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 _____	05/03/2018

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 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on policy and record review and family and staff interviews the facility failed to implement their abuse policies and procedures in the areas of reporting and investigating for 1 of 1 sampled residents (Resident #30) who had a bruise of unknown origin to the inner left thigh. The Findings Included: A review of the facility policy titled" Protecting Residents From Rights Infringement" dated 3/17/2017, read in part: All residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Identification: If the source of the injury was not observed and could not be explained by the residents and the injury is suspicious because of the locations of the injury, the nurse will immediately contact and report the injury to the facility Advocate and a member of management	F 607	On Sunday, 4/22/2018, when bruise was noted by CNA on resident□s left inner thigh, CNA reported to the 3rd shift Nurse who assessed the area, found no break in skin integrity, and documented bruise in Nursing Progress Notes and wrote description of bruise on □Nurses Rounds Report Form□. Resident□s representative notified of bruise per notification preference. The Nurse did not report the bruise to Advocacy or to her supervisor. On Monday morning 4/23/18, during the "Daily Safety Events Report & Risk Management Meeting", (includes Director, Medical Director, DON, ADON, Unit Managers, Risk Manager, Social Workers, Senior Psychologist, Director of Professional Services, QA Director, MDS Coordinators and MDS Assistants), the Gravely 3 Nurse Unit Manager from this resident□s Unit reported that resident had	5/31/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/25/2018

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F 607	Continued From page 1 staff. Notification: Designated staff will report to the State Survey Agency injury of unknown source. Investigation: The investigation team will ensure information is gathered from all involved staff through investigative interviews and results of this investigation will be reported the State Survey Agency. Resident #30 was admitted to the facility on 11/18/2015 with diagnosis that included Cerebrovascular Accident, Alzheimer's and Frontal Lobe Atrophy secondary to head trauma. Review of the annual Minimum Data Set (MDS) dated 4/18/18 revealed that Resident #30 had severely impaired cognition. Further review revealed she had physical and verbal behaviors that occurred 1 to 3 days and wandering and rejection of care behaviors that occurred 1 to 3 days. The assessment also revealed the resident required extensive assistance with bed mobility, dressing, toileting, hygiene and transfers, and supervision for walking. She was assessed as always being incontinent of bowel and bladder and as having 2 or more falls with no injury since her last assessment. The assessment was also coded as Resident #30 not receiving any anticoagulant medications. A review of Resident #30's care plan, dated 4/25/18 revealed a concern with bruising and interventions listed were to monitor, observe and report any bruising. Review of a nursing note dated 4/22/2018 read in part: bruise to Resident's left inner thigh, purple in	F 607	a bruise on inner thigh of unknown etiology. Report also included possible reason: that resident can be aggressive during care, she is intrusive with others, or may have scratched herself. The event was not reported to HCPR or to Advocacy. On the morning of 5/2/18, during the "Daily Safety Events Report & Risk Management Meeting", Team discussed that the location of the bruise should have been a flag for suspicion along with unknown source. Due to time since bruise occurred, a formal investigation was not initiated at this time. DON put a "plan of correction" in place that identified the following practice and training: - Locations of injuries of unknown source that will prompt an investigation include injuries on resident□s face, back, groin and/or injuries in areas not generally vulnerable to trauma. - Nurse Unit Managers will bring RL6 (Resident Incident Response) forms from previous day(s) to Daily Safety Report & Risk Management Meeting. - "Daily Safety Events Report & Risk Management Meeting Team" will review daily RL6 data/reports and determine if any injuries of unknown source, suspicious due to their location, were reported to the Nursing Supervisor and Advocacy as detailed in BMNTC Policy ADM133B "Protecting Residents from Rights Infringements". Director/designee will make final determination if injury is of unknown source and suspicious and will report to the HCPR immediately "but not later than 2 hours after allegation is made,	

