	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		34A001	B. WING			05	/03/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		00,2010
				93	32 OLD US HIGHWAY 70		
BLACK		DICAL TREATMENT CENTER			LACK MOUNTAIN, NC 28711		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		COMPLETION DATE
F 607 SS=D	Develop/Implement CFR(s): 483.12(b)(	t Abuse/Neglect Policies 1)-(3)	F6	607			5/31/18
	• • • •	ility must develop and policies and procedures that:					
		ibit and prevent abuse, tation of residents and resident property,					
		blish policies and procedures uch allegations, and					
	paragraph §483.95	de training as required at , NT is not met as evidenced					
	Based on policy ar and staff interviews	nd record review and family the facility failed to implement and procedures in the areas			On Sunday, 4/22/2018, when bruise wa noted by CNA on resident⊡s left inner thigh, CNA reported to the 3rd shift Nurs		
	of reporting and inv	estigating for 1 of 1 sampled t #30) who had a bruise of			who assessed the area, found no break skin integrity, and documented bruise in Nursing Progress Notes and wrote	in	
	The Findings Includ	-			description of bruise on □Nurses Round Report Form□. Resident□s representative notified of bruise per	ls	
		lity policy titled" Protecting ghts Infringement" dated part:			notification preference. The Nurse did r report the bruise to Advocacy or to her supervisor.	not	
		he right to be free from abuse, riation of resident property and			On Monday morning 4/23/18, during the "Daily Safety Events Report & Risk Management Meeting", (includes Direct Medical Director, DON, ADON, Unit		
	observed and could	source of the injury was not I not be explained by the njury is suspicious because of			Managers, Risk Manager, Social Workers, Senior Psychologist, Director Professional Services, QA Director, MD		
	the locations of the immediately contact	injury, the nurse will t and report the injury to the d a member of management			Coordinators and MDS Assistants), the Gravely 3 Nurse Unit Manager from this resident s Unit reported that resident h	;	

**Electronically Signed** 

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.

05/25/2018

PRINTED: 06/04/2018

						O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION		E SURVEY IPLETED
		34A001	B. WING		0	5/03/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				932 OLD US HIGHWAY 70		
BLACK IVI		CAL TREATMENT CENTER		BLACK MOUNTAIN, NC 28711		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIO
F 607	Continued From page	e 1	F 60	7		
	staff.			a bruise on inner thigh of unkn	own	
				etiology. Report also included		
	Notification: Designation	ated staff will report to the		reason: that resident can be ag		
	•	injury of unknown source.		during care, she is intrusive wi	th others, or	
				may have scratched herself. T		
		vestigation team will ensure ed from all involved staff		was not reported to HCPR or t	o Advocacy.	
	through investigative	interviews and results of this		On the morning of 5/2/18, duri	ng the	
	investigation will be r	eported the State Survey		"Daily Safety Events Report &		
	Agency.			Management Meeting", Team		
				that the location of the bruise s		
		Imitted to the facility on		been a flag for suspicion along		
	11/18/2015 with diag			unknown source. Due to time		
		ident, Alzheimer's and secondary to head trauma.		bruise occurred, a formal inves was not initiated at this time.	-	
		secondary to nead tradina.		"plan of correction" in place that		
	Review of the annual	l Minimum Data Set (MDS)		the following practice and train		
		ed that Resident #30 had		- Locations of injuries of unkno		
	severely impaired co	gnition. Further review		that will prompt an investigatio		
	revealed she had phy	ysical and verbal behaviors		injuries on resident⊡s face, ba	ck, groin	
		lays and wandering and		and/or injuries in areas not ger	nerally	
		aviors that occurred 1 to 3		vulnerable to trauma.		
	•	ent also revealed the		- Nurse Unit Managers will brir		
	-	ensive assistance with bed		(Resident Incident Response)		
	mobility, dressing, to			previous day(s) to Daily Safety	кероп &	
	-	vision for walking. She was being incontinent of bowel		Risk Management Meeting. - "Daily Safety Events Report &	2. Risk	
		naving 2 or more falls with no		Management Meeting Team" v		
	injury since her last a			daily RL6 data/reports and det		
		o coded as Resident #30 not		any injuries of unknown source		
	receiving any anticoa			suspicious due to their location		
				reported to the Nursing Superv		
		#30's care plan, dated		Advocacy as detailed in BMNT		
		oncern with bruising and		ADM133B "Protecting Resider		
		vere to monitor, observe and		Rights Infringements". Directo	-	
	report any bruising.			will make final determination if		
	Dovious of a surely	note deted 1/20/2010		unknown source and suspiciou		
	Review of a nursing i	note dated 4/22/2018 read in		report to the HCPR immediate	y dut not	

Facility ID: 955752

If continuation sheet Page 2 of 23

PRINTED: 06/04/2018 FORM APPROVED

STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		B	COMPI	
		34A001	B. WING		05/0	03/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
BLACK M	OUNTAIN NEURO-MEDI	CAL TREATMENT CENTER		932 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 283	711	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 607	Continued From page	e 2	F 60	)7		
	color, finger shaped of			if events that caused th	ne allegation involve	
		and own outlogy.		abuse or result in serio	-	
	Review of the facility	document titled Nurses		not later than 24 hours		
	Rounds Report for R	esident #30 dated 4/22/2018		caused the allegation of	do not involve	
		ngth purple bruise to left		abuse and do not resu	-	
	upper thigh.			injury". A formal and c		
	Deview of the feeility	abuse allegations and		investigation will be ini		
		abuse allegations and o reveal any investigation		- All nursing staff will re learning how to better		
		h bruise of Resident #30.		identify injuries of unkr	-	
				a suspicious nature, a		
	An interview was con	ducted with the Director of		supervisor and advoca		
	Quality Assurance (C	A) on 5/2/18 at 2:29PM.		BMNTC Policy ADM13	-	
	-	the QA director stated that		Residents from Rights	-	
	-	would investigate any injury		documenting the even	· •	
		The QA Director further stated		the Nursing Progress I		
	that management ma	ted it was the advocacy staff		began 5/7/18 complete - Monthly Nurses meet		
		estigation. The QA Director		review of scenarios of		
		erview that she was not		source. 1) Nurses will	-	
	-	nd the facility had not		bruise, injury, wound is		
		nner thigh bruise to Resident		nature. 2) Identify polic	cy requirements for	
		ty completed the 24 hour		documentation. 3) Mal		
	and 5 days reporting	to the State Survey Agency.		around notification of t		
	An interview was can	ducted with the 1st shift		resident representative supervisor, SAO and A		
		iducted with the 1st shift 2/18 at 2:55PM. During this		requirements and nurs		
		that she "vaguely" recalled		The goal of this trainin		
		esident #30 but could not		awareness, prevent co	-	
		fics about the bruise and did		maintain consistency i		
	not know how the bru	uise occurred. She further		- Office Assistant III in	Administration will	
		ot see or investigate the		document dates Initial	-	
	bruise to Resident #3	30.		(24 hr Report) is sent a		
		ducted with QA Director and		tracking form to ensure		
		DON) on 5/2/18 at 3:30PM.		Investigation Report (5 Report) report is sent v		
		se of unknown origin to left		frame.		
		) was unknown as to how it				
		it was not reported to State		On 5/24/18 BMNTC O	ccupational	

