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BROOKS-HOWELL HOME	266 MERRIMON AVENUE ASHEVILLE, NC 28801

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L 000	INITIAL COMMENTS A complaint investigation survey was conducted from 2//28/22 through 3/2/22. Event ID# B6QS11. 4 of the 12 complaint allegations were substantiated resulting in deficiencies.	L 000		
L 057	.2211(E) PERSONNEL STANDARDS 10A-13D.2211 (e) The facility shall train all staff periodically in accordance with their job duties. This Rule is not met as evidenced by: Based on record review and interviews of facility staff and physician, the facility failed to provide the staff training for escalated verbal and physical behaviors to meet the needs of the dementia residents which resulted in the staff ' s inability to provide a procedure without restraint for 1 of 3 residents reviewed. Findings included: On 3/1/22 at 1:20 pm an interview by phone was conducted with Nurse #1. Nurse #1 stated that Resident #1 had a urinary tract infection (UTI) with increased behaviors and altered mental status (AMS). She stated that staff frequently were unable to redirect the resident during escalated behaviors and furniture would be thrown or knocked over. The behaviors had escalated with the UTI. She stated that the resident would be screaming for long periods. She stated that the facility only provided a 30-minute required annual dementia training that did not provide instruction on how to manage escalated physical and verbal behaviors. The training only provided how to attempt to redirect a	L 057		

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resident. She stated that staff were not trained to manage dementia residents when there was physical behaviors and escalation.

On 2/28/22 at 2:30 pm an interview was conducted with Nurse #2. Nurse #2 stated she had a certification in dementia care that required annual training, but she had not received additional training for the past 2 years. She stated that the facility provided a mandatory 30-minute dementia training on the basics that had not provided instruction on how to manage escalated verbal and physical behaviors.

On 3/2/22 at 12:40 pm an interview was conducted by phone with NA #2. NA #2 stated she was not provided instruction on how to manage Resident #1 ' s verbal and physical behaviors. "I would have to get help from the nurse and was unable to assist or care for the resident." NA #2 stated she had a short training on dementia care that did not help in this situation.

On 3/2/22 at 3:10 pm an interview was conducted with NA #1. NA #1 stated she had an annual internet-based dementia training which was limited to redirection. She stated that staff would resort to leaving the resident alone when escalated which limited ability to provide care and meet needs. She stated when Resident #1 was escalated during a treatment, staff was unsure how to manage the behavior which caused the resident to no longer trust staff.

On 2/28/22 at 2:40 pm an interview was conducted with the Director of Nursing (DON). She stated there was a 30-minute dementia training required each year by nursing staff which was accessed through an internet-based training.

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L 057	Continued From page 2 The training included residents with dementia and how to redirect them. The training did not include escalated verbal and physical behaviors. On 3/1/22 at 11:50 am an interview was conducted with the facility physician. The physician stated he had heard some nursing staff reply with less than effective communication to Resident #1 who was not cooperating. The physician stated the communication was not effective for a resident with dementia. He further stated that some of the staff needed dementia training to manage residents with behaviors.	L 057		
L 077	.2305(B) QUALITY OF CARE 10A.13D.2305 (b) Acute changes in the patient's physical, mental or psychosocial status shall be evaluated and reported to the physician or other persons legally authorized to perform medical acts. This Rule is not met as evidenced by: Based on record review and facility staff and physician interview, the facility failed to notify the physician of a resident ' s (Resident #1) escalated behavior and restraint for administration of medication for 1 of 1 resident reviewed. Findings included: A review of Resident #1 ' s nursing notes for the month of September 2021 did not reveal documentation that the physician was notified of acute behavior escalation and staff restraint of Resident #1 to administer an intramuscular	L 077		

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injection on 9/16/21.

On 2/28/22 at 2:30 pm an interview was conducted with Nurse #2. Nurse #2 stated she was present on 9/16/21 when staff had held Resident #1 during a period of escalated behavior to provide intramuscular antibiotic administration. The resident ' s physician was not notified of the incident.

On 3/1/22 at 1:20 pm an interview by phone was conducted with Nurse #1. Nurse #1 stated that Resident #1 had a urinary tract infection (UTI) with increased behaviors and altered mental status (AMS) on 9/16/21. The staff had held the resident during this period of escalated behavior to provide intramuscular antibiotic administration. The physician was not notified of the incident. The physician was aware of the resident ' s combative behavior.

On 3/1/22 at 11:50 am an interview was conducted with the facility physician. The physician stated he was not notified of an incident with Resident #1 where she was restrained to administer the intramuscular antibiotic he ordered for a UTI. The physician would have liked to have been notified of the escalated behavior.

On 3/2/22 at 2:10 pm an interview was conducted with the Administrator. The Administrator stated she had not informed the physician of the incident on 9/16/21 with Resident #1.

L 078 .2305(C) QUALITY OF CARE — L 078

10A-13D.2305 (c) The facility shall not utilize any chemical or physical restraints for the purpose of

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discipline or convenience, and that are not required to treat the patient's medical condition. An evaluation shall be done to ensure that the least restrictive means of restraint have been initiated on patients requiring restraints.

