNet in the HR section and through the HR Department.

III. Procedure

A. New Employees will receive a review of the policy and procedure related to the Performance Management during New Employee Orientation.

B. Supervisors and managers are responsible for discussing the Job Description and the DHHS Work Performance Plan with new employees within the first 7 days of employment. Both documents are to be reviewed, signed, and placed in the employee file with the new employee receiving a copy of each document. The signed job description is to be submitted to the HR Department immediately after obtaining all signatures.

C. Communicating employee performance expectations:

1. At the beginning of the twelve-month work cycle (July 1-June 30), supervisors shall meet with their employees, establish result expectations regarding their employees' performance, review and discuss the DHHS Values. The supervisor should discuss how their application contributes to achieving result expectations and specify how employees' actual performance will be measured, tracked and monitored throughout the work plan cycle.
2. As of July 30, 2014, all BMNTC Staff work performance plans will include "Strengthening Workforce Responsibilities" to include "Adheres to standards set forth in the BMNTC 'Code of Conduct.
3. Each employee shall have an annual work performance plan established within 30 days from the beginning of the work cycle. The employee's result expectations should be linked to DHHS goals and objectives so the employee understands his or her part in achieving these.
4. Each employee's work plan shall include outcomes/key responsibilities; result expectations; and tracking and monitoring. The outcomes/key responsibilities and their result expectations shall be listed in priority order of importance. Each DHHS employee work plan will also include the prewritten DHHS Values.
5. Result expectations shall be written at the "Successful" level and must have one or more measurement methods (quality, quantity, timeliness, or cost effectiveness). Supervisors shall also discuss result expectations at the "Exceptional" and "Improvement needed" levels and how DHHS Values apply to the results the employee is to achieve.
6. When the work plan is established, it shall be dated and signed by the employee, the supervisor and the supervisor's manager. The employee may be given a copy of the work plan document.

D. Maintaining an ongoing performance dialogue

1. Employees shall be responsible for successfully meeting their result expectations and apply DHHS Values, which includes the collection of their performance documentation, work samples or data that support result expectations and DHHS Values.

2. Progress toward meeting result expectations shall be measured, reported, discussed and documented throughout the work cycle.

3. Supervisors are expected to use appropriate supervisory techniques (i.e., coaching for success, regular feedback, etc.) to support employee efforts to meet or exceed their result expectations and apply DHHS Values.

4. When expectations change during the course of the work cycle, supervisors shall communicate these changes and modify work performance plans as necessary. Changes shall be signed and dated by the employee, supervisor and the supervisor's manager.

5. The supervisor shall conduct an interim review at the mid-point of the work cycle to review the employee's progress towards meeting result expectations and how the application of DHHS Values contributed to the achievement of results. The interim review shall be signed and dated by the employee and the supervisor. A performance rating is not assigned at the interim review. However, performance in a result expectation(s) that is not meeting the "Successful" level or a DHHS Value that is not being demonstrated by the employee shall be documented on an "Improvement Plan." (See "Addressing Poor Performance" below.)

E. Conducting annual performance appraisals

1. At the end of the work cycle, supervisors shall evaluate employees' performance compared to their result expectations that reflect application of DHHS Values. Supervisors shall use verifiable information collected and documented throughout the work cycle to determine the extent to which actual performance has met the result expectations.

2. The overall rating shall use the DHHS Rating Scale for reporting performance. The final appraisal shall be documented on the employee's DHHS work plan.

3. The overall (or end of cycle) rating is determined based on the combined rating for outcomes/key responsibilities that reflect application of DHHS Values.

4. Employees who meet result expectations and consistently apply DHHS Values shall earn the rating of "Successful."

5. An employee in final disciplinary procedure during the work cycle shall not receive a rating above the "Successful" level if the disciplinary action is unresolved.

6. Prior to discussing the overall rating with an employee, a supervisor shall review the final appraisal with the next level manager to ensure that the documentation demonstrates the rating has been earned and is applied consistently.