Facility ID: 955752

If continuation sheet Page 3 of 23

		MEDICAID SERVICES	(X2) MI II TID	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
		34A001	B. WING		05/03/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BLACK M	OUNTAIN NEURO-MEDI	CAL TREATMENT CENTER		932 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO	
F 607	Survey Agency and if	t was not investigated. The	F 60	Therapist completed an evaluation		
	could be reported to	tated she understood how it the State Survey Agency, but ot think it was a suspicious		resident #30 during toileting for ar possible new techniques staff can in decreasing residents discomfor resistance during care.	utilize	
	A telephone interview was conducted on 5/2/18 at 3:35PM with Nurse #6, who authored the nurses note on 4/22/18 about the bruise to the left inner thigh of Resident #30. During this interview she stated that she recalled the note about the bruised finger shaped area on Resident #30's inner thigh. She further stated she did not know how the bruise occurred and that she reported it to the oncoming nurse at the end of her shift. She also stated that a finger shaped bruise to a resident's inner thigh "would be looked into as it is something to be concerned of" and that no management staff followed up with her investigating the bruise. During an interview with the Assistant Director of Nursing on 5/2/18 at 4:32PM she stated, "anything finger shaped is a red flag to us and should be investigated."		<ul> <li>The following Quality Assurance C will be added to the BMNTC Quality Assurance Performance Improver Plan:</li> <li>"Every injury of unknown source the meets definition of suspicion will be reported 100% of the time, per BM policy ADM 133B "Protecting Resist From Rights Infringements", to the Nursing Supervisor, Advocate, an per regulatory timeframes.</li> <li>This objective will be monitored date review of RL6 incidents for timely reporting and reviewed in monthly Assurance meetings through 5/31 any time monitoring identifies a procorrective action will be taken immediately.</li> </ul>	ity nent hat le INTC ident's d HCPR aily with Quality /19. At		
	Party of Resident #30 Responsible Party st	ducted with the Responsible 0 on 5/2/18 a 5:35PM. The ated she was told of the ld the bruise was on the or how it the bruise		The BMNTC Director and Director Nursing are responsible for impler the POC.		
	5/3/18 at 9:00AM. Do stated that her job re- the rights of the resid further stated employ	ducted with Advocate #1 on uring this interview she sponsibilities was to ensure lents were not violated. She vees are instructed to notify rights violations to include				

If continuation sheet Page 4 of 23

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	D. 0938-03 SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMF	PLETED
		34A001	B. WING		05	/03/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BLACK M	OUNTAIN NEURO-MEDI	CAL TREATMENT CENTER		932 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 607	Continued From pag	e 4	F 60	70		
		origin and that a bruise in the				
	-	vn origin to Resident #30 ported to them and they				
	should have investig	ated it. She stated she was				
		se and that it had not been				
	reported to her to inv	estigate.				
	An interview was cor	nducted with Nurse #7 on				
	5/3/18 at 11:02AM. S					
		ered the bruise to Resident being mentioned to her				
		She further stated that she				
	did not report the bru	ise to any management and				
		e of any investigation into				
	how the bruise occur	red.				
	During a follow-up in	terview with the QA Director				
		she stated that there was				
		no 24 hour and 5-day reports e State Survey Agency for				
		n origin to the inner thigh of				
	Resident #30.					
F 609	Reporting of Alleged		F 60	99		5/31/18
SS=D	CFR(s): 483.12(c)(1)	(4)				
	§483.12(c) In respon	se to allegations of abuse,				
		or mistreatment, the facility				
	must:					
	\$483.12(c)(1) Ensure	e that all alleged violations				
	involving abuse, neg	lect, exploitation or				
		ng injuries of unknown				
		priation of resident property, ately, but not later than 2				
		ation is made, if the events				
	that cause the allega	tion involve abuse or result in				
		or not later than 24 hours if				
	the events that cause	e the allegation do not involve		1		1

