Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0107	A. BUILDING: _____ B. WING _____	11/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKS-HOWELL HOME	266 MERRIMON AVENUE ASHEVILLE, NC 28801

(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) COMPLETE DATE
L 039	.2208(E) SAFETY 10A-13D.2208 (e) The facility shall ensure that: (1) the patients' environment remains as free of accident hazards as possible; and (2) each patient receives adequate supervision and assistance to prevent accidents. This Rule is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide planned interventions to prevent falls and reassess interventions to determine effectiveness and/or need to change interventions for 2 of 6 residents sampled for falls. (Residents #2 and #5). The findings included: 1. Resident #5 was admitted to the facility on 12/10/13 with diagnoses including dementia, Alzheimer's Disease with delusions, hypertension, osteoporosis and pelvic inflammatory disease. The Resident-Data Collection tool dated 12/10/13 noted she was disoriented, exhibited dementia and was independent with transfers and ambulation. There was no care plan relating to risk of falls. All care plans were last noted as reviewed in the care plan meeting held 09/09/14. Review of nursing notes revealed Resident #5 exhibited an unsteady gait when ambulating on 10/19/14, 10/20/14, and was using furniture to	L 039	L 039 Falls If a resident sustains a fall, a new fall risk assessment will be completed by the DON and/or designee. The resident will be noted in the next care plan meeting as a "fall risk", and any new approaches noted: Ex 1: Pharmacy will do a med review to look at medications that may pose a fall risk. 2: Have PT/OT screen for need for treatment. 3: Any resident that scores a "10" or above on fall risk assessment will be care planned as a Fall Risk. L 039 continued from page 1 An IDT (interdisciplinary team) meeting will be held each week to address falls. This meeting will be termed the "Fall Meeting". When a resident falls and orders are written to observe the resident, or to send them to the hospital for evaluation, the DON and/or designee will daily check the pink copy of the physicians order from to stay updated on falls.	12/3/14

DHSR NH L&C Black Mountain WRO Received JAN 09 2015 by: vcl

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Nancy Harrison — Administrator — 1-9-15

original signature: 12-8-14

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L 039	Continued From page 1 walk around the room on 10/21/14. The physician ordered physical therapy to be provided beginning on 10/23/14 and occupational therapy to be provided beginning on 10/24/14 to assist in dealing with Resident #5's unsteady gait. Nursing notes dated 10/27/14 at 5:00 PM revealed Resident #5 was found by the nurse aide lying on the floor beside her bed. The resident did not admit to falling and kept saying she did not sleep at all last night. Resident #5 was noted to complain of severe pain upon movement. Resident #5 was noted to be transported to the hospital on 10/27/14 at 6:30 PM. Nursing notes dated 10/28/14 at 1:20 AM that the hospital called the facility to report Resident #5 had been diagnosed with a pelvic fracture and urinary tract infection and would need to use a walker at all times. Nursing notes dated 10/28/14 at 2:30 AM revealed Resident #5 returned to the facility and a bed alarm was placed for the resident's safety. Review of the care plans revealed there was no care plan relating to her fractured hip or fall and need for an alarm or walker since this incident. Resident #5 was observed in bed on 2:33 PM. An alarm box was visible on the upper side rail however, the light indicating it was operational was not blinking. Upon closer inspection, the switch was noted in the off position. Resident #5 was awake at the time of this observation. The resident was again observed awake, in bed with the pressure bed alarm in the off position on 11/12/14 at 3:18 PM. On 11/12/14 at 4:51 PM, an occupational aide (OTA) and nurse aide (NA) #6 were observed assisting Resident #5 transfer from a lying	L 039	L 039 Alarms The staff will be educated by in-service by the DON and/or designee on the use of alarms. If the staff member is not able to attend a physical in-service within 3 days, they will be instructed via telephone on the usage of the alarms. The CNA's will be advised to report if an alarm is non-functional to the charge nurse. L 039 continued from page 2 They will be advised to check the alarm every shift and sign off on the resident flow sheet that this has been completed. The nurse will sign on the TAR that the alarm(s) are in place as ordered. An account of the in-services will be submitted at the next scheduled QA meeting, 2/15. The resident's care plan shall reflect the use of alarms. Addendum-L 039 Falls/Alarms .2208(E) Safety All residents receive a "Fall Risk Assessment" upon admission to identify potential residents that may be affected by this deficient practice. This form is reassessed quarterly and after a fall. The resident will be noted at the next care plan meeting as a "fall risk" and any new approaches noted. If a resident is deemed a "fall risk", a leaf decal is placed by their nametag at their room door to denote a potential for falls. An IDT (interdisciplinary	12/3/14