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F 607	Continued From page 2 color, finger shaped of unknown etiology. Review of the facility document titled Nurses Rounds Report for Resident #30 dated 4/22/2018 read in part: finger length purple bruise to left upper thigh. Review of the facility abuse allegations and investigations failed to reveal any investigation into the left inner thigh bruise of Resident #30. An interview was conducted with the Director of Quality Assurance (QA) on 5/2/18 at 2:29PM. During this interview, the QA director stated that the facility Advocate would investigate any injury of unknown origin. The QA Director further stated that management may also do their own investigation, but stated it was the advocacy staff that would do the investigation. The QA Director stated during this interview that she was not aware of the bruise and the facility had not investigated the left inner thigh bruise to Resident #30 nor had the facility completed the 24 hour and 5 days reporting to the State Survey Agency. An interview was conducted with the 1st shift nurse manager on 5/2/18 at 2:55PM. During this interview she stated that she "vaguely" recalled the bruised area to Resident #30 but could not remember any specifics about the bruise and did not know how the bruise occurred. She further stated that she did not see or investigate the bruise to Resident #30. An interview was conducted with QA Director and Director of Nursing (DON) on 5/2/18 at 3:30PM. The DON stated bruise of unknown origin to left thigh of Resident #30 was unknown as to how it occurred and stated it was not reported to State	F 607	if events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury". A formal and comprehensive investigation will be initiated. - All nursing staff will receive inservice on learning how to better recognize and identify injuries of unknown source and of a suspicious nature, and reporting to their supervisor and advocacy as detailed in BMNTC Policy ADM133B "Protecting Residents from Rights Infringements" and documenting the event and reporting in the Nursing Progress Notes. Training began 5/7/18 completed 5/23/18. - Monthly Nurses meetings will Include review of scenarios of injuries of unknown source. 1) Nurses will discuss if the bruise, injury, wound is of a suspicious nature. 2) Identify policy requirements for documentation. 3) Make judgments around notification of the physician, resident representative, nursing supervisor, SAO and Advocacy, per policy requirements and nursing judgement. The goal of this training is to increase awareness, prevent complacency, and maintain consistency in reporting. - Office Assistant III in Administration will document dates Initial Allegation Report (24 hr Report) is sent and monitor tracking form to ensure that the Investigation Report (5-Workding Day Report) report is sent within correct time frame. On 5/24/18 BMNTC Occupational	

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F 607	Continued From page 3 Survey Agency and it was not investigated. The QA Director further stated she understood how it could be reported to the State Survey Agency, but stated that she did not think it was a suspicious bruise. 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." An interview was conducted with the Responsible Party of Resident #30 on 5/2/18 a 5:35PM. The Responsible Party stated she was told of the bruise but was not told the bruise was on the resident's inner thigh or how it the bruise occurred. An interview was conducted with Advocate #1 on 5/3/18 at 9:00AM. During this interview she stated that her job responsibilities was to ensure the rights of the residents were not violated. She further stated employees are instructed to notify the Advocates of any rights violations to include	F 607	Therapist completed an evaluation resident #30 during toileting for any possible new techniques staff can utilize in decreasing residents discomfort and resistance during care. The following Quality Assurance Objective 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 BMNTC policy ADM 133B "Protecting Resident's From Rights Infringements", to the Nursing Supervisor, Advocate, and HCPR per regulatory timeframes. This objective will be monitored daily with review of RL6 incidents for timely reporting and reviewed in monthly Quality Assurance meetings through 5/31/19. At any time monitoring identifies a problem, corrective action will be taken immediately. The BMNTC Director and Director of Nursing are responsible for implementing the POC.	

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F 607	Continued From page 4 injuries of unknown origin and that a bruise in the inner thigh of unknown origin to Resident #30 should have been reported to them and they should have investigated it. She stated she was not aware of the bruise and that it had not been reported to her to investigate. An interview was conducted with Nurse #7 on 5/3/18 at 11:02AM. She stated that she "somewhat" remembered the bruise to Resident #30's left inner thigh being mentioned to her during shift change. She further stated that she did not report the bruise to any management and that she was unaware of any investigation into how the bruise occurred. During a follow-up interview with the QA Director on 5/3/18 at 3:10PM, she stated that there was no investigation and no 24 hour and 5-day reports were submitted to the State Survey Agency for the bruise of unknown origin to the inner thigh of Resident #30.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		5/31/18

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F 609	Continued From page 5 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and family and staff interviews the facility failed to submit a 24 hour and 5-day report to the State Survey Agency and failed to investigate a bruise of unknown origin for 1 of 1 sampled residents. (Resident #30) The Findings Included: Resident #30 was admitted to the facility on 11/18/2015 with diagnosis that included Cerebrovascular Accident, Alzheimer's and Frontal Lobe Atrophy secondary to head trauma. Review of the annual Minimum Data Set (MDS) dated 4/18/18 revealed that Resident #30 had severely impaired cognition. Further review revealed she had physical and verbal behaviors that occurred 1 to 3 days and wandering and rejection of care behaviors that occurred 1 to 3 days. The assessment also revealed the resident required extensive assistance with bed mobility, dressing, toileting, hygiene and	F 609	On Sunday, 4/22/2018, when bruise was noted by CNA on resident□s left inner thigh, CNA reported to the 3rd shift Nurse who assessed the area, found no break in skin integrity, and documented bruise in Nursing Progress Notes and wrote description of bruise on □Nurses Rounds Report Form□. Resident□s representative notified of bruise per notification preference. The Nurse did not report the bruise to Advocacy or to her supervisor. On Monday morning 4/23/18, during the "Daily Safety Events Report & Risk Management Meeting", (includes Director, Medical Director, DON, ADON, Unit Managers, Risk Manager, Social Workers, Senior Psychologist, Director of Professional Services, QA Director, MDS Coordinators and MDS Assistants), the Gravely 3 Nurse Unit Manager from this	