Facility ID: 955752

If continuation sheet Page 5 of 23

	F DEFICIENCIES	MEDICAID SERVICES				<u>O. 0938-03</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	PLETED
		34A001	B. WING		05	6/03/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BLACK M	OUNTAIN NEURO-MEDI	CAL TREATMENT CENTER		932 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 609	Continued From page	e 5	F 60	9		
		ult in serious bodily injury, to				
		ne facility and to other				
		the State Survey Agency and				
		ces where state law provides				
		-term care facilities) in				
	procedures.	e law through established				
	5402 40(a)(4) Depart					
	§483.12(c)(4) Report	administrator or his or her				
	-	ative and to other officials in				
		e law, including to the State				
		n 5 working days of the				
		eged violation is verified				
		e action must be taken.				
	by:	is not met as evidenced				
	-	iew and family and staff		On Sunday, 4/22/2018, when b	ruise was	
		failed to submit a 24 hour		noted by CNA on resident s lef		
		ne State Survey Agency and		thigh, CNA reported to the 3rd s		
		bruise of unknown origin for		who assessed the area, found r	o break in	
	1 of 1 sampled reside	ents. (Resident #30)		skin integrity, and documented l		
	The Findings Include	d		Nursing Progress Notes and wro		
	The Findings Include	d.		description of bruise on □Nurse Report Form□. Resident□s	SRounds	
	Resident #30 was ad	mitted to the facility on		representative notified of bruise	per	
	11/18/2015 with diagr	•		notification preference. The Nu		
	Cerebrovascular Acci	ident, Alzheimer's and		report the bruise to Advocacy or		
	Frontal Lobe Atrophy	secondary to head trauma.		supervisor.		
		Minimum Data Set (MDS)		On Monday morning 4/23/18, du		
		ed that Resident #30 had		"Daily Safety Events Report & F		
		gnition. Further review		Management Meeting", (include		
		vsical and verbal behaviors lays and wandering and		Medical Director, DON, ADON, Managers, Risk Manager, Socia		
		aviors that occurred 1 to 3		Workers, Senior Psychologist, I		
	days. The assessme			Professional Services, QA Direc		
	resident required exte	ensive assistance with bed		Coordinators and MDS Assistan	ts), the	
	mobility, dressing, toi	In the second second second	1	Gravely 3 Nurse Unit Manager f	rom this	1

Facility ID: 955752

If continuation sheet Page 6 of 23

-		MEDICAID SERVICES			(	OMB NO. 0938	5-05
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			N	(X3) DATE SURVE COMPLETED	Y
		34A001	B. WING			05/03/20 <sup>2</sup>	18
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS	S, CITY, STATE, ZIP CODE		
BLACK M	OUNTAIN NEURO-MEDI	CAL TREATMENT CENTER	932 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 28711				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PR	ROVIDER'S PLAN OF CORRECTION		X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACI	H CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMP	
F 609	Continued From page	e 6	F 60	9			
		vision for walking. She was			Unit reported that resident h	ad	
		being incontinent of bowel			inner thigh of unknown		
	-	aving 2 or more falls with no			Report also included possible	e	
	injury since her last a	ssessment. The			t resident can be aggressive		
		o coded as Resident #30 not		-	e, she is intrusive with others,		
	receiving any anticoa	igulant medications.		-	scratched herself. The event ported to HCPR or to Advoca		
		#30's care plan, dated					
		oncern with bruising and			ning of 5/2/18, during the		
		ere to monitor, observe and		-	ty Events Report & Risk		
	report any bruising.			-	ent Meeting", Team discussed		
					ation of the bruise should ha	ve	
		note dated 4/22/2018 read in ent's left inner thigh, purple in			for suspicion along with ource. Due to time since		
	color, finger shaped of				urred, a formal investigation		
		or unknown chology.			tiated at this time. DON put a	a	
	Review of the facility	document titled Nurses			rection" in place that identifie		
		esident #30 dated 4/22/2018			g practice and training:		
	·	ngth purple bruise to left			of injuries of unknown sourc	e	
	upper thigh.				mpt an investigation include		
				injuries on I	resident⊡s face, back, groin		
	Review of the facility	abuse allegations and		and/or injur	ies in areas not generally		
		o reveal any investigation		vulnerable			
	into the left inner thig	h bruise of Resident #30.			it Managers will bring RL6		
	<b>.</b>				ncident Response) forms from		
		ducted with the Director of		_ · ·	ay(s) to Daily Safety Report 8	\$	
		A) on 5/2/18 at 2:29PM.			gement Meeting.		
		the QA director stated that would investigate any injury			fety Events Report & Risk ent Meeting Team" will review	1	
	-	The QA Director further stated			lata/reports and determine if		
	that management ma			-	s of unknown source,		
	-	ted it was the advocacy staff			due to their location, were		
	-	estigation. The QA Director			the Nursing Supervisor and		
		erview that she was not			as detailed in BMNTC Policy		
	-	nd the facility had not			"Protecting Residents from		
		nner thigh bruise to Resident			ngements". Director/designe		
		ty completed the 24 hour			nal determination if injury is o		
	and 5 days reporting	to the State Survey Agency.			ource and suspicious and wil		
				report to the	e HCPR immediately "but no	at l	

Facility ID: 955752

		MEDICAID SERVICES					<u> </u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·				E SURVEY PLETED
		34A001	B. WING			05	/03/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
				93	2 OLD US HIGHWAY 70		
BLACK M		CAL TREATMENT CENTER		Bl	LACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 609	Continued From page	e 7	F 60	ng			
		ducted with the 1st shift	1.00		later than 2 hours after allegation is m	ahe	
		2/18 at 2:55PM. During this			if events that caused the allegation in		
		that she "vaguely" recalled			abuse or result in serious bodily injury		
		esident #30 but could not			not later than 24 hours if the events th		
		fics about the bruise and did			caused the allegation do not involve		
	· · ·	uise occurred. She further			abuse and do not result in serious boo	dily	
	stated that she did no	ot see or investigate the			injury". A formal and comprehensive	-	
	bruise to Resident #3	30.			investigation will be initiated.		
					- All nursing staff will receive inservice	on	
	An interview was con	nducted with QA Director and			learning how to better recognize and		
		DON) on 5/2/18 at 3:30PM.			identify injuries of unknown source an		
		se of unknown origin to left			a suspicious nature, and reporting to t		
	•	) was unknown as to how it			supervisor and advocacy as detailed i	n	
		it was not reported to State			BMNTC Policy ADM133B "Protecting		
		t was not investigated. The			Residents from Rights Infringements"		
		tated she understood how it			documenting the event and reporting		
	-	the State Survey Agency, but			the Nursing Progress Notes. Training		
		ot think it was a suspicious			began 5/7/18 completed 5/23/18.	_	
	bruise.				<ul> <li>Monthly Nurses meetings will Include review of scenarios of injuries of unkn</li> </ul>		
	A tolophono intorviou	v was conducted on 5/2/18 at			source. 1) Nurses will discuss if the	OWIT	
	-	6, who authored the nurses			bruise, injury, wound is of a suspicious	-	
		it the bruise to the left inner			nature. 2) Identify policy requirements		
		). During this interview she			documentation. 3) Make judgments	.01	
	•	ed the note about the			around notification of the physician,		
		d area on Resident #30's			resident representative, nursing		
	U U U	ner stated she did not know			supervisor, SAO and Advocacy, per p	olicy	
	-	red and that she reported it			requirements and nursing judgement.		
		e at the end of her shift.			The goal of this training is to increase		
	She also stated that a	a finger shaped bruise to a			awareness, prevent complacency, and	d	
		"would be looked into as it is			maintain consistency in reporting.		
		cerned of" and that no			- Office Assistant III in Administration		
	management staff fol				document dates Initial Allegation Repo	ort	
	investigating the brui	se.			(24 hr Report) is sent and monitor		
					tracking form to ensure that the		
	-	vith the Assistant Director of			Investigation Report (5-Workding Day		
	Nursing on 5/2/18 at				Report) report is sent within correct tir	ne	
	anything finger shap	ed is a red flag to us and			frame.		

