

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2021
NAME OF PROVIDER OR SUPPLIER BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 000	Initial Comments An unannounced recertification survey was conducted on 06/14/21 through 06/17/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# LGOU11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 06/14/21 through 06/17/21. There was one allegation investigated and it was not substantiated. Event #ID LGOU11.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to ensure a resident at risk for choking was positioned upright during feeding to maximize eating abilities for 1 of 18 residents reviewed for dining (Resident #1) . The findings included: Resident #1 was admitted on 6/27/17 with a diagnosis that included major neurocognitive disorder.	F 684	Corrective Action Steps Identified Certified Nursing Assistant (CNA)#1 and the CNA's Peer Mentor were immediately debriefed by the Nurse Supervisor on the incident and corrective dining guidelines, including optimal positioning for resident during all oral intake. Implemented on 6/16/2021, Completed on 6/18/2021.	7/15/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/07/2021

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.

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F 684	<p>Continued From page 1</p> <p>A review of Resident #1's annual Minimum Data Set (MDS) assessment dated 3/4/21 revealed she was severely cognitively impaired with memory problems. She was totally dependent on one staff member for eating and had loss of liquids/solids from her mouth when eating or drinking.</p> <p>The current care plan (unable to determine the date when the care plan was last reviewed) for Resident #1 initially dated 7/20/18 was reviewed and revealed she required total assistance for all activities of daily living (ADL) related to Huntington's disease. Resident #1 required total assistance for eating and staff were directed to follow the Dining Guidelines (separate document) due to her being an extreme choke hazard.</p> <p>The physician orders for Resident #1 revealed she received a puree diet consistency with honey thickened liquids, and everything was served by spoon or an adaptive cup with a U-shaped cut out on one side.</p> <p>The Dining Guidelines dated 3/10/21 for Resident #1 revealed she required total assistance for feeding, was to be seated in an upright position in her wheelchair, and not to be served by trained paid feeding assistants.</p> <p>On 6/14/21 at 11:56 AM, an observation of Resident #1 was done during lunch meal. Nurse Aide (NA) #1 was feeding Resident #1 in the dining room while she was laying on her right side with her right ear against the arm rest of the wheelchair. Shirt protectors were placed by NA #1 on the armrest while dark, brown pureed food was observed running out of Resident #1's</p>	F 684	<p>Assessed Resident #1's positioning in wheelchair during eating with Physical Therapist (PT), Occupational Therapist (OT), Speech and Language Pathologist (SLP), and Adaptive Equipment Specialist. Implemented on 6/18/2021, Completed on 6/22/2021.</p> <p>Resident #1's dining guidelines were reviewed by the SLP, OT, and PT to ensure accuracy and clarity in positioning information during meal services. Implemented on 6/17/2021, Completed on 6/18/2021.</p> <p>SLP, OT, and PT developed a training module regarding feeding/serving Resident #1 specific to dining guidelines, specific medical diagnoses contributing to the resident's swallowing challenges, reviewed diet consistency, adaptive equipment, positioning, level of assistance, precautions, behaviors, and methods. Implemented on 6/17/2021, Completed on 6/17/2021.</p> <p>Further training was provided to CNA #1. Implemented on 6/21/2021, Completed on 6/21/2021.</p> <p>Administrator, Director of Standards Management, SLP, OT, and PT met to discuss deficiency and corrective actions. Implemented on 6/18/2021, Completed on 6/18/2021.</p> <p>Above mentioned training was provided to all unit-based staff on identified residential unit. Implemented on 6/23/2021,</p>		