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F 609	Continued From page 6 transfers, and supervision for walking. She was assessed as always being incontinent of bowel and bladder and as having 2 or more falls with no injury since her last assessment. The assessment was also coded as Resident #30 not receiving any anticoagulant medications. A review of Resident #30's care plan, dated 4/25/18 revealed a concern with bruising and interventions listed were to monitor, observe and report any bruising. Review of a nursing note dated 4/22/2018 read in part: bruise to Resident's left inner thigh, purple in color, finger shaped of unknown etiology. Review of the facility document titled Nurses Rounds Report for Resident #30 dated 4/22/2018 read in part: finger length purple bruise to left upper thigh. Review of the facility abuse allegations and investigations failed to reveal any investigation into the left inner thigh bruise of Resident #30. An interview was conducted with the Director of Quality Assurance (QA) on 5/2/18 at 2:29PM. During this interview, the QA director stated that the facility Advocate would investigate any injury of unknown origin. The QA Director further stated that management may also do their own investigation, but stated it was the advocacy staff that would do the investigation. The QA Director stated during this interview that she was not aware of the bruise and the facility had not investigated the left inner thigh bruise to Resident #30 nor had the facility completed the 24 hour and 5 days reporting to the State Survey Agency.	F 609	resident□s Unit reported that resident had a bruise on inner thigh of unknown etiology. Report also included possible reason: that resident can be aggressive during care, she is intrusive with others, or may have scratched herself. The event was not reported to HCPR or to Advocacy. On the morning of 5/2/18, during the "Daily Safety Events Report & Risk Management Meeting", Team discussed that the location of the bruise should have been a flag for suspicion along with unknown source. Due to time since bruise occurred, a formal investigation was not initiated at this time. DON put a "plan of correction" in place that identified the following practice and training: - Locations of injuries of unknown source that will prompt an investigation include injuries on resident□s face, back, groin and/or injuries in areas not generally vulnerable to trauma. - Nurse Unit Managers will bring RL6 (Resident Incident Response) forms from previous day(s) to Daily Safety Report & Risk Management Meeting. - "Daily Safety Events Report & Risk Management Meeting Team" will review daily RL6 data/reports and determine if any injuries of unknown source, suspicious due to their location, were reported to the Nursing Supervisor and Advocacy as detailed in BMNTC Policy ADM133B "Protecting Residents from Rights Infringements". Director/designee will make final determination if injury is of unknown source and suspicious and will report to the HCPR immediately "but not	

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F 609	Continued From page 7 An interview was conducted with the 1st shift nurse manager on 5/2/18 at 2:55PM. During this interview she stated that she "vaguely" recalled the bruised area to Resident #30 but could not remember any specifics about the bruise and did not know how the bruise occurred. She further stated that she did not see or investigate the bruise to Resident #30. An interview was conducted with QA Director and Director of Nursing (DON) on 5/2/18 at 3:30PM. The DON stated bruise of unknown origin to left thigh of Resident #30 was unknown as to how it occurred and stated it was not reported to State Survey Agency and it was not investigated. The QA Director further stated she understood how it could be reported to the State Survey Agency, but stated that she did not think it was a suspicious bruise. 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."	F 609	later than 2 hours after allegation is made, if events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury". A formal and comprehensive investigation will be initiated. - All nursing staff will receive inservice on learning how to better recognize and identify injuries of unknown source and of a suspicious nature, and reporting to their supervisor and advocacy as detailed in BMNTC Policy ADM133B "Protecting Residents from Rights Infringements" and documenting the event and reporting in the Nursing Progress Notes. Training began 5/7/18 completed 5/23/18. - Monthly Nurses meetings will Include review of scenarios of injuries of unknown source. 1) Nurses will discuss if the bruise, injury, wound is of a suspicious nature. 2) Identify policy requirements for documentation. 3) Make judgments around notification of the physician, resident representative, nursing supervisor, SAO and Advocacy, per policy requirements and nursing judgement. The goal of this training is to increase awareness, prevent complacency, and maintain consistency in reporting. - Office Assistant III in Administration will document dates Initial Allegation Report (24 hr Report) is sent and monitor tracking form to ensure that the Investigation Report (5-Workding Day Report) report is sent within correct time frame.	