Facility ID: 955752

If continuation sheet Page 8 of 23

	S FOR MEDICARE &				OMB NO. 0938-03
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34A001	B. WING		05/03/2018
AME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	
BLACK M	OUNTAIN NEURO-MEDIO	CAL TREATMENT CENTER		932 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 28711	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC
F 609	Continued From page	8	F 609	9	
	Party of Resident #30 Responsible Party sta	ducted with the Responsible ) on 5/2/18 a 5:35PM. The ated she was told of the d the bruise was on the or how it the bruise		On 5/24/18 BMNTC Occupationa Therapist completed an evaluation resident #30 during toileting for a possible new techniques staff ca in decreasing residents discomfor resistance during care. The following Quality Assurance	on iny n utilize ort and
	5/3/18 at 9:00AM. Du stated that her job res the rights of the residu further stated employ the Advocates of any injuries of unknown o inner thigh of unknow should have been rep should have investiga	ducted with Advocate #1 on uring this interview she sponsibilities was to ensure ents were not violated. She ees are instructed to notify rights violations to include rigin and that a bruise in the or origin to Resident #30 ported to them and they ated it. She stated she was se and that it had not been		<ul> <li>will be added to the BMNTC Qua Assurance Performance Improve Plan:</li> <li>"Every injury of unknown source meets definition of suspicion will reported 100% of the time, per B policy ADM 133B "Protecting Re From Rights Infringements", to th Nursing Supervisor, Advocate, a per regulatory timeframes.</li> </ul>	ality ement that be MNTC sident's ne
	An interview was con 5/3/18 at 11:02AM. Si "somewhat" remember #30's left inner thigh the during shift change. Si did not report the bruit	estigate. ducted with Nurse #7 on he stated that she ered the bruise to Resident being mentioned to her She further stated that she ise to any management and e of any investigation into		This objective will be monitored or review of RL6 incidents for timely reporting and reviewed in month Assurance meetings through 5/3 any time monitoring identifies a p corrective action will be taken immediately. The BMNTC Director and Director Nursing are responsible for imple	y Quality 1/19. At problem,
F 610	on 5/3/18 at 3:10PM, investigation and no 2 were submitted to the the bruise of unknown Resident #30.	erview with the QA Director she stated there was no 24 hour and 5-day reports 25 State Survey Agency for 26 origin to the inner thigh of 26 Correct Alleged Violation	F 610	the POC.	5/31/18

Facility ID: 955752

If continuation sheet Page 9 of 23

		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 06/04/20 FORM APPROVE MB NO. 0938-039
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(>	(3) DATE SURVEY COMPLETED
		34A001	B. WING				05/03/2018
NAME OF P	ROVIDER OR SUPPLIER	l		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BLACK M	OUNTAIN NEURO-MEDI	CAL TREATMENT CENTER		32 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 28711			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 610	Continued From page	9 9	F	610			
		se to allegations of abuse, or mistreatment, the facility					
	§483.12(c)(2) Have e violations are thoroug	vidence that all alleged hly investigated.					
		t further potential abuse, or mistreatment while the gress.					
	designated represent accordance with Stat Survey Agency, within incident, and if the all appropriate corrective	the results of all administrator or his or her ative and to other officials in e law, including to the State n 5 working days of the eged violation is verified e action must be taken.					
	Based on record revinterviews the facility bruised area to the in residents (Resident # unknown origin.	iew and family and staff failed to investigate a ner left thigh for 1 of 1 30) sampled for a bruise of			On Sunday, 4/22/2018, when bru noted by CNA on resident □s left thigh, CNA reported to the 3rd sh who assessed the area, found no skin integrity, and documented br Nursing Progress Notes and wrot	inner ift Nurse break i ruise in te	e n
	The Findings Include Resident #30 was ad 11/18/2015 with diag	mitted to the facility on			description of bruise on Ourses Report FormO. ResidentOs representative notified of bruise p notification preference. The Nurs	ber	
	Cerebrovascular Acci	ident, Alzheimer's and secondary to head trauma.			report the bruise to Advocacy or t supervisor.		
	dated 4/18/18 revealed severely impaired cog revealed she had phy	Minimum Data Set (MDS) ed that Resident #30 had gnition. Further review vsical and verbal behaviors lays and wandering and			On Monday morning 4/23/18, dur "Daily Safety Events Report & Ris Management Meeting", (includes Medical Director, DON, ADON, U Managers, Risk Manager, Social	sk Directo Init	r,