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L 039	Continued From page 2 position to a standing position, then assisting her to ambulate with a walker to the sink. The bed alarm did not activate when Resident #5 moved or stood up from the bed. Interview with the OTA on 11/12/14 at 5:07 PM revealed she had not turned off the alarm when she entered the room and since it did not sound when Resident #5 was transferred, the alarm had not been turned on. Interview with NA #6 on 11/12/13 at 5:10 PM revealed she had been in to check on Resident #5 since starting her second shift, however, did not check to see if the bed alarm was turned on. She further stated that it was the responsibility for the staff who put Resident #5 to bed, to ensure the alarm was turned on. Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), together on 11/13/14 at 11:35 AM, revealed the bed alarm was to alert staff of Resident #5 attempting to get up from bed. The alarm was placed in use on 10/28/14 per DON. Although the alarm was not added to the care plan, nurses and nurse aides report off to each other to assure each staff are up to date with the latest condition and needs of each resident. The DON stated that nurses and nurse aide were to make rounds to assure interventions were in place and that everyone was responsible to check that Resident #5's alarm was turned on. 2. Resident #2 was admitted to the facility on 12/10/13 with diagnoses including atrial fibrillation, confusion, cerebral vascular accident, difficulty walking, muscle weakness, uncontrolled hypertension, depressive disorder and anxiety.	L 039	team) meeting will be held each week to address falls. This meeting will be termed the "Fall Meeting." When a resident falls and orders are written to observe the resident, or to send them to the hospital for evaluation, the DON or ADON will daily check the pink copy of the physicians order form to stay updated on falls. The "Fall Meetings" began on December 16, 2014. The plan of care for resident #2, #5, and other residents include the bed in low position, a functioning fall mat/personal alarm. The alarms are checked on and charted on each shift by the charge nurse and the resident's CNA. The nurse will initial the TAR stating that the alarm is in working order and turned "on". This initialing of the Flow sheet and TAR started on 12/4/14. The monitoring of the alarms will continue indefinitely. New interventions for resident #5 include working with PT/OT and having pharmacy consultant review chart for meds that pose a potential fall risk. Resident #2 is not on medication and is a Hospice patient and not eligible for PT or OT. We will increase the 1:1 care. All falls are noted in incident reports. These reports are investigated by the DON, discussed at QA meeting & signed by DON, Administrator and Medical Director. Staff Development RN held inservices for nurses and CNAs on 12/12/14. Sign in sheets recorded those attending. If staff was unable to attend inservices within 3 days, they were instructed via telephone on alarm usage. The CNAs were advised to report if an alarm	

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L 039	Continued From page 3 The Resident-Data Collection tool dated 12/10/13 noted she required one person assistance with transfers and could ambulate with a device (unspecified) and had cognitive impairment. She was identified by the facility as being cognitively impaired. A plan of care was originally developed on 12/31/13 for being at risk for falls with a goal to have no falls over the next 90 days. Interventions included physical therapy as ordered, walker with assistance and gait belt while ambulating. Review of the Medication Administration Records (MARs) revealed the use of a bed alarm and floor alarm had been in place since 01/30/14 and nursing staff were initialing the MARs indicating both were in place on all shifts. The fall care plan was updated 03/25/14 noting there were no falls since admission and no changes were made to the interventions, including the addition of the bed alarm and floor alarm. The medical record indicated that care plan meetings were held on 04/10/14, 06/24/14 and 09/09/14, however, no changes were written on the care plan indicating it was reviewed or updated and the use of a bed alarm or floor alarm was not listed as an intervention. Nursing notes dated 10/07/14 at 7:00 AM revealed Resident #2 was found on the floor at the end of the bed with her back against her recliner. No injuries were noted and neurochecks were started. The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were interviewed together on 11/13/14 at 11:56 AM and revealed that a floor alarm was already in place at the time of this fall. Neither could say if a bed alarm was also in place or if either were sounding.	L 039	was not functional to notify the charge nurse. An account of the inservices will be submitted a the next scheduled QA meeting on 2/15/15. The resident's care plan will reflect the use of alarms.	12/16/14

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L 039	Continued From page 4 Nursing notes dated 10/16/14 at 9:00 PM the resident's sitter had taken the Resident #2 to her room and reported that the resident stood up and then sat on the floor. She sustained no apparent injury and was given medication for extreme agitation and combativeness. On 11/13/14 at 11:56 AM, the DON and ADON were interviewed together and stated that this fall was witnessed and she was with the sitter so no additional interventions were considered necessary. Nursing notes dated 10/28/14 at 6:45 AM revealed Resident #2 was discovered sitting on the floor with her back against the easy chair. She stated she wanted to get up for the day and did not ask for assistance. She sustained no apparent injuries and neurochecks were started. On 11/13/14 at 11:56 AM, the DON and ADON were interviewed together and stated that they did not know if a bed alarm or floor alarm had sounded at the time of this fall. An interview was conducted on 11/13/14 at 1:06 PM with Nurse #2 who wrote this nursing note. She stated the fall occurred around shift change and she thought the floor alarm was sounding but that she did not hear it herself. On 11/13/14 at 11:56 AM, the DON and ADON were interviewed together. The ADON stated she would not have thought it necessary to document if an alarm was sounding at the time of a fall. The DON stated that short of having a full time sitter, there was nothing else the facility believed they could provide for Resident #2 to prevent further falls. The DON reviewed the medical record and stated the bed alarm and floor alarm were placed at the time of admission for Resident #2. The DON and ADON stated they met and discussed each fall and also discussed it with family. The DON then stated that Resident #2's	L 039		