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F 684	<p>Continued From page 2</p> <p>mouth. NA #1 used 3 shirt protectors to clean up the mess from the uneaten food running out of her mouth onto the armrest. While feeding Resident #1, NA#1 did not attempt to reposition her upright in her wheelchair.</p> <p>An interview with Nurse #1 took place on 6/16/21 at 9:39 AM. She revealed Resident #1's head should be upright while being fed during meals. She stated if Resident #1 was laying on the arm rest or sideways, then she would not feed her for safety purposes. Nurse #1 indicated she would hold Resident #1's head up gently and try to feed her best she could.</p> <p>On 6/16/21 at 3:35 PM, NA #1 was interviewed and revealed he passed the NA certification exam last week and completed the required training for feeding residents, which included positioning, timing, and aspiration prevention. He recalled feeding Resident #1 on 6/14/21 during lunch meal. He stated Resident #1 was being fed on her right side laying on the armrest because she was "flip flopping around and cannot control anything." He provided protection so food wouldn't get on her because "lots of food was running out of her mouth." He further stated even if he had moved her upright or repositioned her, she would still try and go back to that lying down position. NA #1 indicated Resident #1 lying down during meals was not a safe feeding position but that was the only way he could get her to eat. He stated there was not much you could do to keep her in an upright position. NA #1 further stated he was not sure about the Dining Guidelines of positioning for Resident #1 because he was still learning. However, he did recall there was a folder in the dining room that showed NAs Dining Guidelines for adaptive equipment, positioning,</p>	F 684	<p>Completed on 6/25/2021.</p> <p>SLP, OT, and PT to develop and deliver a training module regarding feeding/serving according to dining guidelines, specific medical diagnoses contributing to resident's swallowing challenges, reviewed diet consistency, adaptive equipment, positioning, level of assistance, precautions, behaviors, and methods. Training to be provided to all unit based staff throughout the facility. Implemented 7/8/2021, Completed by 7/15/2021.</p> <p>OT, PT, SLP, and Clinical Dietitian will review dining guidelines and Quick Reference Tool for Eating for all residents to ensure accuracy and clarity in positioning information during meal services. Implemented on 6/18/2021, Completed by 7/15/2021.</p> <p>Ongoing Monitoring and Improvement:</p> <p>OT, PT, SLP, and Clinical Dietitian to review and enhance resident dining guidelines specific to optimal positioning for various resident profiles as a part of the BMNTC New Employee Curriculum (NEC). Initial revision to begin at the July 2021 NEC, monthly thereafter.</p> <p>SLP, OT, PT, and Clinical Dietitian to develop an annual in-service on resident guidelines, contributing factors to serving hard to serve residents, positioning, and precautions, behaviors, and methods.</p>		

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F 684	<p>Continued From page 3</p> <p>and thickened liquids. He indicated he "felt like she was safe, and he was doing his best."</p> <p>During an interview with Speech Therapist (ST) #1 on 6/16/21 2:36 PM, she revealed Resident #1 should be positioned as upright as possible during meals without restricting her movements. If Resident #1 was laying on the armrest during feeding, she would have attempted to reposition her to an upright position before the next bite was served. ST #1 stated Resident #1 was not cleared to be fed laying down. She further stated Resident #1 was a severe choking risk, and NAs were directed to Dining Guidelines as reference. The Dining Guidelines were updated every few months and placed in a binder in the dining room. The ST stated she was the primary instructor for feeding assistant training during the NA program, as well as for new employee orientation.</p> <p>On 6/17/21 at 11:39 AM, an interview was conducted with Occupational Therapy (OT) #2. She revealed per the Dining Guidelines, Resident #1 should be sitting upright while being fed during meals. It is normal for her to sway and throw herself uncontrollably and she favored the right side, which helps her swallow. OT #2 stated if Resident #1 was laying on her right-side during a meal, she would prop her back to an upright position (center of the chair) and observe her movements. If food was running out of her mouth, she would stop serving and give Resident #1 a break and reassess.</p> <p>An interview with Nurse #2 (unit manager) was conducted on 6/16/21 at 03:58 PM. She revealed Resident #1 was to be positioned upright during meals. Nurse #2 stated the book of Dining Guidelines was located in every dining room on</p>	F 684	<p>First Annual In-service to occur in November 2021, and annually thereafter.</p> <p>OT, PT, SLP, and Clinical Dietitian in conjunction with QA, will develop a QAPI regarding staff compliance with dining room guidelines.</p> <p>Therapeutic Services Team (OT, PT, SLP, and Clinical Dietitian) will monitor resident meal servings for residents with Dining Guidelines to ensure compliance with diet consistency, adaptive equipment, positioning, level of assistance, and methods to feed/serve. Monitoring to occur for three residents per week for twelve weeks, then a monthly sampling thereafter to be determine based on initial findings. Findings will be communicated to the Quality Assurance (QA) Department monthly.</p> <p>Monitoring objective will become a part of Quality Assurance and Performance Improvement(QAPI) Plan and reviewed at the quarterly QA meeting.</p> <p>Facility corrective actions for cited deficiency to be completed by 7/15/2021.</p>		

