STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345459	A. BUILDING _____ B. WING _____	04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATES	619 LAUREL LAKE DR COLUMBUS, NC 28722

(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 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident interviews, family interview, and staff interviews, the facility failed to place call bells within the reach for 2 of 23 sampled residents. (Residents #1 and #20). The findings included: 1. Resident #1 was admitted to the facility on 04/16/02 with diagnoses including senile dementia. The Minimum Data Set, an annual dated 01/07/14 coded her as having severely impaired cognition, needing supervision with eating and limited assistance with walking and hygiene. The current care plan, addressing activities of daily living skills, last updated 04/08/14 included the intervention to remind the resident to call for assistance and keep call light in reach. Resident #1 was observed with her call cord out of reach as follows: *Resident #1 was observed on 04/14/14 at 10:28 AM in a wheelchair in her room with the call light hooked on call box located on the wall out of her reach.	F 246	WillowBrooke Court does ensure that all residents receive services in the facility with reasonable accommodations of individual needs and preferences. All residents were immediately checked to assure call lights were accessible prior to surveyors leaving the facility on 4-16-14. On 4-17 and 4-18-14 all direct care staff received in-services training regarding the importance of checking to assure that call lights were accessible to all residents prior to leaving resident rooms, or leaving residents alone. For the identified resident, a longer call bell cord was put in her room for easier accessibility. Clips were added or replaced if needed on all call lights so they would not have to be secured to the side rail . The Nursing Assistants on each shift were assigned to check each resident to assure that the call lights were within reach and that was documented as part of a QI for 2 weeks. The Director of Nursing made rounds on 4-17 and 4-18-14 to check for proper placement of call lights as a follow-up to the QI. Charge Nurse will be responsible to check for call light accessibility each shift for one month with documentation. Random room checks will be completed weekly for 3 weeks and then monthly for 6 months. Room checks will be completed by the administrative staff to include 5 rooms with documentation regarding call light accessibility. This will be reviewed in the QA meetings quarterly for continued compliance and documentation .	5/15/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathryn H. Dobson, LNHA	Administrator	5/19/14

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

DHSR Black Mountain WRO Received MAY 23 2014 By: SKH

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F 246	Continued From page 1 *On 04/14/14 at 3:04 PM, Resident #1 was in her personal chair dozing and the call cord was attached to the box on the wall out of her reach. *On 04/15/14 at 9:01 AM, Resident #1 was in her personal chair reading the paper and the call cord was attached to the box on the wall out of her reach. *On 04/15/14 at 10:50 Am while sitting in her personal chair with the call cord attached to the box on the wall out of her reach. *Resident #1 was in her personal chair in her room with the call cord attached to the box on the wall out of her reach on 04/15/14 at 1:55 AM. On 04/15/14 at 1:55 AM, Resident #1 was asked by the surveyor how she called for someone if she needed assistance. She responded "lots of different ways" but was unable to articulate a way. The surveyor showed her the call cord and asked if she knew what the call cord was for and she used her hands to simulate pushing the call button down to activate it. On 04/16/14 at 8:44 AM, Resident#1 was in her personal chair with the call cord attached to her pants. When asked if she knew what the call bell was, she responded it called someone. Nursing Assistant (NA) #2 stated at 04/16/14 at 8:55 AM the call cord should be where residents could reach them. She further stated she brought Resident #1 back from the dining room this morning and placed the call cord on her lap. She could not comment on why the call cord was hanging on the wall the previous couple of days. NA #3 stated on 04/16/14 at 8:56 AM that this morning she noted the call cord was on the wall and she had moved it down to her bed.	F 246	**Additional staff education was given to all staff on May 6 and 7th to address the plan of correction. All new employees will have call light accessibility procedures as part of orientation by the Assistant Director of Nursing and documented on the new hire orientation checklist. The call light portion of the checklist will be completed for the new hire prior to the first resident assignment.** **Ongoing monitoring for Tag F246 is the responsibility of the Director of Nursing and The Assistant Director of Nursing for continued compliance. All Corrective actions will be by May 15, 2014**	5/15/14