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F 609	Continued From page 8 An interview was conducted with the Responsible Party of Resident #30 on 5/2/18 a 5:35PM. The Responsible Party stated she was told of the bruise but was not told the bruise was on the resident's inner thigh or how it the bruise occurred. An interview was conducted with Advocate #1 on 5/3/18 at 9:00AM. During this interview she stated that her job responsibilities was to ensure the rights of the residents were not violated. She further stated employees are instructed to notify the Advocates of any rights violations to include injuries of unknown origin and that a bruise in the inner thigh of unknown origin to Resident #30 should have been reported to them and they should have investigated it. She stated she was not aware of the bruise and that it had not been reported to her to investigate. An interview was conducted with Nurse #7 on 5/3/18 at 11:02AM. She stated that she "somewhat" remembered the bruise to Resident #30's left inner thigh being mentioned to her during shift change. She further stated that she did not report the bruise to any management and that she was unaware of any investigation into how the bruise occurred. During a follow-up interview with the QA Director on 5/3/18 at 3:10PM, she stated there was no investigation and no 24 hour and 5-day reports were submitted to the State Survey Agency for the bruise of unknown origin to the inner thigh of Resident #30.	F 609	On 5/24/18 BMNTC Occupational Therapist completed an evaluation resident #30 during toileting for any possible new techniques staff can utilize in decreasing residents discomfort and resistance during care. The following Quality Assurance Objective 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 BMNTC policy ADM 133B "Protecting Resident's From Rights Infringements", to the Nursing Supervisor, Advocate, and HCPR per regulatory timeframes. This objective will be monitored daily with review of RL6 incidents for timely reporting and reviewed in monthly Quality Assurance meetings through 5/31/19. At any time monitoring identifies a problem, corrective action will be taken immediately. The BMNTC Director and Director of Nursing are responsible for implementing the POC.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		5/31/18

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F 610	Continued From page 9 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and family and staff interviews the facility failed to investigate a bruised area to the inner left thigh for 1 of 1 residents (Resident #30) sampled for a bruise of unknown origin. The Findings Included: Resident #30 was admitted to the facility on 11/18/2015 with diagnoses that included Cerebrovascular Accident, Alzheimer's and Frontal Lobe Atrophy secondary to head trauma. Review of the annual Minimum Data Set (MDS) dated 4/18/18 revealed that Resident #30 had severely impaired cognition. Further review revealed she had physical and verbal behaviors that occurred 1 to 3 days and wandering and	F 610	On Sunday, 4/22/2018, when bruise was noted by CNA on resident□s left inner thigh, CNA reported to the 3rd shift Nurse who assessed the area, found no break in skin integrity, and documented bruise in Nursing Progress Notes and wrote description of bruise on □Nurses Rounds Report Form□. Resident□s representative notified of bruise per notification preference. The Nurse did not report the bruise to Advocacy or to her supervisor. On Monday morning 4/23/18, during the "Daily Safety Events Report & Risk Management Meeting", (includes Director, Medical Director, DON, ADON, Unit Managers, Risk Manager, Social	

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F 610	Continued From page 10	F 610		

rejection of care behaviors that occurred 1 to 3 days. The assessment also revealed the resident required extensive assistance with bed mobility, dressing, toileting, hygiene and transfers, and supervision for walking. She was assessed as always being incontinent of bowel and bladder and as having 2 or more falls with no injury since her last assessment. The assessment was also coded as Resident #30 not receiving any anticoagulant medications.

A review of Resident #30's care plan, dated 4/25/18 revealed a concern with bruising and interventions listed were to monitor, observe and report any bruising.

Review of a nursing note dated 4/22/2018 read in part: bruise to Resident's left inner thigh, purple in color, finger shaped of unknown etiology.

Review of the facility document titled Nurses Rounds Report for Resident #30 dated 4/22/2018 read in part: finger length purple bruise to left upper thigh.

Review of the facility abuse allegations and investigations failed to reveal any investigation into the left inner thigh bruise of Resident #30.