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L 039	Continued From page 5 bed alarm was not working so she thought it was removed. The DON stated that due to the resident's low body weight, it did not always sound when she moved in bed. The DON was unable to provide any documentation supporting the bed alarm did not function correctly due to the resident's low body weight or provide any verbal information as to when the bed alarm was removed from use for Resident #2. Neither the DON or the ADON could state any specific information that their investigations found after each fall, no documentation was provided and neither could provide any evidence that alternative interventions were discussed or tried in the attempt to prevent further falls occurring for Resident #2. Resident #2 was observed in bed on 11/12/14 at 10:45 AM. A floor alarm mat was in place and observed working, however, no bed alarm was noted in place. She was positioned on an air mattress. Resident #2 was observed in bed without a bed alarm but the floor mat was in use on 11/12/14 at 2:35 PM and 3:47 PM. On 11/12/14 at 3:55 PM Nurse Aide (NA) #3, who was caring for Resident #2 stated she was unaware of any bed alarm used for this resident. At this time, NA #2 was observed assisting Resident #2 ambulate to the bathroom with a slow shuffling gait to the bathroom using a rolling walker and hands on assist. On 11/13/14 at 8:43 AM, Resident #2 was observed in bed with no bed alarm but with the floor mat alarm in place. At 8:45 AM NA #4 stated she did not recall anything but a floor mat alarm being used for Resident #2.	L 039		

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L 039	Continued From page 6 On 11/13/14 at 9:30 AM, NA #5 stated that the only alarm used for Resident $2 was a floor mat alarm. During the interview held with the DON and ADON on 11/13/14 at 11:56 AM, staff were unable to provide any information that alternatives to interventions were discussed and/or attempted after Resident #2 experienced 3 falls in October 2014. On 11/13/14 at 1:05 PM, Nurse #1 stated that she signed off the MAR that there was a bed alarm and floor alarm , however, stated Resident currently only has a floor alarm. Nurse #1 stated that Resident #2 received a new mattress a few weeks ago and thought the bed alarm was removed then.	L 039		
L 064	.2301(D) PATIENT ASSESSMENT AND CARE PLANNING 10A-13D.2301 (d) The facility shall review comprehensive assessments and plans of care no less frequently than once every 90 days and make necessary revisions to ensure accuracy. This Rule is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to update care plans for 4 of 9 sampled residents after changes to interventions were made by the facility. (Residents #1, #2, #4, and #5). The findings included: 1. Resident #2 was admitted to the facility on 12/10/13 with diagnoses including atrial	L 064	L 064 Patient Assessment and Care Care plans will be reviewed every 90 days by the IDT (interdisciplinary team) and revisions will be made to allow the staff has access to the current care plan to ensure the resident's needs are met. The facility's new computer system, when implemented has a care plan program that will stream line the care planning process. When a resident has a fall, hospitalization or other significant change, the care plan will be updated at the next care planning session, and not wait until the next quarterly scheduled care planning session for that particular resident.	12/03/14

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L 064	Continued From page 7 fibrillation, confusion, cerebral vascular accident, difficulty walking, muscle weakness, uncontrolled hypertension, depressive disorder and anxiety. The Resident-Data Collection tool dated 12/10/13 noted she required one person assistance with transfers, could ambulate with a device (unspecified) and had cognitive impairment. She was identified by the facility as being cognitively impaired. Her initial plans of care dated 12/31/13 included: a. Risk for falls but having no falls. The goal was to have no falls in the next 90 days. b. Potential for bleeding and bruising due to Coumadin (an anticoagulant medication). The goal was to for her PT/INR to be in the range of 2-3 for the next 3 months. Both of these care plans were noted as reviewed and continued without changes on 03/25/14. Care plan meetings were documented as being held on 04/10/14, 06/24/14 and 09/09/14. The care plans were not updated or changed in any manner at since 03/25/14. Review of the medical record revealed Resident #2 was admitted under Hospice services on 04/10/14 which was not reflected on any care plan. Resident #2's Coumadin was discontinued on 06/24/14. No changes were made to this care plan. Nursing notes revealed Resident #2 fell on 10/07/14, 10/16/14 and 10/28/14. There was no change to the fall care plan which also did not include the use of a fall mat alarm or personal alarm. On 11/12/14 at 2:35 PM, at 3:47 PM and 3:55 PM, Resident #2 was observed in a low bed with a floor mat alarm in place but no bed alarm. The	L 064	Addendum L064 .0230 (D) Patient Assessment and Care Planning All residents have the potential to be affected by this deficient practice. Resident #2. Care plans were brought up to date. Resident is on Hospice care as evidenced by the care plan. Resident's anti-coagulant medicine was discontinued. She is no longer at risk for bruising or bleeding. Resident uses a fall mat & personal alarm. CNA and medicine nurse both check and chart that the alarm is in place, in working order, and turned to "on" position. The care plans are reviewed by the IDT every 90 days. Resident was placed on "Fall Meeting Schedule" for weekly meetings with IDT. Resident #5. Care plans were brought up to date. Resident is noted as a fall risk & the problem is care planned. She is to use a walker at all times to ambulate. She has a "falling leaf" placed by her name tag at her room door to denote to staff that she has a potential for falls. Resident has a bed alarm that is in working order. The CNA's and med nurse check and document every shift that the alarm is on the bed and functional. Resident #1. Alteration in skin integrity R/T reddened area on coccyx. Any areas will be measured weekly and placed on "Skin Care Documentation Form" and if the area of skin breaks open, it will then be documented on the "Wound/Skin Record" form.	