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F 246	Continued From page 2 Interview with the Director of Nursing on 04/16/14 at 11:35 AM revealed call cords should be within the resident ' s reach. She further stated she did not think Resident #1 knew how to activate the call cord due to her dementia. On 04/16/14 at 1:53 PM, Resident #1 ' s family member stated he was sure the resident knew what the light was used for. 2. Resident #20 was readmitted to the facility on 10/27/12. Diagnoses included metabolic encephalopathy, atrial fibrillation, congested heart failure and urine retention. The annual Minimum Data Set (MDS) dated 11/05/13 and the quarterly MDS dated 01/28/14 coded her as being cognitively intact and requiring extensive assistance with all activities of daily living skills. On 04/15/14 at 10:48 AM, Resident #20 was in her room in her wheelchair on the window side of the bed where her personal chair was located. At this time the call bell was observed out of sight, located on the opposite side of the bed, on the top side rail which was lowered. The bed was made and the call cord would not be easily accessed. At this time, Resident #20 was asked about the accessibility of the call cord. She stated that when staff make the bed and the side rails are put down, then she cannot access the call bell. At 10:55 AM on 04/15/14, Resident #20 asked nurse aide (NA) #2 who came into the room to move the call cord where she could reach it. NA #2 stated she did not make Resident #20's bed this date and did not know who did. On 04/15/14 at 1:48 AM, NA #4 stated she did not know who made Resident 320's bed this morning.	F 246		5/15/14

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F 246	Continued From page 3 On 04/16/14 at 8:42 AM, Resident #20 stated that "often" when staff make her bed in the morning, the call cord is left out of reach. She further stated "it seems like everyday" the call cord is out of reach. Nursing Assistant (NA) #2 stated at 04/16/14 at 8:55 AM the call cord should be where residents could reach them. She further stated she thought the call cord itself was too short for good accessibility. NA #3 stated at 04/16/14 at 8:56 AM that often the call cord was placed on the right (door) side of the bed on that side rail when Resident #20 was in bed. If the call cord was left on that side once she was out of bed, it would be inaccessible to her. NA #3 stated the call cord would be accessible if positioned on the left (window) side of the bed. Interview with the Director of Nursing on 04/16/14 at 11:35 AM revealed call cords should be within the resident's reach.	F 246		5/15/14
F 272 SS=B	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:	F 272	**WillowBrooke Court does ensure that all Residents have a comprehensive, accurate Assessment according to the State RAI Procedure.** **The two identified residents that had (CAA's) for urinary retention were immediately reviewed by the Assistant director of Nursing and the (CAA's) were re-written to include more comprehensive information. Both residents were care planned appropriately for the urinary retention on their current care plan.**	5/20/14

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F 272	Continued From page 4 Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility documentation, staff and resident interview the facility failed to provide a complete Care Area Assessment related to the use of an indwelling urinary catheter for 2 of 12 sampled residents (Residents #24 and #20). The findings included: 1. Resident #24 was admitted on 11/08/09 and the diagnoses included Parkinson's disease and	F 272	**The Assistant Director of Nursing who completes the MDS assessments on all residents will In service the care plan team by May 20, 2014 to ensure that CAA's are comprehensive and all areas of need are addressed on the resident's plan of care.** **Audits will be completed by the Director of Nursing, Assistant Director of Nursing or designee that will randomly select 2-3 MDS comprehensive assessment (CAA's) to be reviewed monthly and documented on a (CAA) audit tool and then reviewed by the QI team during the quarterly meetings for 12 months. The (CAA) audit tool will ensure that (CAA's) are comprehensive and identify any issues that need to be on the plan of care.** **The ongoing compliance for F tag 272 is the responsibly of the MDS coordinator with the supervision of the Director and Assistant Director of Nursing. Corrective Action will be completed by May 20, 2014**	5/20/14