An interview was conducted with the Director of Quality Assurance (QA) on 5/2/18 at 2:29PM. During this interview, the QA director stated that the facility Advocate would investigate any injury of unknown origin. The QA Director further stated that management may also do their own investigation, but stated it was the advocacy staff that would do the investigation. The QA Director stated during this interview that she was not aware of the bruise and the facility had not

Workers, Senior Psychologist, Director of Professional Services, QA Director, MDS Coordinators and MDS Assistants), the Gravely 3 Nurse Unit Manager from this resident□s Unit reported that resident had a bruise on inner thigh of unknown etiology. Report also included possible reason: that resident can be aggressive during care, she is intrusive with others, or may have scratched herself. The event was not reported to HCPR or to Advocacy.

On the morning of 5/2/18, during the "Daily Safety Events Report & Risk Management Meeting", Team discussed that the location of the bruise should have been a flag for suspicion along with unknown source. Due to time since bruise occurred, a formal investigation was not initiated at this time. DON put a "plan of correction" in place that identified the following practice and training:
- Locations of injuries of unknown source that will prompt an investigation include injuries on resident□s face, back, groin and/or injuries in areas not generally vulnerable to trauma.
- Nurse Unit Managers will bring RL6 (Resident Incident Response) forms from previous day(s) to Daily Safety Report & Risk Management Meeting.
- "Daily Safety Events Report & Risk Management Meeting Team" will review daily RL6 data/reports and determine if any injuries of unknown source, suspicious due to their location, were reported to the Nursing Supervisor and Advocacy as detailed in BMNTC Policy ADM133B "Protecting Residents from

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investigated the left inner thigh bruise to Resident #30.

An interview was conducted with the 1st shift nurse manager on 5/2/18 at 2:55PM. During this interview she stated that she "vaguely" recalled the bruised area to Resident #30 but could not remember any specifics about the bruise and did not know how the bruise occurred. She further stated that she did not see or investigate the bruise to Resident #30.

An interview was conducted with QA Director and Director of Nursing (DON) on 5/2/18 at 3:30PM. The DON stated bruise of unknown origin to left thigh of Resident #30 was unknown as to how it occurred and stated it was not reported to state and investigated. The QA Director further stated she understood how it could be reported, but stated that she did not think it was a suspicious bruise.

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,

Rights Infringements". Director/designee will make final determination if injury is of unknown source and suspicious and will report to the HCPR immediately "but not later than 2 hours after allegation is made, if events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury". A formal and comprehensive investigation will be initiated.
- All nursing staff will receive inservice on learning how to better recognize and identify injuries of unknown source and of a suspicious nature, and reporting to their supervisor and advocacy as detailed in BMNTC Policy ADM133B "Protecting Residents from Rights Infringements" and documenting the event and reporting in the Nursing Progress Notes. Training began 5/7/18 completed 5/23/18.
- Monthly Nurses meetings will Include review of scenarios of injuries of unknown source. 1) Nurses will discuss if the bruise, injury, wound is of a suspicious nature. 2) Identify policy requirements for documentation. 3) Make judgments around notification of the physician, resident representative, nursing supervisor, SAO and Advocacy, per policy requirements and nursing judgement. The goal of this training is to increase awareness, prevent complacency, and maintain consistency in reporting.
- Office Assistant III in Administration will document dates Initial Allegation Report (24 hr Report) is sent and monitor tracking form to ensure that the

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F 610	Continued From page 12 "anything finger shaped is a red flag to us and should be investigated." An interview was conducted with the Responsible Party of Resident #30 on 5/2/18 a 5:35PM. The Responsible Party stated she was told of the bruise but was not told the bruise was on the resident's inner thigh or how it the bruise occurred. An interview was conducted with Advocate #1 on 5/3/18 at 9:00AM. During this interview she stated that her job responsibilities was to ensure the rights of the residents were not violated. She further stated employees are instructed to notify the Advocates of any rights violations to include injuries of unknown origin and that a bruise in the inner thigh of unknown origin to Resident #30 should have been reported to them and they should have investigated it. She stated she was not aware of the bruise and that it had not been reported to her to investigate. An interview was conducted with Nurse #7 on 5/3/18 at 11:02AM. She stated that she "somewhat" remembered the bruise to Resident #30's left inner thigh being mentioned to her during shift change. She further stated that she did not report the bruise to any management and that she was unaware of any investigation into how the bruise occurred. During a follow-up interview with the QA Director on 5/3/18 at 3:10PM, she stated that there was no complete and thorough investigation for the bruise of unknown origin to the inner thigh of Resident #30.	F 610	Investigation Report (5-Workding Day Report) report is sent within correct time frame. On 5/24/18 BMNTC Occupational Therapist completed an evaluation resident #30 during toileting for any possible new techniques staff can utilize in decreasing residents discomfort and resistance during care. The following Quality Assurance Objective 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 BMNTC policy ADM 133B "Protecting Resident's From Rights Infringements", to the Nursing Supervisor, Advocate, and HCPR per regulatory timeframes. This objective will be monitored daily with review of RL6 incidents for timely reporting and reviewed in monthly Quality Assurance meetings through 5/31/19. At any time monitoring identifies a problem, corrective action will be taken immediately. The BMNTC Director and Director of Nursing are responsible for implementing the POC.	
F 641	Accuracy of Assessments	F 641		5/31/18

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F 641 SS=D	Continued From page 13 CFR(s): 483.20(g)	F 641		

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
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.