7. Supervisors shall discuss the final appraisals with each employee. The supervisor and employee shall sign and date the completed final appraisal indicating that the discussion has taken place. The manager's signature indicates there is sufficient documentation to warrant the rating given. Employees shall be provided an opportunity to comment on their rating. An employee's signature does not imply agreement with the overall rating, but indicates the rating has been discussed with the supervisor. Should the employee refuse to sign the work plan, the supervisor documents this and asks the manager to witness the employee's refusal to sign the work plan.

8. The work plan becomes confidential once the final performance appraisal is completed with ratings assigned and signatures.

9. The employee shall be provided a copy of the final work plan.

10. The work plan, including the final overall rating, all signatures and the final completed appraisal of the employee shall be submitted to the respective division or facility human resources office by the date established annually by DHHS Human Resources.

F. Addressing Poor Performance

1. When an employee's performance falls below the level of "Successful" at any time during the performance cycle or DHHS Values are not being demonstrated, the supervisor shall document the deficiency and take action. That action may be an Improvement Plan and Disciplinary Action. Performance issues are typically managed through the improvement plan while conduct issues may necessitate moving directly to the level of disciplinary action. Supervisors are encouraged to consult with the human resources office to determine the best course of action before meeting with the employee.

2. The supervisor shall document the performance that falls short of expectations by preparing an improvement plan. The improvement plan will specify (a) the performance problem, (b) the steps to be taken to improve performance, including the timeframe for improvement, (c) the consequence of failure to improve and (d) a follow-up date. An improvement plan shall be considered successfully completed only when the employee's actual performance has improved to the point where result expectations and/or DHHS Values are being met.

3. Performance deficiencies that occur during the work cycle shall be referenced in the annual performance appraisal and documented on the improvement plan. The status of the employee's improvement plan shall be summarized on the performance appraisal.

4. Unresolved deficiencies at the improvement plan level shall be addressed using the DHHS Human Resources Disciplinary Action policy. For deficiencies that advance to the level of disciplinary action, employee improvement plans shall be referenced in the disciplinary action.

G. Supporting Employee Development: All DHHS employees shall have a development plan. Supervisors shall work with employees to identify strengths and weaknesses, and help them prepare a development plan. Individual development plans may specify how employees can more fully apply their strengths in their current positions, enhance their performance in their current positions or develop the skills and experience they will need for possible future assignments.

H. Transitions: When employees move into or out of their positions, relevant performance information shall be communicated in a timely way.

1. Probationary employees shall have work plans within 30 days of their date of employment. Special reviews shall be conducted for probationary employees at the third and sixth month to document progress toward the completion of the probationary period. Before appointing an employee to permanent status, the supervisor shall provide documentation on the employee's work plan that s/he is meeting result expectations and applying DHHS Values.

2. Employees in training progressions shall have work plans established within 30 days from the date of employment. Before each salary increase is granted within the trainee progression, the supervisor shall provide documentation on the work plan that performance is meeting result expectations that also reflects consistent application of DHHS Values.

3. Employees whose responsibilities are changed substantially, either within their current position or by transfer (promotion, lateral transfer, or demotion), shall have work plans established within 30 days following the new assignment.

4. When an employee transfers from an agency or university to DHHS or from one DHHS division or facility to another, the releasing agency, university, division or facility shall send a completed work plan summarizing the employee's performance from the last appraisal up to the date of transfer. This work plan shall be provided before the employee's first day with the receiving agency. The receiving supervisor may use this performance documentation when completing the employee's final appraisal.

5. When a supervisor leaves a work unit, the next-level supervisor shall ensure that completed work plans for each employee supervised by the departing supervisor are made available to the employees' new supervisor.

I. Access and Use of Performance Information

1. The original work plan shall be maintained in the employee's personnel file located in the respective division or facility's human resources office for a minimum of three years. Each employee is notified by the supervisor where

the work plan is kept. Completed final performance appraisals (with ratings, supporting documentation, and signatures and dates) shall be treated as confidential. Final performance appraisals shall also be disposed of in a confidential manner according to G.S. 121-5 (b) & (c).