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L 064	Continued From page 8 floor alarm remained in place and no bed alarm was observed while Resident #2 was in bed when observed on 11/13/14 at 8:43 AM. Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) together on 11/13/14 at 11:56 AM revealed the care plans were reviewed Quarterly. The DON stated the bed alarm was placed on the bed the day of admission but she could not say when the bed alarm was removed. The ADON referred to her personal notes indicating that staff were aware of the falls and need for alarms, Hospice admission and discontinuation of Coumadin. ADON stated these changes were verbally shared with staff but she had not updated the written plans of care since 03/25/14. 2. Resident #5 was admitted to the facility on 12/10/13 with diagnoses including dementia, Alzheimer's Disease with delusions, hypertension, osteoporosis and pelvic inflammatory disease. The Resident-Data Collection tool dated 12/10/13 noted she was disoriented, exhibited dementia and was independent with transfers and ambulation. When the original care plans were developed on 12/31/13, there was no care plan relative to falls. Nursing notes dated 10/19/14, 10/20/14, and 10/21/14 revealed Resident #5 started having an unsteady gait. The physician ordered physical therapy on 10/23/14 and occupational therapy on 10/24/14. Nursing notes dated 10/27/14 at 5:00 PM, Resident #5 was found lying on the floor by the bed. She was sent to the hospital who reported to the nursing staff on 10/28/14 at 1:30	L 064	Resident will be repositioned frequently and kept off the area of redness. Protein intake will be increased to aid in healing. Observe for increased redness, open areas, drainage. Apply treatment as ordered. Weekly meetings will be held to address all wounds. IDT will attend these meetings. They will be called "Pressure Ulcer Meetings". This was implemented 12/16/14 Resident #4 Care Plan brought up to date. Alteration in air exchange R/T asthma. Resident will have no dyspnea & able to do ADL's for the next 90 days. Approaches to reach goal of no dyspnea include pacing activity with rest, inhalers, meds & treatment as ordered, observe for dyspnea and check respiratory status and check O2 stats as needed. Fall Risk: resident will not have a fall next 90 days. A falling leaf will be placed near her room door to denote a fall risk. A weekly meeting with IDT for "Fall Meeting Schedule". Resident should have an uncluttered room. Resident will ambulate with a walker at all times. Aleration in comfort R/T pain. Resident will have minimal or no pain. Approaches to have minimal or no pain include medications as ordered, assess pain on 1-10 scale and monitor effects of pain meds. When a resident is care planned, the cumulative diagnosis sheet will be checked for all diagnosis and problems. When a resident has a fall, hospitalization or acute episode, the care plan will be updated at the next meeting.	12/16/14

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L 064	Continued From page 9 AM she fractured her pelvis and had a urinary tract infection. The nursing note dated 10/28/14 at 1:30 AM revealed Resident #5 would need a walker at all times. The care plan was not updated to reflect the change in Resident #5's ambulatory status, need for therapies or her having a fall history. On 11/12/14 at 2:33 PM Resident #5 was observed awake in bed with a pressure alarm in the bed that was turned off. The alarm remained off while Resident #5 was in bed when observed on 11/12/14 at 3:18 PM and at 4:51 PM. Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) together on 11/13/14 at 11:35 AM revealed the care plans were reviewed quarterly. The ADON referred to her personal notes indicating that staff were aware of the falls, and that an alarm in bed was initiated, along with a low bed to prevent further falls. ADON stated these changes were verbally shared with staff but she had not updated the written plans of care since 03/25/14. 3. Resident #1 was admitted to the facility on 06/29/07. Resident #1's diagnoses included but were not limited to high blood pressure, history of colon polyps, high cholesterol, dementia, depression, and short term memory loss. Resident #1's care plan was updated on 01/07/14 indicated the resident had needs of self-care deficit related to dementia, goals listed was to have needs met; spiritual, emotional, and physical; approaches included the following: 1) activities of daily living (ADLs) done by staff, 2) meds given by staff, 3) diet as ordered, 4) meals in main dining room for socialization, 5) monthly	L 064	ADON who is responsible for care plans was inserviced by DON on 12/3/14 on keeping care plans up to date and need to expound on needs, goals, & approaches to care plans. ADON or other RN on 7-3 shift will update care plan if revisions are necessary or if a care needs to be changed. The IDT will decide if revisions need to be made on care plans.	12/3/14