Facility ID: 955752

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				D. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		34A001	B. WING		05/	/03/2018
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, Z	ZIP CODE	
BLACK M	OUNTAIN NEURO-MEDI	CAL TREATMENT CENTER		932 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 287 <sup>,</sup>	11	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETIC DATE
F 610	Continued From page	e 10	F 61	10		
	days. The assessme resident required exter mobility, dressing, toi transfers, and superv assessed as always b and bladder and as h injury since her last a assessment was also receiving any anticoa A review of Resident 4/25/18 revealed a co interventions listed we report any bruising. Review of a nursing r part: bruise to Reside color, finger shaped of Review of the facility Rounds Report for Re	ensive assistance with bed leting, hygiene and ision for walking. She was being incontinent of bowel aving 2 or more falls with no ssessment. The o coded as Resident #30 not gulant medications. #30's care plan, dated oncern with bruising and ere to monitor, observe and note dated 4/22/2018 read in ent's left inner thigh, purple in		<ul> <li>Workers, Senior Psychol Professional Services, G</li> <li>Coordinators and MDS</li> <li>Gravely 3 Nurse Unit M</li> <li>resident s Unit reporter</li> <li>a bruise on inner thigh G</li> <li>etiology. Report also in</li> <li>reason: that resident ca</li> <li>during care, she is intru</li> <li>may have scratched he</li> <li>was not reported to HCI</li> <li>On the morning of 5/2/1</li> <li>"Daily Safety Events Ref</li> <li>Management Meeting",</li> <li>that the location of the k</li> <li>been a flag for suspicion</li> <li>unknown source. Due f</li> <li>bruise occurred, a formative source of injuries of that will prompt an investing</li> </ul>	QA Director, MDS Assistants), the anager from this d that resident had of unknown ncluded possible n be aggressive sive with others, or rself. The event PR or to Advocacy. 8, during the eport & Risk Team discussed oruise should have n along with to time since al investigation time. DON put a lace that identified nd training: f unknown source stigation include	
	investigations failed to into the left inner thigh An interview was con Quality Assurance (Q During this interview, the facility Advocate w of unknown origin. T that management ma investigation, but stat that would do the inve	abuse allegations and o reveal any investigation h bruise of Resident #30. ducted with the Director of (A) on 5/2/18 at 2:29PM. the QA director stated that would investigate any injury he QA Director further stated y also do their own ed it was the advocacy staff estigation. The QA Director erview that she was not		<ul> <li>and/or injuries in areas vulnerable to trauma.</li> <li>Nurse Unit Managers (Resident Incident Resp previous day(s) to Daily Risk Management Meeting - "Daily Safety Events F Management Meeting T daily RL6 data/reports a any injuries of unknown suspicious due to their I reported to the Nursing Advocacy as detailed in</li> </ul>	will bring RL6 ponse) forms from Safety Report & ting. Report & Risk Team" will review and determine if source, location, were Supervisor and	

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		MEDICAID SERVICES					D. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		34A001	B. WING			05/	/03/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BLACK M		CAL TREATMENT CENTER	932 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 28711				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETIC DATE
F 610	Continued From page	e 11	F 6 <sup>2</sup>	10			
		nner thigh bruise to Resident			Rights Infringements". Director/design will make final determination if injury is unknown source and suspicious and v	s of	
	An interview was con nurse manager on 5/2 interview she stated t the bruised area to R			report to the HCPR immediately "but r later than 2 hours after allegation is m if events that caused the allegation inv abuse or result in serious bodily injury	ade, volve		
	remember any specif not know how the bru stated that she did no			not later than 24 hours if the events th caused the allegation do not involve abuse and do not result in serious boo	at		
		ducted with QA Director and DON) on 5/2/18 at 3:30PM.			<ul><li>injury". A formal and comprehensive investigation will be initiated.</li><li>All nursing staff will receive inservice learning how to better recognize and</li></ul>	on	
	The DON stated bruis thigh of Resident #30	se of unknown origin to left was unknown as to how it			identify injuries of unknown source and a suspicious nature, and reporting to t	heir	
	occurred and stated i and investigated. The she understood how			supervisor and advocacy as detailed in BMNTC Policy ADM133B "Protecting Residents from Rights Infringements"	and		
	stated that she did no bruise.	t think it was a suspicious			documenting the event and reporting i the Nursing Progress Notes. Training began 5/7/18 completed 5/23/18.		
	3:35PM with Nurse #	was conducted on 5/2/18 at 6, who authored the nurses t the bruise to the left inner			- Monthly Nurses meetings will Include review of scenarios of injuries of unknown source. 1) Nurses will discuss if the		
	stated that she recalle bruised finger shaped	area on Resident #30's			bruise, injury, wound is of a suspicious nature. 2) Identify policy requirements documentation. 3) Make judgments		
	how the bruise occurr to the oncoming nurs	ner stated she did not know red and that she reported it e at the end of her shift.			around notification of the physician, resident representative, nursing supervisor, SAO and Advocacy, per p	olicy	
	resident's inner thigh something to be conc	a finger shaped bruise to a "would be looked into as it is erned of" and that no			requirements and nursing judgement. The goal of this training is to increase awareness, prevent complacency, and	1	
	management staff fol investigating the bruis	se.			maintain consistency in reporting. - Office Assistant III in Administration v document dates Initial Allegation Repo		
	During an interview w Nursing on 5/2/18 at	/ith the Assistant Director of 4:32PM she stated,			(24 hr Report) is sent and monitor tracking form to ensure that the		

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	S FOR MEDICARE &				OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34A001	B. WING		05/03/2018
IAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	
BLACK M	OUNTAIN NEURO-MEDI	CAL TREATMENT CENTER		932 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 28711	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC
F 610	Continued From page	e 12	F 610		
		ed is a red flag to us and		Investigation Report (5-Workding Da Report) report is sent within correct t frame.	
	Party of Resident #30 Responsible Party sta	ducted with the Responsible ) on 5/2/18 a 5:35PM. The ated she was told of the d the bruise was on the or how it the bruise		On 5/24/18 BMNTC Occupational Therapist completed an evaluation resident #30 during toileting for any possible new techniques staff can ut in decreasing residents discomfort an resistance during care.	
	5/3/18 at 9:00AM. Du stated that her job res the rights of the resid further stated employ the Advocates of any injuries of unknown o inner thigh of unknow should have been rep should have investiga	ducted with Advocate #1 on uring this interview she sponsibilities was to ensure ents were not violated. She ees are instructed to notify rights violations to include rigin and that a bruise in the or origin to Resident #30 ported to them and they ated it. She stated she was se and that it had not been estigate.		The following Quality Assurance Obj will be added to the BMNTC Quality Assurance Performance Improvement Plan: "Every injury of unknown source that meets definition of suspicion will be reported 100% of the time, per BMN policy ADM 133B "Protecting Reside From Rights Infringements", to the Nursing Supervisor, Advocate, and H per regulatory timeframes.	nt TC nt's
	5/3/18 at 11:02AM. S "somewhat" remember #30's left inner thigh I during shift change. S did not report the brui	ered the bruise to Resident being mentioned to her She further stated that she ise to any management and e of any investigation into		This objective will be monitored daily review of RL6 incidents for timely reporting and reviewed in monthly Q Assurance meetings through 5/31/19 any time monitoring identifies a prob corrective action will be taken immediately.	uality 9. At lem,
	on 5/3/18 at 3:10PM, no complete and thor	erview with the QA Director she stated that there was ough investigation for the igin to the inner thigh of		The BMNTC Director and Director of Nursing are responsible for implement the POC.	