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F 684	Continued From page 4 each unit for each individual resident as a feeding reference for nurse aides and feeding assistants. If she saw NA #1 feeding Resident #1 while she was lying down, she would assist him to reposition her so that she could be fed properly. During an interview with the Director of Nursing (DON) on 6/17/21 at 9:04 AM, she revealed the way NA #1 was feeding Resident #1 on 6/14/21 was not ideal and unacceptable. She stated she would have educated and redirected NA #1 if she had observed him feeding her laying down. The DON indicated NA #1 should have asked for help to get Resident #1 straightened up if he couldn't do it himself. On 6/17/21 at 9:29 AM the Administrator was interviewed, and she revealed if she observed NA #1 feeding Resident #1 while she was laying down on her right side, she would have asked him to stop feeding and reassess the Dining Guidelines. She would then have provided him with further education and instruction immediately before he continued to feed Resident #1. The Administrator stated that her background was speech therapy, and she participated in the instruction of the feeding assistant training for the NA program.	F 684			
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.	F 761		7/15/21	

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F 761	<p>Continued From page 5</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§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.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to discard 1 opened bottle of expired antifungal powder for 1 of 10 medication carts (East Medication Cart at the third floor of Raspberry Hall).</p> <p>The findings included:</p> <p>Review of the facility's Medical Procedure Manual that was updated on 02/12/2021, under drug maintenance and disposal, recorded in part, "All medications which have reached their expiration date, should be returned to the pharmacy for disposal."</p> <p>During a medication storage check for the East medication cart at the third floor of Raspberry Hall on 06/16/21 at 11:11 AM, an opened bottle of antifungal powder with active ingredient of</p>	F 761	<p>Corrective Action Steps</p> <p>Expired antifungal powder was immediately discarded per Black Mountain Neuro-Medical Treatment Center (BMNTC) Medical Procedure Med015 Drug Maintenance and Disposal when discovered on 6/16/2021. A new bottle of foot power was pulled from stock, opened, initialed, and dated by nursing for use per BMNTC Medical Procedure Med018 Drug Labeling and Packaging. Implemented on 6/16/2021, Completed on 6/16/2021.</p> <p>DON, Director of Standards Management, and Pharmacy Director met to discuss what had happened to cause error.</p>		

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F 761	<p>Continued From page 6</p> <p>Miconazole Nitrate 2% expired on 10/31/20 was found in the medication cart and ready to be used. A handwriting with black marker of "Opened 06/02/21" was seen on the bottle. Approximately 85% of the original weight of 71 gram of this antifungal powder had been used.</p> <p>During an interview with Nurse #3 on 06/16/21 at 11:16 AM he stated he had been checking the expiration date of every medication each time before administering to the resident. In addition, he had checked the medication cart at least once daily. He did not know why he missed the antifungal and attributed the incident as an oversight. He did not know who had opened and dated the antifungal powder on 06/02/21. He acknowledged that nursing staff who had opened the antifungal should check the expiration date and return it to the pharmacy.</p> <p>During an interview with the Pharmacy Manager on 06/16/21 at 1:48 PM she stated pharmacy staff had performed nursing unit inspections routinely to check each medication cart thoroughly for expired medication at least once per month or as needed. She did not know why this expired antifungal powder was not identified during the routine checks. It was her expectation for the expired antifungal to be removed from the medication cart before it was used.</p> <p>During an interview with the Director of Nursing (DON) on 06/16/21 at 2:30 PM she stated the expired antifungal powder should not be stored in the medication cart or been in use. All nursing staff should check the expiration date of each medication before administration. It was her expectation for the facility to be free of expired medications.</p>	F 761	<p>Outcome of discussion identified human error as cause of cited deficiency without any individual staff being identified as responsible. Noted that antifungal powder is a floor stock item, stored in the medication room. BMNTC procedure for monitoring for expired meds had been followed by Nursing and Pharmacy. Routine monthly monitoring had not led to recognition of expired medications prior to this survey. Implemented on 6/29/2021, Completed on 6/29/2021.</p> <p>Director of Nursing (DON) immediately completed an inspection of all medication carts and medication rooms on all five residential units for any expired medications. No expired medications were found. Implemented on 6/16/2021, Completed on 6/16/2021.</p> <p>The BMTNC Pharmacy staff completed an inspection of all ten medication carts ten medication carts throughout the facility to ensure all items on the medication carts were in date. Implemented on 6/24/2021, Completed on 6/24/2021.</p> <p>DON and Pharmacy Director reviewed BMNTC Medical Procedure MED 015: Drug Maintenance and Disposal to ensure accuracy and clarity. Implemented on 6/29/2021, Completed on 6/29/2021.</p> <p>Director of Pharmacy and DON developed and delivered a training module for BMNTC floor nurses. Training included deficiency listing, review of procedures for</p>		