This Rule is not met as evidenced by:
Based on record review and interviews of facility staff and the physician, the facility failed to provide the resident (Resident #1) a restraint-free environment.

Findings included:

Resident #1 was admitted to the facility with the diagnosis of dementia.

Resident #1 had an undated care plan which documented activity of daily living deficit and required limited assistance and end-stage vascular dementia with increased periods of agitation, aggression, and combativeness.

Nurses Note dated 9/16/21 at 6:30 pm by Nurse #1 documented that Resident #1 had agitation and behaviors which continued to escalate with banging objects on the table and walls and screaming.

Statement written by Nurse #1 dated 9/19/21 documented she was assigned to Resident #1. On 9/16/21 at 7:45 pm Nurse #1 entered Resident #1 ' s room. There were 2 nursing assistants (NA) present. Resident #1 was sitting in her wheelchair cursing and throwing objects,

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including furniture. The resident was assisted to stand, and the NAs held the resident. The "NAs were tiring as the resident was moving and resisting." The resident was assisted to her bed for the second injection without difficulty. The resident was informed of the procedure and encouraged. The resident did not complain of pain or discomfort, she was angry.

On 3/1/22 at 1:20 pm an interview by phone was conducted with Nurse #1. Nurse #1 stated she was assigned to Resident #1 on 9/16/21 and administered the intramuscular (IM) antibiotic. She stated that the resident had a urinary tract infection (UTI) and had increased behaviors and altered mental status (AMS) for the past 3 days prior to the IM administration. She stated there were 2 required IM administrations of antibiotic and she requested assistance. There were 2 NAs and the nursing supervisor in the resident ' s room to assist. She stated that the resident was screaming the whole time the staff were in the room and during the IM administration. The supervisor could have directed Nurse #1 not to administer the IM injection now during escalated behavior. The resident had a UTI with AMS and it was critical that she received antibiotics. She stated that she was trained from prior employment how to restrain a resident without injury. She stated nursing staff were not trained to manage dementia residents when there was physical behaviors and escalation. She stated she had not received this type of dementia training as an employee at the facility. She stated she arrived at 7 pm and was assigned the resident ' s IM Rocephin to administer. The 2 NAs that were in the room during IM administration knew the resident well. " I administered 2 IM injections in the gluteus, once when the resident was standing and one while

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she was lying in the bed." The NAs assisted the resident to stand, and the first IM was administered. The resident screamed during the entire procedure. The resident was laid down in the bed to de-escalate her. This did not change her behavior. The resident was turned to her side, and I asked the NAs to stabilize the resident ' s arms with their palms, and the nursing supervisor was asked to stabilize the resident ' s legs with her palms. Use of palms was to prevent injury. The injection was done without difficulty. The resident was resistant. She stated that because she had an order and there was a concern for sepsis, she provided the IM injection at this time. The resident had not wanted to be held. "The hold was not forceful but was stabilized for 30 seconds. The resident was screaming and spitting the whole time. The physician was not advised, he knew the resident was combative."
Statement written by Nurse #2 dated 9/19/21 documented that she was familiar with Resident #1. She was asked by NA #1 to assist Nurse #1 provide an IM for Resident #1. The resident had been having escalated behaviors and started treatment for an urinary tract infection which was suspected to have had affected the behaviors. Upon entry to Resident #1 ' s room she was banging on the foldable chair and was trying to turn the chair over and was yelling at the NAs. The resident was assisted to stand by the 2 NAs for the first of two IM injections. The resident was assisted to the bed by the 2 NAs for the second IM injection. Resident #1 continued to curse at the NAs and staff but stopped yelling. The injections could have waited until the escalated behavior was decreased and having four staff in the room did not help the situation.

On 2/28/22 at 2:30 pm an interview was

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conducted with Nurse #2. Nurse #2 stated she was present on 9/16/21 with Resident #1 when the resident had a positive urine culture with increased behavior and required antibiotics. The physician ordered IM Rocephin (antibiotic). Nurse #3 stated she observed the assigned nurse had 2 nursing assistants help the resident to stand and provide the first of two IM injections of Rocephin. The resident did not state no or refuse by body language. The resident had escalated after the first injection and the resident was placed back in bed for comfort. The resident was turned to her side for the second injection. The resident cooperated when asked to stand and roll over in her bed. The resident was able to make her needs known. The resident received her second injection. The resident was known to have behaviors and bang on objects. The resident was at her base line before the injection but escalated after the first injection and was screaming. The NAs were supportive and explained each step before moving the resident. The assigned nurse (Nurse #1) explained the injection before it was provided. Nurse #2 stated she would have attempted to de-escalate the resident between injections but was not sure it was possible due to the altered mental status (AMS) the resident was experiencing. The resident needed the antibiotic to treat her UTI.

Statement dated 9/19/21 written by NA #2 documented she entered Resident #1 ' s room on 9/16/21 on evening shift. NA #2 heard the resident screaming and cursing from the hall. The resident was offered her dinner meal tray but refused. NA #2 returned to the room several times and the resident had not eaten. Upon return to the room the resident had thrown her food on the floor. The resident had physical and verbal behaviors. Nurse #2 assisted NA #2 with

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the resident. The resident had turned her furniture over onto the floor and was uncontrollable. I was asked to assist with an injection. NA #2 assisted another NA to help the resident stand and prepare her for an injection. After the injection the resident was assisted back to her bed and received the second injection. There were several staff in the room. The resident calmed down after the staff left her room.