Findings included:

1. Resident #140 was admitted to the facility on 4/24/12 with diagnoses that included but were not limited to cerebrovascular incident, hypertension and history of stroke.

A review was completed of Resident #140's most recent MDS dated 4/4/18 coded as an annual assessment. The assessment coded the resident as having received an anticoagulant for 7 out of 7 days of the assessment period.

A review was also completed of Resident #140's previous MDS dated 1/17/18 coded as a quarterly. The assessment coded the resident as having received an anticoagulant for 7 out of 7 days of the assessment period.

A review of Resident #140's January 2018, March 2018 and April 2018 physician orders and medication administration records revealed Resident #140 did not receive any anticoagulant medication during the assessment period of the MDS.

Two residents on Gravely 3 were taking Plavix at the time of their assessments and use of anticoagulant was incorrectly coded at NO410E. Plavix is an anti-platelet medication.

On 5/1/18 when question was raised about coding anticoagulants vs. antiplatelets, the G3 MDS Coordinator did an immediate review of the MDS Manual Section N. Under section NO410E it states to record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look back period. It also stated "Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here".

Significant Correction to previous comprehensive assessment for Resident #140 was completed on 5/8/18 with 0 coded for NO410E □anticoagulant□ and submitted to CMS. Significant Correction to prior quarterly assessment was completed on 5/8/18 for Resident #73 with 0 coded for NO410A □anticoagulant□ and submitted to CMS.

Pharmacy provided medication listing for all residents on anticoagulants and antiplatelets and specifically on Gravely 3,

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F 641	Continued From page 14 An interview was conducted on 5/2/18 at 5:23 pm with the Director of Quality Assurance, who is currently responsible for completing the MDS assessments. During this interview she stated that she coded the MDS for anticoagulant use on both assessments in error and stated she would modify the assessments. 2. Resident #73 was admitted to the facility on 12/03/14 with diagnoses that included but were not limited to coronary artery disease status post stent placement and hypertension. A review was completed of Resident #73's most recent MDS dated 3/1/18 coded as a quarterly assessment. The assessment coded the resident as having received an anticoagulant for 7 out of 7 days of the assessment period. A review of Resident #73's February 2018 and March 2018 physician orders and medication administration records revealed Resident #73 did not receive any anticoagulant medication during the assessment period of the MDS. An interview was conducted on 5/3/18 at 10:15 am with the Director of Quality Assurance, who is currently responsible for completing the MDS assessments. During this interview she stated that she coded the MDS for anticoagulant use on the assessment in error and stated she would modify the assessments.	F 641	other than Residents #140 and #73, one other resident is on anticoagulant and the MDS was reviewed and found to be correct (Coumadin/anticoagulant) 5/8/18. Review of MDS Manual Section N completed with all 3 MDS Coordinators. MDS coding of NO410E was reviewed on all other listed residents by 2 other BMNTC MDS Coordinators and found to be coded correctly. Training with MDS Coordinators on additional anticoagulants other than common types (Heparin, Coumadin), being used at BMNTC include Xarelto, Eliquis and Lovenox. Completed 5/8/2018. The following objective has been added to the BMNTC Quality Assurance Performance Improvement Plan: "Correct coding of Section N "anti-coagulants" for residents receiving anti-coagulants or anti-platelets on MDS Resident Assessment Instrument will be 100% of the time". This objective will be monitored quarterly through 5/31/19 by the MDS Coordinators. Each MDS Coordinator will monitor MDS Assessments (other than their own) for coding of section N anticoagulants to assure correct coding of residents use of medications. At any time monitoring identifies a problem, corrective action will be taken immediately. MDS Coordinators each responsible for implementing this POC.	