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(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) COMPLETE DATE
L 064	Continued From page 10 weights, 6) take to activities as tolerated, and 7) toilet and assist with peri-care as needed. Review of Resident #1's medical record revealed a document titled "care plans sign-in sheet." The sheet had dates listed of 07/08/14 and 10/07/14 with staff signatures written by each date which indicated the staff person that had attended the care plan meeting. Care plan needs, goals, approaches, and/or interventions did not address that ADL care was needed for this resident or that the resident had a pressure sore to the coccyx area. The care plan did not identify specifics related to ADL care or reflect the care required for pressure sores. Further review of Resident #1's medical record revealed the following nurse's entries: · 09/28/14 reddened area 4x4 cm noted to coccyx · 09/29/14 resident's skin fragile and reddened area to coccyx treated per orders · 10/06/14 reddened area to coccyx, barrier cream applied · 10/27/14 resident's skin condition is clean, dry, and fragile · 11/10/14 resident's skin warm and dry with reddened area on coccyx, barrier cream applied Interview with the Assistant Director of Nursing (ADON) on 11/13/14 at 11:43 AM revealed she was responsible for the care plans. She indicated	L 064		

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L 064	Continued From page 11 the care plans are updated on an "as need to basis" and the information was communicated to the staff through a meeting each morning and in the change of shift reports. She further revealed the care plan team meets every 3 months which includes herself, the Director of Nursing (DON), and the Physician. She stated the care plans should reflect the specific care needed and/or required for each individual resident. She further stated she was aware the care plans were not specific to the resident, were not individualized, and that she had not had a chance to individualize the care plans. Interview with the Director of Nursing (DON) on 11/13/14 at 11:43 AM, she stated her expectation was for the care plans to be specific and reflect the care that was to be provided to the resident. 4. Resident #4 was admitted to the facility on 09/09/14. Resident #4's diagnoses included but were not limited to high blood pressure, asthma, high cholesterol, physical decline, and history of falls. Resident #4's care plan dated on 09/30/14 indicated the resident had needs of self-care deficit related to diagnosis, goals listed was will have needs met; spiritual, emotional, physical, and nutritional; with approaches that included the following: 1) meds given by staff, 2) encourage activities, 3) orientation board in room, 4) main dining room meals x 2 meals/day, 5) bathed 2x week by staff, 6) beauty shop as needed, 7) Chaplin visits, as needed, and 8) reminder of appointments. Care plan needs, goals, and/or approaches did not address that the resident had a fall on	L 064		

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L 064	Continued From page 12 10/19/14, had breathing difficulties related to asthma, and/or had pain. The care plan did not identify specifics and/or interventions in the areas of falls, breathing problems, or pain. Resident #4's medical record was reviewed and revealed the following nurse's entries: · 10/19/14 resident found lying in floor on her left side · 10/20/14 resident complaining of pain extending up to lower occipital (eye) area of her head with nausea and dizziness · 10/22/14 resident complaining of pain and discomfort · 10/28/14 resident complaining of pain · 11/06/14 resident complaining of pain and wheezing very loudly · 11/08/14 resident complaining of difficulty breathing and pain Interview with the Assistant Director of Nursing (ADON) on 11/13/14 at 11:43 AM revealed she was responsible for the care plans. She indicated the care plans are updated on an "as need to basis" and the information was communicated to the staff through a meeting each morning and in the change of shift reports. She further revealed the care plan team meets every 3 months which includes herself, the Director of Nursing (DON), and the Physician. She stated the care plans should reflect the specific care needed and/or required for each individual resident. She further stated she was aware the care plans were not	L 064		

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L 064	Continued From page 13 specific to the resident, were not individualized, and that she had not had a chance to individualize the care plans. Interview with the Director of Nursing (DON) on 11/13/14 at 11:43 AM, she stated her expectation was for the care plans to be specific and reflect the care that was to be provided to the resident.	L 064		
L 080	.2305(E) QUALITY OF CARE 10A-13D.2305 (e) The facility shall ensure measures are taken to prevent the formation of pressure sores and to promote healing of existing pressure sores. The facility shall ensure that patients with limited mobility receive appropriate care to promote comfort and maintain skin integrity. This Rule is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to assess and track a pressure ulcer to ensure the prescribed treatment was effective for 1 of 2 residents sampled for pressure ulcers. (Resident #2). The findings included: Resident #2 was admitted to the facility on 12/10/13 with diagnoses including atrial fibrillation, confusion, cerebral vascular accident, difficulty walking, muscle weakness, uncontrolled hypertension, depressive disorder, and anxiety. The Resident-Data Collection tool dated 12/10/13 noted she required one person assistance with transfers and could ambulate with a device (unspecified) and had cognitive impairment. This	L 080		