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F 272	Continued From page 5 urinary retention. The annual Minimum Data Set (MDS) dated 01/20/14 indicated Resident #24 had intact cognition with the Brief Interview for Mental Status (BIMS) score of 13 out of 15. The MDS further revealed that Resident #24 was coded with an indwelling catheter. A review of the annual Care Area Assessment (CAA) dated 01/28/14 revealed that Resident #24 had a urinary catheter for urinary retention. No other urinary issues related to the indwelling catheter were addressed in the CAA. The CAA did not address whether the facility would proceed to care plan. The CAA did not include Resident #24's strengths and weaknesses, causes and effects, risk factors, complications, or how multiple triggered conditions might affect the need or care of the catheter. There was no analysis in the CAA as to what the care plan would address. Interview on 04/16/14 with Assistant Director of Nursing (ADON) who completed the MDS revealed that she expected the CAA to paint a picture of the whole resident. 2. Resident #20 was most recently readmitted to the facility on 10/27/12. Her diagnoses included urine retention, diabetes, metabolic encephalopathy, and atrial fibrillation. The annual Minimum Data Set (MDS) dated 11/05/13 coded her with intact cognition, requiring extensive assistance with toileting and having an indwelling urinary catheter. The Care Area Assessment (CAA) dated 11/12/13 did not include a comprehensive analysis of the description of the problem, the resident's strengths and weaknesses, the causes and	F 272		5/20/14

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F 272	Continued From page 6 contributing factors and the risk factors relating to the use and need of the indwelling urinary catheter. The CAA included a checklist that indicated Resident 320 also had pain, restricted mobility, neurogenic bladder and diabetes, however, no description of these areas was included as to how they related to the use or need for an indwelling urinary catheter. The CAA summary stated "Resident has foley cath (catheter) r/t (related to) neurogenic bladder. Will proceed to care plan." Observations on 04/15/14 at 10:48 Am revealed Resident 320 had an indwelling urinary catheter in place. Resident #20 stated at this time that she had the catheter since being hospitalized as she could not pass urine. Interview with the MDS coordinator on 04/16/14 at 10:53 AM revealed the CAA information drove the care plan. She stated she looked at the CAA originally written by the restorative nurse and made sure the diagnoses was present and that a care plan would be developed. She stated the main thing for this CAA was for the reason the catheter was in use. Interview with the Director of Nursing on 04/16/14 at 11:32 AM revealed the CAA should have had more information.	F 272		5/15/14
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329	**WillowBrooke Court does ensure that each resident's drug regimen will be free from unnecessary drugs.** **The physician visited and reviewed the resident's medications on April 23, 2014 and decided to try and discontinue the Lexapro with close monitoring of the resident's behavior by the staff.**	5/15/14

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F 329	Continued From page 7 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide indication for increasing the dose of Lexapro, an antidepressant, from 5 milligrams (mg) to 10 mg daily for 1 of 5 sampled resident reviewed for unnecessary medications (Resident #13). The findings included: Resident #13 was admitted on 01/13/11 with diagnoses including malaise and fatigue, dementia without behavioral disturbances, and depression. The annual Minimum Data Set (MDS) dated 07/23/13 indicated Resident #13 had intact cognition with the Brief Interview for Mental Status (BIMS) score of 9 out of 15. The MDS further indicated Resident #13 displayed little or	F 329	Behavior flow records done daily and Geriatric Depression Scales done every two weeks for 6 weeks beginning 4-24-14 and ending 6-5-14 by the nursing staff and the Social Worker for the identified resident will reflect any changes in behavior and mood. The completed documentation on the identified resident will be reviewed during the May 2014 QI meeting. All other residents currently on psychotropic medications will be reviewed by May 16, 2014 by the Director of Nursing and/or her designee to ensure that the documentation supports the medications being given. Physician progress notes, nurses notes, and the behavior sheets will ensure that all residents on psychotropic medications have the proper documentation to support the medications. Should any changes in medications be needed then the physician will make the changes and communicate this to the staff for the adjustment of the documentation. Results of any changes in behavior or mood will be reviewed by the Social Services Director and nursing staff immediately following the change and then by the QI team during the QI Meetings held quarterly for 12 months. The Director of Nursing , Assistant Director of Nursing and the RN Supervisor will audit monthly beginning May 1, 2014 using the Psychoactive Medication Tracking Form and other related documents for all residents on psychotropic medications to ensure compliance. This will be an ongoing monthly review.	5/15/14