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F 761	Continued From page 15	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to dispose/discard out of date medications in 1 of 3 medication rooms and in 1 of 5 medication carts reviewed for medication storage. Findings included: The facility policy provided by the Director of	F 761	On 5/2/18 when expired medications (eye drops and Epipens) were identified during survey in medication cart and medication room on identified Unit, these out of date medications were immediately returned to Pharmacy (and replaced) per BMNTC MED Procedure 015 Disposal of Drugs. On 5/3/18 DON checked all medication	5/31/18

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F 761	Continued From page 16 Nursing (DON) for disposal of drugs revised on February 28. 2018 read in part: 4. All medications which have reached their expiration date should be returned to the pharmacy for disposal. 8. Nursing staff will check all medication rooms and storage areas for medications on a weekly basis, any expired medications will be remove. 9. Nursing unit inspections will also be conducted monthly by pharmacy staff. Stock supplies and night drug cabinet contents will also be checked for expiration date. 1. An observation on G1 medication room was conducted on 5/3/18 at 8:45 AM. There were two epinephrine 0.3mg injection box (for life threatening allergic reaction) were found. One epinephrine box (two injection doses in a box) with an expiration date of January 2018 and another epinephrine box (two injection doses in a box) with an expiration date of April 2018. An interview with Nurse #5 revealed that nursing staff should be checking the medication room stock weekly and remove all out of date medications. Nurse #5 also stated that the epinephrine injection should have been removed and returned to pharmacy. 2. An observation was conducted on 5/3/18 at 8:32 AM in G1 West medication cart. A bottle of Xalatan eye drops (use for Glaucoma) for Resident #137 was found in use and in the medication cart. The eye drop bottle dated to be discarded on 4/15/18. An interview with Nurse #5 revealed the eye drop was given by another nurse and she was not aware that it was out of date. Nurse #5 also stated the Xalatan eye drop should have been	F 761	carts and medication rooms on all Units for any expired medications and none were found. On 5/4/18 members of Nursing and Executive Team (Director, DON, ADON, Medical Director, QA Director) met to discuss what had happened to cause error. Outcome of discussion identified human error as cause of cited deficiency without any individual staff being identified as responsible. Noted that Epipens were stored in locked compartment in medication room. BMNTC procedure for monitoring for expired meds, by Nursing weekly and Pharmacy monthly, had not lead to recognition of expired medications. Director of Pharmacy and DON reviewed and revised BMNTC Medical Procedures (MED 027 Eye Drops/Ointment, Instillation and Storage Of, MED025AA Epinephrine Auto-Injector (Epipen) Administration and Storage, MED 015 Drug Maintenance and Disposal) related to disposing of drugs and administration of eye drops to ensure: - procedures clearly detail dating of medications (by Pharmacy when dispensing and/or when Nurse breaks seal on any new mediation bottle or container) and, - procedure for monitoring for expired medications by Nursing (weekly) and Pharmacy (monthly) and, - procedure for disposal of medications found to be expired (return to Pharmacy). - DON and Director of Pharmacy revised practice to include that Epipens would be stored in un-locked area of medication	

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F 761	Continued From page 17 discarded on the expiration date. An interview with the DON on 5/3/18 at 11:13 AM revealed her expectation for medication storage was for the nurses to check the medication cart and medication room weekly. The pharmacy staff also check the medication storage monthly. She further stated that nurses should follow the facility procedure for removing the out of date medications.	F 761	cart. - DON and Director of Pharmacy will provide guides displayed on medication carts and in medication rooms as a quick reminder of procedures for checking and monitoring for expired medications. Completed 5/24/18. DON providing training with all Nurses that includes deficiency listing, review of procedures for checking medications for expiration date weekly (and documenting) and prior to administration to resident. Complete 5/30/18. Starting on 5/25/18 all Unit medication carts and medication rooms will be monitored for expired medications by DON/designee twice a month x 3 months and monthly thereafter, with random spot checks, to ensure that any expired mediations have been properly disposed of. Monitoring objective will become a part of QAPI Plan by 5/25/18 and reviewed monthly in QA meeting DON and Director of Pharmacy will be responsible for plan of correction implementation.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		5/31/18

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F 880	Continued From page 18	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 880	Continued From page 19 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to ensure blood glucose meters (glucometers) were properly disinfected/sanitized after use during 3 of 3 observations of a glucometer use. Findings included: The facility policy provided by the Director of Nursing (DON) for cleaning multiuse test device with a revised date of February 28, 2018 read in part: 1. Following each use of glucometer will be cleaned with a germicidal disposable cloth to remove any large contaminates. 2. A second germicidal disposable cloth will be used to clean the exterior again. 3. The device will be placed on	F 880	Each resident who lives at BMNTC and receives routine blood glucose monitoring has an individual glucometer used only for that specific resident. In discussion 5/4/18 about deficiency related to ensuring that glucometers were properly disinfected/sanitized after use, errors noted during Surveyor observations occurred due to glucometers not being cleaned consistently per BMNTC MED Procedure 006A "Cleaning, Multiuse Test Device" which listed procedure for cleaning per glucometer manufacturer□s guidelines.	