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L 080	Continued From page 14 tool also indicated she had a stage II pressure ulcer on her coccyx. She was identified by the facility as being cognitively impaired. Review of the care plans revealed on 03/25/14 a care plan was developed for impaired skin integrity. The goal was for skin to heal in the next 3 months with interventions to provide treatment as ordered, complete laboratory testing as ordered, provide supplements as ordered, attempt frequent position changes, provide a gel overlay for mattress and provide a cushion for the wheelchair. The record reflected that care plan meetings were held on 04/10/14, 06/24/14 and 09/09/14, however, the skin integrity care plan never changed or was updated. Nursing notes revealed on 09/20/14 at 2:00 PM a blister was noted on the heel of Resident #2's right foot. Nursing notes dated 09/21/14 at 12:40 PM the blister on the right heel was treated with skin prep. The resident would not allow measurements of the blister but it was estimated to be 3 centimeters (cm) by 3 cm and purple in color. On 09/21/14 Hospice ordered the treatment of skin prep to the right heel area of hematoma twice a day and float her heels in bed as tolerated. Nursing notes described Resident #2's heel wound as follows: *09/27/14 at 3:00 PM (weekly note) blister on right heel of foot and skin prep was being applied; *09/30/14 at 5:00 PM right heel noted with small amount of cream colored drainage on dressing. Due to the resident's anxiety, it was difficult to visualize the heel but the note continued describing the area as approximately 2 cm in	L 080	L 080 Quality of Care Residents will have pressure ulcers documented and measured on a new screening tool entitled WOUND/SKIN RECORD until the area is healed. Staff will evaluate the area weekly and document the findings on the form. If the prescribed treatment shows no sign of improvement within 14 days, the treatment will be amended and/or changed. The nursing notes shall reflect the progress of the treatments to the area. One nurse will be responsible for the weekly measuring and recording on the WOUND/SKIN RECORD to insure quality and continuity of care. An IDT (interdisciplinary team) meeting will be held weekly and termed "Pressure Ulcer Meeting". Addendum L 080 2305(E) Quality of Care Upon admission, all residents are checked with a head to toe assessment to observe for any alteration in skin integrity. This would include bruising, skin tears, rashes, surgical incisions, and pressure ulcers. If any alteration in skin integrity is observed,	12/3/14

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L 080	Continued From page 15 diameter of dark eschar-type tissue noted under right heel. *10/04/14 at 2:00 PM (weekly note) erupted blister on right heel; *10/04/14 at 10:45 PM antibiotic ointment put on right heel. It was open and blood was coming through the socks and the resident refused any treatment. A new physician's order dated 10/05/14 discontinued the skin prep to the right heel area due to it no longer being a hematoma and started the new order to clean the wound with sea cleanse, pat dry and apply comfeel to the open wound every 7 days as as needed until heeled. Nursing notes continued with descriptions of the right heel as follows; *10/15/14 at 10:00 PM right heel is open. The spot looked a lot better; *10/21/14 at 1:30 PM area on heel had black eschar tissue over 75% of wound area and other 25% was red and raw. Tissue around heel was reddened up to area of lower ankle; *10/27/14 at 11:00 AM wound was less red and inflamed; *10/30/14 at 11:30 AM right heel with small amount of serous drainage in sock and dark purplish dry tissue across back of heel; *11/02/14 11:00 AM area on right heel has minimal drainage and open are has decreased in size. On 11/12/14 at 3:15 PM, Nurse #2 stated that Resident #2 refused to allow her to change her heel dressing this date and she would try again tomorrow. She further stated that the resident often resisted getting her heel dressing changed and once the dressing was in place, the resident usually removed it within a couple of hours via	L 080	it will be measured, charted, treated as ordered and observed until healed as cited by deficient practice. Resident #2. The area on the right heel was measured and results charted on the chart and a "Skin Care Documentation Form" and "Decubitis/Pressure Report." Hospice was notified of the right heel breakdown. Orders were received to float the heels and cleanse area with Sea Cleanse BID & PRN. Heel protectors are to be worn when out of bed. The area will be measured and charted weekly by treatment nurse until healed. (Resident is very resistant to care). All licensed nurses and CNA's were educated on decubitis pressure ulcer management and Decubitis/Pressure Ulcer Report by the Staff Development Nurse. This was completed on 12/9/14. The CNA's were also instructed to notify the licensed nurse of any changes in skin integrity.	12/9/14

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L 080	Continued From page 16 rubbing the dressing off. On 11/13/14 at 9:13 AM, Resident #2's right heel area was observed to be approximately 2 cm by 2 cm scabbed over with new pink skin around the wound area. Nurse #1 applied a new comfeel dressing after cleansing with sea cleanse. On 11/13/14 at 9:22 AM Nurse #1 who changed Resident #2's dressing this date stated the wound appeared smaller and improved since she changed it last week. She further stated the resident did not allow her to measure the area. When asked where the measurements would be she stated possible on the Medication Administration Record (MAR). The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were interviewed together on 11/13/14 at 12:35 PM. They stated nurses who provided medications were responsible for wound care. DON stated Resident#2's heel wound should be measured weekly per the policy at each dressing change to indicate the process of healing. Review of the policy Skin Care Protocol, revised 05/15/03 provided by the DON revealed for "Broken Area - Stage II" interventions included to measure the area, clean with wound cleanser, apply hydrocolloid dressing, change every 7 days and as needed until healed, check daily until healed, if no improvement notify physician, fill out decubitus documentation sheet and treatment sheet, and measure every Sunday 7-3 or 3-11 and write a progress note. For a Stage III, staff were to notify the physician and leave a note for the DON of any skin problems. The DON reviewed the medical record and confirmed there were no weekly measurements and descriptions recorded for Resident #2's heel other than that on 09/30/14.	L 080		