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		NO. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3	. ,	MPLETED
		34A001	B. WING		a	5/03/2018
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, Z	IP CODE	
BLACK M	OUNTAIN NEURO-MEDI	CAL TREATMENT CENTER		932 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 2871	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICII	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 641	Continued From page	e 13	F 64	1		
SS=D	CFR(s): 483.20(g)					
	resident's status.	of Assessments. st accurately reflect the Γ is not met as evidenced				
	Based on record reviews and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) for 2 of 2 residents (Resident #140 and #73) reviewed for accuracy of assessments.			Two residents on Grave Plavix at the time of thei and use of anticoagulan coded at NO410E. Plav anti-platelet medication.	ir assessments t was incorrectly vix is an	
	4/24/12 with diagnos limited to cerebrovas and history of stroke.			On 5/1/18 when questio about coding anticoagul antiplatelets, the G3 MD an immediate review of Section N. Under section states to record the num anticoagulant medication	ants vs. OS Coordinator did the MDS Manual on NO410E it ober of days an n was received by	
	recent MDS dated 4/ assessment. The ass	eted of Resident #140's most 4/18 coded as an annual sessment coded the resident n anticoagulant for 7 out of 7 ent period.		the resident at any time look back period. It also code antiplatelet medica aspirin/extended release clopidogrel here".	o stated "Do not ations such as	
	previous MDS dated quarterly. The asset	ssment coded the resident n anticoagulant for 7 out of 7		Significant Correction to comprehensive assessen #140 was completed on coded for NO410E □ant submitted to CMS. Sign to prior quarterly assess	nent for Resident 5/8/18 with 0 ticoagulant⊡ and nificant Correction	
	2018 and April 2018 medication administr	#140's January 2018, March physician orders and ation records revealed ot receive any anticoagulant		completed on 5/8/18 for 0 coded for NO410A ⊡a submitted to CMS.	Resident #73 with	
		e assessment period of the		Pharmacy provided med all residents on anticoag antiplatelets and specific	gulants and	

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		MEDICAID SERVICES			OMB NO. 0938-039
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		34A001	B. WING		05/03/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE
BLACK M	OUNTAIN NEURO-MEDI	CAL TREATMENT CENTER		932 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 28711	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE COMPLETIC HE APPROPRIATE DATE
F 641	Continued From page	e 14	F 64	1	
	An interview was con with the Director of Q currently responsible assessments. During that she coded the M both assessments in modify the assessme 2. Resident #73 was 12/03/14 with diagnos	ducted on 5/2/18 at 5:23 pm uality Assurance, who is for completing the MDS g this interview she stated DS for anticoagulant use on error and stated she would ints.		<ul> <li>other than Residents #140 a other resident is on anticoag MDS was reviewed and fou correct (Coumadin/anticoag</li> <li>Review of MDS Manual Sec completed with all 3 MDS C MDS coding of NO410E wa all other listed residents by BMNTC MDS Coordinators be coded correctly. Training Coordinators on additional a other than common types (I Coumadin), being used at E Xarelto, Eliquis and Loveno 5/8/2018.</li> </ul>	gulant and the ind to be gulant) 5/8/18. ction N coordinators. is reviewed on 2 other and found to g with MDS anticoagulants Heparin, BMNTC include
	A review was comple recent MDS dated 3/ assessment. The ass as having received an days of the assessme A review of Resident March 2018 physician administration record not receive any antico the assessment period An interview was con am with the Director of currently responsible assessments. During that she coded the M	ted of Resident #73's most 1/18 coded as a quarterly sessment coded the resident in anticoagulant for 7 out of 7 ent period. #73's February 2018 and in orders and medication s revealed Resident #73 did bagulant medication during od of the MDS. ducted on 5/3/18 at 10:15 of Quality Assurance, who is for completing the MDS g this interview she stated DS for anticoagulant use on ror and stated she would		The following objective has the BMNTC Quality Assurant Performance Improvement "Correct coding of Section N "anti-coagulants" for resident anti-coagulants or anti-plate Resident Assessment Instru- 100% of the time". This objective will be monited through 5/31/19 by the MDS Each MDS Coordinator will Assessments (other than th coding of section N anticoagu assure correct coding of residentiations. At any time m identifies a problem, correct be taken immediately.	nce Plan: N Ints receiving elets on MDS ument will be ored quarterly S Coordinators. monitor MDS eir own) for gulants to sidents use of nonitoring

Facility ID: 955752

				E CONSTRUCTION	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		34A001	B. WING		05/03/2018
NAME OF PR	ROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE	
BLACK M	OUNTAIN NEURO-MEDI	CAL TREATMENT CENTER		932 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 28711	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO
F 761	Continued From page	e 15	F 761		
F 761 SS=D	Label/Store Drugs an CFR(s): 483.45(g)(h)		F 761		5/31/18
	Drugs and biologicals	y and cautionary			
	§483.45(h) Storage c	f Drugs and Biologicals			
	Federal laws, the fact biologicals in locked	ordance with State and ility must store all drugs and compartments under proper , and permit only authorized cess to the keys.			
	locked, permanently storage of controlled the Comprehensive I Control Act of 1976 a abuse, except when the package drug distribut quantity stored is min be readily detected. This REQUIREMENT by: Based on observation facility failed to dispose	cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the himal and a missing dose can T is not met as evidenced on and staff interviews, the se/discard out of date medication rooms and in 1		On 5/2/18 when expired medicatior drops and Epipens) were identified survey in medication cart and medic	during
		reviewed for medication		room on identified Unit, these out of medications were immediately return Pharmacy (and replaced) per BMN MED Procedure 015 Disposal of Dr	f date med to TC