2. Information obtained during the performance management process about individual employees or from specific units of the department shall be a consideration by management in making other personnel decisions. Decisions involving promotions, performance-based disciplinary actions, performance-based salary increases, and reductions in force shall be supported by a current appraisal on file.

3. When current or former State employees are being considered for hire or promotion, their past work performance plans and appraisals may be obtained for review by those involved in making the hiring or promotion decision. This right to access is based on State policy (Employment and Records, Section 3) and on the employee's signature on the state application that authorizes the release of information relevant to job requirements.

J. Training and Communication

1. New employees to DHHS shall be given access to the DHHS Performance Management policy during orientation.

2. New supervisors and managers shall participate in the DHHS performance management supervisor training within the first year of assuming supervisory duties. Division and facility performance management trainers shall meet the curriculum and training requirements established by DHHS Human Resources.

3. The manager of the new supervisor shall conduct the performance management requirements of employees until performance management training is completed by the new supervisor.

K. Performance Disputes

The end of cycle summary page of the work performance plan shall contain the statement: Performance Rating Dispute Process: An employee may dispute the accuracy of an annual overall rating of less than "Exceptional" by filing a complaint on DHHS Form PRD-1, which must be received by the respective division or facility human resources manager within 15 calendar days from the date the employee receives his/her copy of the completed work performance plan and performance appraisal. Performance appraisals other than the current appraisal are not appealable under the DHHS performance rating dispute process. Copies of the dispute process (DHHS Directive Number III-9) and the Performance Rating Dispute Process Complaint Filing Form (DHHS Form PRD-1) are available from all DHHS human resources offices.

Department of Health and Human Services

Work Performance Plan - Professional/Knowledge Worker Role

Employee Information

Employee's Name:	Position:	Work Cycle Dates From: To:	Division/Facility:	Section/Unit:

Initial Discussion

Date of Initial Work Performance Plan Discussion:	As discussed with my supervisor, I understand the DHHS Values as they relate to the achievement of my Result Expectations, and the methods we will use to document results. I also understand the work performance plan is not intended to include all possible performance expectations and may take into account my performance in relation to the position description, agency policies and procedures, any assigned or delegated work not specifically stated in the performance plan, and any standards of conduct that a reasonable person would expect an employee to adhere to. Employee's Signature: Date:

Supervisor's Name:	Position:	Supervisor's Signature:	Date:
Manager's Name:	Position:	Manager's Signature:	Date:

Date of Interim Review Discussion:	Improvement Plan Needed: ☐ Yes (attached) ☐ No
Employee's Signature: Comments (optional):	Date:
Supervisor's Signature: Comments (optional):	Date:
Manager's Signature:	Date:

OVERALL SUMMARY RATING:

Vision: *All North Carolinians will enjoy optimal health and well-being.*

DHHS Mission: *The NC DHHS, in collaboration with its partners, protects the health and safety of all North Carolinians and provides essential human services.*

Goals: *(1)* Manage resources to *provide effective and efficient delivery of* services to North Carolinians.

(2) Expand awareness, understanding and use of information to enhance the health and safety of North Carolinian.

(3) Provide outreach, support and services to individuals and families identified as being at risk of compromised health and safety to eliminate or reduce those risks. (4) Provide services and support to individuals and families experiencing health and safety needs to assist them in living successfully in the community.

(5) Provide services and protection to individuals and families experiencing serious health and safety needs who are not, at least temporarily, able to assist themselves with the goal of helping them to return to independent, community living.

Revised

Demonstration of DHHS Values is an expectation of every DHHS employee.