On 3/2/22 at 12:40 pm an interview was conducted by phone with NA #2. NA #2 stated she was asked to assist with an injection for Resident #1. Nurse #1 instructed NA #2 to assist the resident to stand and hold her under the armpits for support. NA #2 stated she assisted the resident to stand and lowered her pants for an injection. The resident was screaming the entire time. NA #2 stated that the resident had escalated behavior earlier that day and had asked nursing to assist her with Resident #1 who was uncooperative. NA #2 stated Nurse #1 instructed her to assist Resident #1 to her bed and to roll her on her side for the second injection. The resident continued to scream. NA #2 stated she held the resident ' s hand so she could not interfere with the injection. NA #1 held the resident ' s other hand and Nurse #2 held the resident ' s legs during the injection.

On 3/2/22 at 3:10 pm an interview was conducted with NA #1. NA #1 stated she was present for the IM administration administered to Resident #1. She stated that she knew the resident very well. The resident was already escalated when Nurse #1 asked for help to provide an IM injection. The resident was resistant, and Nurse #1 should have waited until the resident calmed down. NA #1 stated she held the resident ' s hand. The resident was screaming for the entire

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administration, the whole time. The resident was scared. NA #1 stated she held the resident because Nurse #1 was afraid the resident might move during the injection. After the incident the resident became uncooperative, non-verbal with staff, and continuously angry. The resident did not trust the staff anymore.

On 2/28/22 at 2:40 pm an interview was conducted with the Director of Nursing (DON). She stated that the IM medication administration incident with Resident #1 was investigated and reported to DHHS as required. The nurse assigned (Nurse #1) was terminated. There was facility staff training for abuse and the investigation was presented to the quality assurance team, which met every month. There was no restraint training. The DON stated she was not aware that holding the resident still for a procedure was a form of restraint.

On 3/1/22 at 11:50 am an interview was conducted with the facility physician. The physician stated Resident #1 had a positive urine culture with UTI and antibiotics were ordered. He stated that he was not informed that there was an incident in 9/16/21 with Resident #1 where she was restrained to receive her IM antibiotic for the UTI. He stated that the had numerous communications with the family regarding their concerns and was very familiar with the resident. The resident was a poor historian. She had dementia who was anxious, frail and could be more sensitive than having actual reality.

On 3/2/22 at 2:10 pm an interview was conducted with the Administrator. She stated Resident #1 was held during IM administration of antibiotic due to an altered mental status. The resident was unable to make her needs known due to UTI

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L 078	Continued From page 10 which caused an altered mental status. The resident was experiencing escalated behaviors. She stated that the facility completed an investigation for abuse but was not aware that holding the resident to provide a treatment during escalated behavior was a form of restraint.	L 078		
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 interview the facility failed to label opened food items stored in 1 of 1 walk-in freezer and in 1 of 2 nourishment rooms, Cummings Health Unit nourishment room, and failed to discard opened/cooked food items stored in 1 of 1 walk-in refrigerator on the labeled discard date. This practice had the potential to affect foods served to residents. The findings included: 1. On 2/28/22 at 2:15 PM an observation of the	L 166		

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walk-in freezer was conducted with the dietary aide (DA #1). The observation revealed a tin foil package of opened beef tips with mushrooms. No label was present on this item.

During an interview with the DA #1 on 2/28/22 at 2:18 PM she stated the food items did not contain a label so she would discard them.

2. On 2/28/22 at 2:20 PM an observation of the walk-in refrigerator was conducted with the DA #1. The observation revealed items dated to be discarded on 02-27-2022 were observed. These items were pancakes, cherries, and chopped ham. Items were discarded by the DA #1.

During an interview with the DA #1 on 2/28/22 at 2:22 PM she stated the food items were not discarded on the written discard date like they should have been, and she discarded them.

3. On 2/28/22 at 2:26 PM an observation of the walk-in refrigerator was conducted with the DA #1. The observation revealed two bags of cooked scrambled eggs that had a label on it reading, prepared on 02-18-2022 and a discard date of 02-23-2022.

During an interview with the DA #1 on 2/28/22 at 2:27 PM she stated the food items were not discarded on the written discard date, so she discarded them.

4. On 2/28/22 at 4:35 PM an observation of the Cummings Health Unit (CHU) level 2 nourishment room revealed a loaf of cinnamon raisin bread that had one printed label with a date of 12-26-21. No other writing or labels located.

During an interview with the Dietary Manager on

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L 166	Continued From page 12 2/28/22 at 4:38 PM she stated the date was not correct. Raisin bread was discarded. On 02-28-2022 at 3:15 pm the Dietary Manager stated first, and second shifts were responsible for discarding food/beverages on the labeled discard dates. She stated she just had an in-service on 02-25-2022 related to how to label and date food/beverages upon taking the items	L 166		