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L 080	Continued From page 17 On 11/13/14 the first entry was documented on the Decubitus/Pressure Ulcer Report for Resident #2 which indicated that she had a stage III to her right heel 1 cm by 1 cm in size dark eschar in color.	L 080		
L 135	.2605(A)(1) DRUG STORAGE AND DISPOSITION 10A-13D.2605 (1) All drugs shall be maintained under locked security except when under the direct physical supervision of a nurse or pharmacist. This Rule is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep the treatment cart locked and in a secured area for 1 of 1 treatment cart located on the BTU floor. The findings included: On 11/12/14 at 3:26 PM an observation was conducted of the treatment cart. It was located in an unlocked clean storage room on the BTU hall. The storage room was located on a resident hallway. The door to the storage room was open, and the room was unattended. Upon further review the treatment cart was observed to be unlocked. On 11/13/14 at 08:23 AM an observation was conducted that revealed the treatment cart was stored in an unsecured storage room on the BTU hall. The treatment cart was noted to be unlocked. On 11/13/14 at 08:57 AM an observation was conducted of the treatment cart. Again it was observed to be stored in the unlocked and	L 135	L 135 Drug Storage and Disposition Staff will be provided education by in-services by DON and/or designee regarding the storage of medication and treatment supplies. The clean workroom door is to remain closed at all times with no medications (liquids, creams, ointments, etc.) sitting on top of the cart. The charge nurse will have a key to the cart. An audit by the DON/designee will be initiated every day x 7 days, every other day x 7 days, and then once a month x 2 months to check staff compliance. If staff are not compliant, revisions will be added. An account of the in-service will be submitted a the next QA meeting 2/15.	12/3/14

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L 135	Continued From page 18 unattended clean storage room on the BTU hall. The door to the storage room was ajar and the treatment cart was observed to be unlocked. Nurse #1 entered the storage room and stated she had no knowledge of a key that would lock the treatment cart. On 11/13/14 at 09:55 AM an observation was conducted of the treatment cart. The cart remained unlocked and in an unsecured storage area on the BTU residential hall. The cart was observed to have a bottle of chlorhexidine mouth rinse, a bottle of Listerine mouth wash, and a jar of hydrocerine topical cream on top of the cart. Individual drawers in the cart were labeled with resident names and contained various creams and ointments used for treatment purposes. The drawers were revealed to be unlocked and accessible to whomever opened them. Medications observed in the unlocked drawers included, but were not limited to Nystop powder, lotrisone cream, Anusol HC cream, Nizoral shampoo, and antibiotic ointments. On 11/13/14 at 10:00 AM an interview was conducted with Nurse #1, who was the acting charge nurse for the BTU hall. She indicated it was her expectation that the door to the clean storage room should remain locked and the treatment cart should be locked with the medications removed from the top of the cart. She stated all of the nurses that worked on the hall provided treatments to the residents and had access to the cart. On 11/13/14 at 10:20 AM an interview was conducted with Nurse #2, who issued medications on the BTU hall. She acknowledged that nurses on both sides of the hall used the treatment cart that was stored in the clean storage area. She stated the cart contained resident treatment supplies including creams and ointments. Nurse #2 further revealed that she did	L 135	Addendum - L 135 .2605 (A)(1) Drug Storage & Disposition Failure to keep all drugs maintained under locked security can result in harm to residents. Med rooms or rooms where the treatment carts are kept should have doors closed at all times. Medication carts are to remain locked. The key to these carts are carried by the medicine nurse(s). There will be no medications - liquids, creams, ointments, etc. - sitting on top of the unattended med carts as cited by deficient practices. Staff will be provided education by inservices, by the Staff Development Coordinator regarding the storage of medications and treatment supplies. This inservice was concluded on 12/3/14. An audit by the Staff Development RN was initiated immediately and will continue every day x 7, then every other day x 7 days. Then once a month x 2 to check staff compliance. If staff are not compliant, revisions may be added as well as staff being disciplined. An account of the audit will be submitted to the next QA meeting on 2/15/15.	12/3/14

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L 135	Continued From page 19 not recall the door to the storage area or the treatment cart being locked. On 11/13/14 at 10:25 AM an interview was conducted with the Director of Nursing. She acknowledged it was her expectation that the door to the storage area and the treatment cart remained locked, and the top of the cart free of all medications and treatment supplies. She stated all of the nurses were aware of the need to keep the treatment cart and storage area locked, they just did not do it.	L 135		
L 166	.2701(O) PROVISION OF NUTRITION & DIETETIC SVCS 10A-13D.2701 (o) Food services shall comply with Rules Governing the Sanitation of Restaurants and Other Foodhandling Establishments (15A NCAC 18A .1300) as promulgated by the Commission for Public Health which are incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food under sanitary conditions. Copies of these Rules can be accessed online at http://www.deh.enr.state.nc.us/rules.htm. This Rule is not met as evidenced by: Based on observations and staff interviews, the facility failed to dispose of health shakes within 14 days of being thawed and failed to label, date and/or keep loaves of bread securely closed to prevent contamination in 1 of 3 food storage areas. The findings included:	L 166	L 166 Provision of Nutrition & Dietetic Svcs The Dietary Department will ensure that bread is properly received, labeled and stored by the following: 1. The Dietary Manager shall in-service the dietary department on proper procedure for receiving, labeling, and storage of bread. 2. The Dietary Manager or assistant or designated employee shall check and review bread daily X 3 months and 5 times a week thereafter. 3. The Dietary Manager shall educate the food vendor and receive signed understanding for proper delivery, labeling and storage of bread. 4. Bread monitoring shall be placed on the management checklist and remain on the checklist on a regular basis.	12/3/14