Event ID: 636R11

Facility ID: 955752

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ΔΤΕΜΕΝΤ Ο							
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	1 Y /	E SURVEY IPLETED
		34A001	B. WING			0	5/03/2018
IAME OF PR	OVIDER OR SUPPLIER	·		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER				93	32 OLD US HIGHWAY 70		
		CAL TREATMENT CENTER		В	LACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 761	Continued From page	<u>a</u> 16	F 76	61			
		sposal of drugs revised on		01	carts and medication rooms on all Uni	te.	
		ad in part: 4. All medications			for any expired medications and none		
	-	heir expiration date should			were found.		
		armacy for disposal. 8.					
	Nursing staff will chec			On 5/4/18 members of Nursing and			
	storage areas for me			Executive Team (Director, DON, ADO	N.		
	any expired medication			Medical Director, QA Director) met to	,		
	Nursing unit inspectio			discuss what had happened to cause			
	monthly by pharmacy	staff. Stock supplies and			error. Outcome of discussion identifie	d	
	night drug cabinet co	ntents will also be checked			human error as cause of cited deficier	су	
	for expiration date.				without any individual staff being ident as responsible. Noted that Epipens we		
		G1 medication room was			stored in locked compartment in	_	
		at 8:45 AM. There were two			medication room. BMNTC procedure		
	epinephrine 0.3mg in	-			monitoring for expired meds, by Nursi	-	
		eaction) were found. One			weekly and Pharmacy monthly, had no		
		injection doses in a box)			lead to recognition of expired medicati	ons.	
		e of January 2018 and			Director of Phormaoy and DON review	od	
	box) with an expiratio	box (two injection doses in a			Director of Pharmacy and DON review and revised BMNTC Medical Procedu		
	box) with an expiratio	in date of April 2018.			(MED 027 Eye Drops/Ointment, Instilla		
	An interview with Nur	se #5 revealed that nursing			and Storage Of, MED025AA Epinephr		
		ing the medication room			Auto-Injector (Epipen) Administration		
	stock weekly and rem	•			Storage, MED 015 Drug Maintenance		
	medications. Nurse #				Disposal) related to disposing of drugs		
		should have been removed			and administration of eye drops to ens		
	and returned to pharr				- procedures clearly detail dating of		
					medications (by Pharmacy when		
		s conducted on 5/3/18 at			dispensing and/or when Nurse breaks		
		medication cart. A bottle of			seal on any new mediation bottle or		
	Xalatan eye drops (us				container) and,		
		ound in use and in the			- procedure for monitoring for expired		
		eye drop bottle dated to be			medications by Nursing (weekly) and		
	discarded on 4/15/18				Pharmacy (monthly) and,	_	
	An intonvious with New	and #E roundlad the ave drag			- procedure for disposal of medication		
		se #5 revealed the eye drop			found to be expired (return to Pharmac		
		nurse and she was not of date. Nurse #5 also			- DON and Director of Pharmacy revis		
		e drop should have been			practice to include that Epipens would stored in un-locked area of medication		

Facility ID: 955752

TATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED	
	CONTECTION	BERTH TOXITON NOMBER.	A. BUILDING				
		34A001	B. WING			5/03/2018	
NAME OF PROVIDER OR SUPPLIER BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER				STREET ADDRESS, CITY, STATE, ZIP COD	E		
				932 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 28711			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 761	revealed her expecta was for the nurses to and medication room also check the medic	DON on 5/3/18 at 11:13 AM ation for medication storage o check the medication cart o weekly. The pharmacy staff cation storage monthly. She urses should follow the facility	F 76	<ul> <li>cart.</li> <li>DON and Director of Pharma provide guides displayed on ri- carts and in medication rooms reminder of procedures for ch- monitoring for expired medica Completed 5/24/18.</li> <li>DON providing training with a that includes deficiency listing procedures for checking medi- expiration date weekly (and d and prior to administration to Complete 5/30/18.</li> <li>Starting on 5/25/18 all Unit me- carts and medication rooms w monitored for expired medica DON/designee twice a month and monthly thereafter, with ri- checks, to ensure that any ex- mediations have been proper- of.</li> <li>Monitoring objective will beco QAPI Plan by 5/25/18 and rev- monthly in QA meeting</li> <li>DON and Director of Pharmaco- responsible for plan of correct</li> </ul>	nedication s as a quick ecking and tions. Il Nurses (, review of cations for ocumenting) resident. edication vill be tions by x 3 months andom spot pired y disposed me a part of viewed		
F 880 SS=D	Infection Prevention CFR(s): 483.80(a)(1)		F 88	implementation. 30		5/31/18	
	§483.80 Infection Co The facility must esta infection prevention a designed to provide a	ablish and maintain an and control program					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORI	D: 06/04/2018 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34A001	B. WING		05	/03/2018
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP COL	DE	
BLACK M	OUNTAIN NEURO-MEDIC	CAL TREATMENT CENTER		2 OLD US HIGHWAY 70 .ACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 880	comfortable environm development and tran diseases and infection §483.80(a) Infection p program. The facility must estal and control program ( a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable di staff, volunteers, visite providing services und arrangement based u	tent and to help prevent the asmission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at ving elements: em for preventing, identifying, g, and controlling infections seases for all residents, pors, and other individuals	F 880			
	procedures for the pro- but are not limited to: (i) A system of surveil possible communicabi infections before they persons in the facility; (ii) When and to whor communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including but (A) The type and dura depending upon the in involved, and (B) A requirement tha	standards, policies, and ogram, which must include, lance designed to identify ble diseases or can spread to other can spread to other can spread to other spread to other can spread of infections can spread of infections can spread to can be used for a t not limited to:				