Demonstrated Values by Role **Professional/Knowledge Worker**
Transparent: DHHS shares information, planning and decision-making processes and communicates openly with its customers and partners. • Checks to see if information is accessible, chooses best action after considering any impact on the agency. • Adapts and maintains focus and minimizes complexity or contradictions by using plain language. • Shares information within the legal parameters.
Results-Oriented: DHHS emphasizes accountability and measures its work by the highest standards. • Consistently remains open to ideas offered by others; supports and uses best practices /accepted industry standards to work toward achieving desired outcomes. • Builds value of preferred alternatives by relating them to the other party's needs; responds to objections by emphasizing value benefit; exposes problems with undesirable alternatives. • Considers both the benefits of success and challenges of failure before acting.
Anticipatory: DHHS actively monitors changes in the needs of its customers and the impact of its services and applies new and innovative approaches in a timely, targeted and effective manner. • Analyzes the organization to identify key relationships, trends and best practices to achieve team performance measures. • Facilitates feedback and information from a variety of sources to introduce innovation and meet mutually acceptable resolution. • Creates novel combinations of processes or makes connection between differing ideas to solve problems. • Eases the implementation and acceptance of change in the workplace.
Collaborative: DHHS values internal and external partnerships. • Clarifies the specific customer issue or request and makes recommendations. • Draws upon diverse sources (individuals, disciplines, bodies of knowledge) for ideas and openly contributes own ideas about the issues. • Listens to and fully involves others in team decisions and actions; and is accountable for individual and team outcomes. • Openly shares information and expertise.
Customer-Focused: North Carolinians are the center of our service design and delivery and the allocation of human and fiscal resources. • Helps customers feel valued and appreciated by clarifying the issue, focusing on a solution and taking action. This helps build confidence with the customer. • Recommends effective ways to monitor and evaluate customer concerns, issues, and satisfaction and anticipate customer needs. • Maintains professionalism in difficult situations by remaining issue-oriented.

Outcomes (Key Responsibilities): List 2 to 4	Result Expectations: List 1 to 3 Measurable Expectations per Outcome The supervisor shall discuss with the employee how DHHS Values are to be demonstrated to achieve each Result Expectation.	Tracking Sources and Frequency:	Documentation to Support Results and DHHS Values:	Rating:
			Combined Outcome Rating: Place this rating on the first page in the "Overall Rating" box.	

Revised

EMPLOYEE DEVELOPMENT PLAN

(A development plan is an action plan for enhancing an employee's level of performance in order to achieve and exceed expectations in the current job or prepare for new responsibilities.)

Define the knowledge/skills/behavior to be enhanced:	Method to develop knowledge/skill/ behavior:	Timeline:	Results:

We have discussed the knowledge/skills/behavior that the employee will be developing over the next year.
Employee's Signature: Date:
Supervisor's Signature: Date:

End of Cycle Summary

Supervisor's Comments:

I have discussed and reviewed the documentation with the employee.

Supervisor's Signature: **Date:**

Employee's Comments:

Employee's Signature: **Date:**

Manager's Signature: **Date:**

Revised

Performance Rating Dispute Process: An employee may dispute the fairness of an annual overall summary rating of less than Exceptional by filing a complaint on NC DHHS Form PRD-1, which must be received by the division/facility HR manager within 15 calendar days from the date the employee receives his/her copy of the Work Performance Plan and Overall Summary Rating. Performance reviews other than the annual review are not appealable under the NC DHHS Performance Rating Dispute Process. Copies of the Dispute Process (NC DHHS Directive Number III-9) and NC DHHS Form PRD-1 are available from all NC DHHS Human Resources offices.

Performance Rating Scale:

Exceptional: Work performance that consistently far exceeded result expectations and DHHS values.

Successful: Work performance that consistently achieved expectations and DHHS values and at times may have exceeded expectations and DHHS values.

Improvement Needed: Work performance that did not consistently meet expectations or DHHS values and/or has failed to make reasonable progress toward previously outlined deficiencies in achieving expectations or DHHS values.

Improvement Plans

In the event an Improvement Plan is necessary during the work cycle, the supervisor should discuss the need for improvement with the local HR office. An Improvement Plan can be written at any time during the work cycle that the employee is not meeting the successful level of performance. Improvement Plans should include **(1)** the specific expectation(s) that are not being met; **(2)** what the employee needs to do to bring performance up to the successful level; **(3)** how progress will be tracked; and **(4)** what consequences may occur if performance is not improved to meet the expectation.