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	34A001	A. BUILDING _____ B. WING _____	05/03/2018

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

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F 880	Continued From page 20 a clean surface and allowed to air dry then placed back in case. A review of manufacturer's instruction label for germicidal wipes read in part: Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full two (2) minutes. Let it air dry. 1.A. An observation was conducted on 5/1/18 at 4:43 PM of Nurse #1 when obtaining a Finger Stick Blood Sugar (FSBS) for Resident #135. The nurse entered the resident's room and followed the proper procedure for handwashing and gloving before taking the FSBS. The nurse returned to the medication cart and placed the glucometer in the glucometer carrying case. The nurse proceeded to place the glucometer in the medication cart without disinfecting/sanitizing. The nurse was interviewed right after and she stated that she will disinfect the glucometer before she leaves her shift that evening like around 11 PM. Nurse #1 further stated that she doesn't disinfect the glucometer after use except she'll clean the before her shift ends. B. Nurse #2 was observed obtaining FSBS on 5/2/18 at 10:42 AM for Resident #136. The nurse entered the resident's room and followed proper procedure for handwashing and gloving before taking FSBS. Nurse #2 returned to the medication cart and wiped the glucometer with a germicidal wipe. He then tossed the wipe into the trash bin, and placed the glucometer on top of the table in the medication room. Continuous observation of the glucometer revealed the surface appeared dry in less than a minute. Nurse #2 did not ensure the glucometer remained wet with germicidal	F 880	BMNTC MED Procedure 006A Cleaning, Multiuse Test Device was revised 5/17/28 and now includes cleaning glucometer per Germicidal Disposable Cloth and now states: - Following each use of glucometer machine, the exterior will be cleaned with a Germicidal Disposable Cloth. - A second Germicidal Disposable Cloth is to be used by unfolding wipe and wrapping machine inside to allow surface of machine to remain wet a full 2 minutes. - Remove machine and place on clean paper towel to allow to air dry. Revised BMNTC MED Procedure 006A "Cleaning, Multiuse Test Device" is now displayed at every Nursing station. Every Nurse is to review revised procedure and sign to signify understanding of revision. Completed 5/17/18. Starting 5/4/18 Competency Review and observation for use of and cleaning of glucometer machine will be completed upon new Nurse hire and annually thereafter. Monitoring for compliance in following procedure for cleaning the glucometer machine after use will include: DON/designee will observe cleaning of glucometer after use by 3 nurses a week x 4 weeks and then 2 nurses monthly thereafter for correct cleaning/sanitizing per procedure starting on 5/25/18. Monitoring objective will become a part of QAPI Plan by 5/25/18 and reviewed	

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F 880	Continued From page 21 solution for a full 2 minutes. An interview with Nurse #2 revealed it was the facility's procedure to wipe glucometer after each use with germicidal wipes. Nurse #2 indicated he was not aware of the procedure for the germicidal wipe to leave it wet for full 2 minutes. Nurse #2 also acknowledged that the glucometer was not left wet for 2 minutes after he wiped it. C. An observation was conducted on 5/2/18 at 11:27 AM with Nurse #3. The nurse entered Resident #126's room and proceeded to do FSBS. He followed the proper procedure for handwashing and gloving before taking FSBS. Nurse #2 returned to the medication cart, wiped the glucometer with a germicidal wipe. He then tossed the wipe into the trash bin, and placed the glucometer on top of the medication cart. Continuous observation of the glucometer revealed the surface appeared dry in less than a minute. Nurse #2 did not ensure the glucometer remained wet with germicidal solution for a full 2 minutes. Nurse #3 was interviewed and he indicated that the facility instruction for glucometer be disinfected after each use. Nurse #3 also indicated he was not aware of the germicidal wipe instruction to leave wet for full 2 minutes for disinfection. An interview with the DON on 5/3/18 at 10:41 AM revealed her expectation regarding cleaning glucometer was for the nursing staff to follow the facility procedure and the manufacturer's instruction of the germicidal wipe. The DON also indicated that they needed to review and that they will change their facility policy regarding cleaning	F 880	monthly in QA meeting DON will be responsible for implementation of POC.	

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F 880	Continued From page 22 of glucometer.	F 880		