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F 329	Continued From page 8 no interest in doing things, feeling tired or having little energy but did not indicate feeling down, depressed, or hopeless. The MDS revealed Resident #13 received an antidepressant within the last 7 days. The annual Care Area Assessment (CAA) dated 07/23/13 triggered psychosocial well-being related to Resident #13 had little interest or pleasure in doing things. Resident preferred to spend most of her time in her room lying in bed. The CAA further revealed Resident would eat her meals in the dining room and would go on lunch outings if prompted and this was not a new concern for the resident and the facility would proceed to care planning. The CAA also triggered for psychotropic drug use related to Resident diagnoses of anxiety, depression, and insomnia which required medication and the facility would proceed to care planning. The CAA did not trigger for mood problems for Resident #13. The quarterly MDS dated 03/25/14 revealed Resident #13 had a BIMS score of 11 out of 15 which indicated intact cognition and further revealed resident received antidepressant medication within the last 7 days. Resident #13 required extensive assistance with transfer and limited assist with locomotion. Resident was feeling tired and had little or no energy but did not indicate feeling down, depressed, or hopeless. A review of the care plan initiated on 12/11/12 and last updated on 4/1/14 stated Resident #13 had a problem with depression with insomnia/anxiety requiring psychotropic drug use and included 2 goals: will have at least 6 hours uninterrupted sleep and will maintain weight. Interventions to achieve goal included: medication as ordered, monitor for side effects of medication, decrease external stimuli, notify MD/Geriatric Nurse Practitioner (GNP) as needed, consult with	F 329	**The facility pharmacy consultant will also conduct monthly reviews for dosage reduction of all psychotropic medications per state and federal regulations. The summary of each report is reviewed by the staff in attendance at the quarterly QI meeting each month.** **The direct care staff did attend in-service education on May 6th and 7th, 2014 for additional training and requirements of the plan of correction.** **Ongoing compliance of tag F 329 is the responsibility of the Director of Nursing, the Assistant Director of Nursing and the Social Services Director. All corrective action will be completed by May 15, 2014**	5/15/14

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F 329	Continued From page 9 psychologist, allow resident to vent feelings, and encourage activities outside of room. A review of Resident #13's medical record from 01/01/14 to 04/16/14 revealed there were no psychologist notes. Behavior monitoring sheets that indicated any incidences of withdrawn, insomnia-difficulty falling and staying asleep from months of January, February, and March of 2014 indicated no instances of withdrawn behavior and one instance of insomnia on 02/18/14. Nurse's notes on 02/24/14 revealed that resident did not want to propel self in wheel chair and did not want to do as much for self as previously and Lexapro 5 mg was increased to 10 mg every day related to depression. Nurse practitioner progress note dated 02/24/24 indicated that Resident #13 would continue all other medications and increased Lexapro from 5 mg to 10 mg every day. Nurse practitioner's progress note further revealed Resident #13 denied any anxiety or depression and provided no indication for the increased dose of Lexapro. A telephone interview with the Nurse Practitioner on 04/16/14 at 2:30 PM with the Director of Nursing (DON) present revealed that Nurse Practitioner did not remember Resident #13 and shared that she may have received information from the staff that prompted her to increase the Lexapro and that she may have been interrupted by someone and that may be the reason why she did not document the indication for the increase of Lexapro in her progress notes. Nurse Practitioner further shared that she does not remember why she increased the dose of Lexapro and stated that she would do better with her documentation.	F 329		5/15/14

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F 329	Continued From page 10 Interview with DON on 04/16/14 at 2:45 PM revealed that she did not see any documentation in the Resident #13's medical record regarding depression symptoms or behaviors to support the increase in the Lexapro dose except for one note, written on 02/24/14, regarding Resident #13 not wanting to propel self in the wheel chair and not wanting to do as much for self. DON shared that perhaps she may change behavior monitoring sheet to offer more choices for nurses to document type of behavior.	F 329		5/15/14