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIE	PLE CONSTRUCTION		10. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	· ,	3	· · /	COMPLETED	
		34A001	B. WING		0	05/03/2018	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD			0/00/2010	
			932 OLD US HIGHWAY 70				
BLACK M		CAL TREATMENT CENTER		BLACK MOUNTAIN, NC 28711			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 880	circumstances. (v) The circumstance must prohibit employ	s under which the facility ees with a communicable	F 88	30			
	contact with residents contact will transmit t	procedures to be followed					
	§483.80(a)(4) A syste identified under the fa corrective actions tak						
		le, store, process, and to prevent the spread of					
	IPCP and update the	<i>r</i> iew. ct an annual review of its ir program, as necessary. is not met as evidenced					
	facility failed to ensur	n and staff interviews the e blood glucose meters roperly disinfected/sanitized 3 observations of a		Each resident who lives at BI receives routine blood glucose has an individual glucometer of that specific resident.	e monitoring used only for		
	Findings included:			In discussion 5/4/18 about det related to ensuring that glucor properly disinfected/sanitized	neters were after use,		
	Nursing (DON) for cle with a revised date of part: 1. Following eac	vided by the Director of eaning multiuse test device February 28, 2018 read in th use of glucometer will be		errors noted during Surveyor occurred due to glucometers i cleaned consistently per BMN Procedure 006A "Cleaning, M	not being TC MED ultiuse Test		
	remove any large cor germicidal disposable	cidal disposable cloth to ntaminates. 2. A second e cloth will be used to clean The device will be placed on		Device" which listed procedur cleaning per glucometer manu guidelines.			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			SURVEY PLETED
		34A001	B. WING	05	05/03/2018	
NAME OF PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	03/2010	
			932 OLD US HIGHWAY 70			
BLACK M	OUNTAIN NEURO-MEDI	CAL TREATMENT CENTER		BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 880	Continued From pag	e 20	F 880			
		allowed to air dry then placed	1 000	-	aning	
	back in case.			BMNTC MED Procedure 006A Cle Multiuse Test Device was revised 5	•	
				and now includes cleaning glucom		
	A review of manufact	turer's instruction label for		Germicidal Disposable Cloth and n	•	
	germicidal wipes rea	d in part: Unfold a clean wipe		states:		
		urface. Allow treated surface		- Following each use of glucometer		
		ull two (2) minutes. Let it air		machine, the exterior will be cleane	ed with	
	dry.			a Germicidal Disposable Cloth.		
	1 A An observation	was conducted on 5/1/18 at		- A second Germicidal Disposable to be used by unfolding wipe and	Cloth is	
		when obtaining a Finger		wrapping machine inside to allow s	urface	
		SBS) for Resident #135. The		of machine to remain wet a full 2 m		
		sident's room and followed		- Remove machine and place on cl		
	the proper procedure	e for handwashing and		paper towel to allow to air dry.		
	gloving before taking	the FSBS. The nurse				
		cation cart and placed the		Revised BMNTC MED Procedure (		
		cometer carrying case. The		"Cleaning, Multiuse Test Device" is		
		place the glucometer in the		displayed at every Nursing station.	•	
	medication cart witho	out disinfecting/sanitizing.		Nurse is to review revised procedu		
	The nurse was interv	viewed right after and she		sign to signify understanding of rev Completed 5/17/18.	151011.	
		isinfect the glucometer		Completed 3/17/18.		
		er shift that evening like		Starting 5/4/18 Competency Review	w and	
		e #1 further stated that she		observation for use of and cleaning		
	doesn't disinfect the	glucometer after use except		glucometer machine will be comple		
	she'll clean the befor	e her shift ends.		upon new Nurse hire and annually thereafter.		
		erved obtaining FSBS on				
		or Resident #136. The nurse		Monitoring for compliance in follow	•	
		s room and followed proper		procedure for cleaning the glucome	eter	
		ashing and gloving before #2 returned to the medication		machine after use will include: DON/designee will observe cleaning	a of	
	-	ucometer with a germicidal		glucometer after use by 3 nurses a		
		d the wipe into the trash bin,		x 4 weeks and then 2 nurses month		
		meter on top of the table in		thereafter for correct cleaning/sanit	•	
		. Continuous observation of		per procedure starting on 5/25/18.	J	
		aled the surface appeared				
	dry in less than a mir	nute. Nurse #2 did not ensure		Monitoring objective will become a		
	the glucometer rema	ined wet with germicidal		QAPI Plan by 5/25/18 and reviewe	d	

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						0.0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	SURVEY
		34A001	B. WING		05/	/03/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
BLACK M	OUNTAIN NEURO-MEDI	CAL TREATMENT CENTER		932 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 880	Continued From page	e 21	F 880	D		
	solution for a full 2 m	inutes.		monthly in QA meeting		
	facility's procedure to use with germicidal w was not aware of the wipe to leave it wet for also acknowledged th left wet for 2 minutes C. An observation wa 11:27 AM with Nurse Resident #126's roon FSBS. He followed th handwashing and glo Nurse #2 returned to the glucometer with a tossed the wipe into the glucometer on top of Continuous observation revealed the surface minute. Nurse #2 did	as conducted on 5/2/18 at #3. The nurse entered n and proceeded to do ne proper procedure for oving before taking FSBS. the medication cart, wiped a germicidal wipe. He then the trash bin, and placed the the medication cart.		DON will be responsible for implementation of POC.		
	the facility instruction disinfected after each indicated he was not					
	revealed her expecta glucometer was for th facility procedure and instruction of the gerr indicated that they ne	DON on 5/3/18 at 10:41 AM tion regarding cleaning ne nursing staff to follow the I the manufacturer's micidal wipe. The DON also eeded to review and that they ity policy regarding cleaning				

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34A001	B. WING		05/03/2018
	ROVIDER OR SUPPLIER OUNTAIN NEURO-MEDIC	CAL TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 932 OLD US HIGHWAY 70 BLACK MOUNTAIN, NC 28711	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 880	Continued From page of glucometer.	≥ 22	F 88		

Event ID: 636R11

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