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L 166	Continued From page 20 1. On 11/12/14 at 11:28 AM, the BTU dining room area was inspected. Observations of the upper cabinet at this time revealed 6 loaves of bread as follows: *an opened loaf of whole wheat bread containing 8 slices. The open end of the plastic wrapper was loosely twisted closed and there was visible green mold approximately the size of a quarter on the sides of several slices of bread. There was no use or sell by date found on the package. *an opened loaf of white bread containing 6 slices, loosely twisted closed, with no use or sell by date on the package. *an opened loaf of white bread containing 4 slices, secured by a plastic tab with a sell by date of 11/01/14. *a full unopened loaf of raisin bread secured with a plastic tab with a sell by date of 11/08/14. *an opened loaf of raisin bread containing 5 slices, loosely twisted closed, with no use or sell by date on the package. *an opened loaf of raisin bread containing 2 slices, twisted and knotted closed with no use or sell by date. Interview and observations with the Dietary Manager (DM) on 11/12/14 at 12:12 PM revealed the bread was provided by the kitchen staff based on written request by the nursing staff as to what was needed. The bread was provided in order to make residents fresh toast upon request. Nursing staff was responsible for keeping the cabinets clean and the bread disposed of when out of date. DM also stated the bread was good for 14 days after the sell by date. She confirmed the sell by date was on the plastic tab that kept the bread closed tightly and if the tab was missing, there was no date to refer to. On 11/12/14 at 2:58 PM, Nurse Aide #1 stated	L 166	Addendum - L 166 Provision of Nutrition and Dietetic Services The Dietary Department will ensure that the bread and the nutritional shakes will be properly received, labeled and stored by the following: 1. All outdated items were discarded and the bread vendor was contacted, educated about delivery and receiving, with a signed agreement of understanding. 2. The Dietary Manager shall inservice the dietary department of the proper storage, rotation and disposal of health shakes and bread in the kitchen and nourishment rooms as follows: a. the bread vendor will deliver bread to facility with at least 7 day shelf life. b. the cook supervisor or available dietary aide shall check each loaf of bread and label with a use by sticker. c. the dietary manager or assistant dietary manager or cook supervisor will review the bread dates and storage procedures in the kitchen and nourishment rooms daily x 3 months and 5 times a week thereafter. d. the bread monitoring will be placed on the management checklist and remain on the checklist on a regular basis. The dietary manager, assistant dietary manager or cook supervisor will fill out checklist daily. e. all health shakes shall be dated by	

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BROOKS-HOWELL HOME	266 MERRIMON AVENUE ASHEVILLE, NC 28801

(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) COMPLETE DATE
L 166	Continued From page 21 that she determined if the bread was fresh by looking at the date. If no date was on the package, she would squeeze it for freshness and smell it. She stated they use the bread for toast. On 11/13/14 at 2:02 PM, the Director of Nursing stated staff should be using one loaf of bread before opening another, closely it tightly between uses and always checking the date before use. On 11/13/14 at 3:40 PM DM stated that the bread was delivered close to or at the sell by date and she would discuss this with the bread company to ensure bread was delivered in time to serve to residents before the sell by date. 2. On 11/12/14 at 11:28 AM, the BTU dining room area was inspected. Observations of the resident's refrigerator at this time revealed there were 3 of 26 health shakes cartons ready for use which were labeled as being removed from the freezer on 10/27/14 and labeled with a use by date of 11/09/14. Interview and observations with the Dietary Manager (DM) on 11/12/14 at 12:12 PM revealed the health shakes were out of date. DM further stated the refrigerator was checked for out dated items daily by dietary staff when it was restocked. She further stated the refrigerator was checked and restocked this date but these shakes were missed being noted as out of date and should have been disposed of. .	L 166	an available dietary aide with two dates: a thaw date and a use by date. f. the dietary manager or assistant dietary manager or cook supervisor will check the dates of the shakes in the kitchen and nourishment rooms daily x 3 months and 5 times a week thereafter. g. shake date marking shall be placed on the management checklist and remain on the checklist on a regular basis. The dietary manager or assistant dietary manager or cook supervisor will fill out the checklist daily. h. the dietary manager or assistant dietary manager will report all findings of monitoring checklists to the next quarterly QA meeting and future QA meetings	12/3/14