Attachment E (1)

Management Investigation Report
Black Mountain Neuro-Medical Treatment Center

This information is privileged and confidential. All DSOHF facilities are members of the North Carolina Quality Center Patient Safety Organization (NCQC POS) and this information has been collected within the Patient Safety Evaluation System (PSES) for the purpose of reporting to the NCQC PSO. This information is Patient Safety Work Product (PSWP) and may not be disclosed unless authorized by the Facility CEO or DSOHP PSO Contact person in accordance with the Patient Safety Quality Improvement Act (PSQIA) 42 CFR Part 3. In addition, this information is confidential pursuant to NC Gen. Stat. 122C-52 and 122C-191, the Health Insurance Portability and Accountability ACT (HIPAA) 45 CFR Parts 160, 162, 164; and may be protected by federal regulations for Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2.

Case Reference #	

Incident/Occurrence Information

Date of Incident		Time of Incident	
Name of Reporter/Title			
Staff Intervention:	Yes		
Describe			
Staff Intervention:	No		
Describe			
List Obstacles:			
Protective Action:	Yes ☐ No ☐	Date:	Time:
Describe			
Description of Incident/Occurrence			
Resident(s) Involved in Incident			
Resident Name	Resident ID #	Unit	

Resident Name	Resident ID #	Unit

Interview Information

Alleged Responsible Employee(s) Name/Title	Date of Employment

Witness Name(s) / Title	Witness Name(s) / Title

Date of Closure Conference			
Closure Participant Names / Titles		**Closure Participant Names / Titles**	
Case Reference Number:			
Date Investigation Initiated		**Date Investigation Completed**	
Investigation Team Names / Titles		**Investigation Team Names / Titles**	
Advocacy Determination	☐ Unsubstantiated ☐ Substantiated ☐ Abuse ☐ Neglect ☐ Exploitation ☐ Other	**Management Determination Notes**	
Just Culture Behavior	**Human Error:**	**At Risk Behavior:**	**Reckless Behavior:**

SUMMARY OF MANAGEMENT FINDINGS
(Also, address any mitigating factors affecting adherence to policy/procedure)

Attachment E (3)

MANAGEMENT OUTCOMES / ACTION REQUESTED

MANAGEMENT FINDINGS COMMUNICATED BY WHOM & TO WHOM

Investigation Report Submitted To	

Staff Conducting Investigation/Title	Date

For Administrative Use Only

Date Notice of Action Sent		Date Notice of Action Completed	
Date Management Actions Instituted			

Attachment E (4)

Management Investigation Notes

This information is privileged and confidential. All DSOHF facilities are members of the North Carolina Quality Center Patient Safety Organization (NCQC POS) and this information has been collected within the Patient Safety Evaluation System (PSES) for the purpose of reporting to the NCQC PSO. This information is Patient Safety Work Product (PSWP) and may not be disclosed unless authorized by the Facility CEO or DSOHP PSO Contact person in accordance with the Patient Safety Quality Improvement Act (PSQIA) 42 CFR Part 3. In addition, this information is confidential pursuant to NC Gen. Stat. 122C-52 and 122C-191, the Health Insurance Portability and Accountability ACT (HIPAA) 45 CFR Parts 160, 162, 164; and may be protected by federal regulations for Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2.

Case Reference Number: _____ Date of Interview: _____

Manager: _____ Time of Interview: _____

Attachment E (s)

Management Investigation
Witness Statement

This information is privileged and confidential. All DSOHF facilities are members of the North Carolina Quality Center Patient Safety Organization (NCQC POS) and this information has been collected within the Patient Safety Evaluation System (PSES) for the purpose of reporting to the NCQC PSO. This information is Patient Safety Work Product (PSWP) and may not be disclosed unless authorized by the Facility CEO or DSOHP PSO Contact person in accordance with the Patient Safety Quality Improvement Act (PSQIA) 42 CFR Part 3. In addition, this information is confidential pursuant to NC Gen. Stat. 122C-52 and 122C-191, the Health Insurance Portability and Accountability ACT (HIPAA) 45 CFR Parts 160, 162, 164; and may be protected by federal regulations for Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2.

Case Reference Number: _____ Date of Interview: _____

Witness Signature: _____ Time of Interview: _____