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F 761	Continued From page 7 During an interview with the Administrator on 06/17/21 at 11:36 AM she stated each medication cart should be checked at least once daily. It was her expectation for the facility to be free of expired medications.	F 761	<p>checking medications for expiration date weekly and prior to administration to resident, treatment cart versus medication cart storage, and a review BMNTC Medical Procedure MED 015: Drug Maintenance and Disposal. Implemented on 7/2/2021, Completed on 7/2/2021.</p> <p>DON and Pharmacy Director initiated use of new treatment carts for all units, inclusive of training on use of treatment cart, appropriate storage of items, labeling and monitoring of items, and treatment carts versus medication carts use. Implemented on 7/2/2021, Completed on 7/2/2021.</p> <p>DON and Pharmacy Director developed signage clearly indicating proper storage of medications, inclusive of storage location, labeling, and expiration date monitoring. Implemented on 7/5/2021, Completed on 7/5/2021.</p> <p>Pharmacy Director to implement and train on reference cards on MARS notebook to include the following information: - Insulins expire 28 DAYS after opening - Eye drops expire 30 DAYS after opening&. (Lantaprost should be stored in fridge until opened) - All else (eye ointments, inhalers, nasal sprays, ointments, creams, injections, patches, liquids, sprays, etc.) expire on manufacturer date on package unless otherwise noted by pharmacy - Expiration dates are NOT found on pharmacy labels unless a nurse writes it</p>		

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F 761	Continued From page 8	F 761	<p>on an auxiliary label for insulin/eye drop or a specialty product - Please do not use any product on a resident without checking the expiration date first.</p> <p>To be completed by 7/15/2021.</p> <p>Director of Pharmacy to develop an annual in-service on Medication Expiration information to be delivered by a BMNTC Pharmacist. First Annual In-service to occur in September 2021, and annually thereafter.</p> <p>Director of Pharmacy to develop and deliver a training session on Expired Medication information at as a part of the BMNTC New Employee Curriculum (NEC). Initial to occur 7/12/021, monthly thereafter.</p> <p>Director of Pharmacy to order new auxiliary labels with indicated discard dates (28 days vs 30 days after opening. Implemented on 6/30/2021, Completed by 7/15/2021.</p> <p>Director of Pharmacy to order new labels with pre-printed Opened on and Discard on labels to streamline process and provide a prompt for nursing staff. Implemented on 6/30/2021, Completed by 7/15/2021.</p> <p>Director of Pharmacy in conjunction with the DON and Quality Assurance (QA), will develop a QAPI regarding monitoring for expired medications.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 761	Continued From page 9	F 761	<p>All Unit medication carts, and medication rooms will be monitored for expired medications by the Pharmacy department twice a month x 3 months and monthly thereafter, with random spot checks, to ensure that any expired medications have been properly disposed of. Findings will be communicated to the QA Department monthly.</p> <p>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 medications have been properly disposed of. Findings will be communicated to the QA Department monthly.</p> <p>Facility corrective actions for cited deficiency to be completed by 7/15/2021.</p>		