

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

PRINTED: 01/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34A001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/27/2012
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NAME OF PROVIDER OR SUPPLIER BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 932 OLD US 70 HIGHWAY BLACK MOUNTAIN, NC 28711
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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) COMPLETION DATE
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interviews the facility failed to submit the 24-Hour Initial Report within twenty-four hours to the Health Care Personnel Registry (HCPR) for 2 of 3 reports of resident mistreatment (Resident #137 and #145) and failed to report the findings of the investigation in the 5-Day Working Report to the HCPR within 5 days of the allegation being reported for 1 of 3 reports of resident mistreatment (Resident #137).</p> <p>The findings are:</p> <p>1. Review of a 24-Hour Initial Report to the HCPR revealed an allegation of staff to resident abuse involving Resident #137 on 12/01/12. The report stated a nurse aide (NA) pushed Resident #137's wheel chair with her foot hard enough to turn him around. The report was signed by the Assistant Director of the facility on 12/06/12 and faxed to the HCPR on 12/06/12. The 5-Day working report was signed by the Assistant Director of the facility on 12/13/12 and faxed to the HCPR on 12/13/12.</p> <p>An interview was conducted with Resident Advocate (RA) #1 on 12/27/12 at 12:35 PM. RA</p>	F 226	<p>24 Hour and 5 Day reports of allegations of abuse, neglect, exploitation or a significant injury of unknown origin have been reported correctly within the time frame standards of Federal regulations and Health Care Personnel Registry (HCPR) for such events that have occurred since survey visit on 12/27/13.</p> <p>Any allegations of abuse, neglect, exploitation or significant injuries of unknown origin will be made to the Advocacy Department during working hours. After-hours and on weekends, allegations of abuse, neglect, exploitation or significant injury of unknown origin will be reported to the Senior Administrative Officer/Advocate on call and a voicemail notification by the Senior Administrative Officer of the report left on Advocacy Department phone.</p> <p>During business hours, Advocacy will <u>immediately</u> notify Administration of an allegation of abuse, neglect, exploitation or a significant injury of unknown origin. Administration will submit a 24 Hour notice to the HCPR by 5:00 p.m. on the day of the report. Notification means submission of the "Advocacy Report to Administration" form that is used to complete the 24 Hour notice to the HCPR.</p> <p>After-hour and weekend/holiday reports of abuse, neglect, exploitation or significant injury of unknown origin will be noted in the 8:30 a.m. management "Shift Report Meeting" on the next working day. A 24 Hour notice will be submitted to the HCPR by 5:00 p.m. on the day that the report was reviewed in the 8:30 a.m. "Shift Report Meeting" (participants of the 8:30am "Shift Report Meeting" will include, at a minimum, the Director/designee, Director of Nursing/designee, and the Senior Advocate/designee).</p> <p>Records will continue (on an ongoing basis) to be maintained by the Quality Assurance Director of reports received in the 8:30 a.m. "Shift Report meeting" (this initially started 11/26/12).</p> <p>Investigation of an allegation of abuse, neglect, exploitation or significant injury of unknown origin will be completed within 5 working days of the incident and a report of the findings presented to the Director/designee no later than 3:00pm on the 5th day.</p> <p>The Director/administration designee staff will submit the 5 Day report of the investigation to the HCPR by the close of business on the 5th working day following the initial report of the incident.</p>	1/20/13 1/20/13 1/20/13 1/20/13 1/20/13 1/2013

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

Richard L. Rhea

TITLE

Assistant Director

(X6) DATE
01/16/2013

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.

Original Signature Date: 1-14-2013



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F 226	<p>Continued From page 1</p> <p>#1 stated the abuse allegation involving Resident #137 was reported to her by a NA on 12/03/12 and she turned in her initial findings to the facility Director on 12/05/12. RA #1 further stated she turned in her summary report to the Program Director on 12/07/12. This information was utilized by Administrative staff for the completion of the 24-hour and 5 day reports to the HCPR. RA #1 confirmed she was late turning in her findings to Administrative staff because she had not completed all the staff interviews. The interview further revealed RA #1 did not substantiate the allegation based on her investigation.</p> <p>During an interview on 12/27/12 at 3:15 PM the Assistant Director stated several months ago the job of transmitting the 24-hour and 5 day reports to the HCPR was shifted to Administrative staff. The Assistant Director further stated when he signed off on the 24-hour and 5 day reports involving Resident #137 he realized there was a problem and Administrative staff had continued to revise the system for tracking the due dates for the 24- hour and 5 day reports to the HCPR. The Assistant Director confirmed he expected the 24-hour and 5 day reports to be reported to the HCPR per the facility policy.</p> <p>2. Review of a 24-Hour Initial Report to the HCPR revealed an allegation of staff to resident abuse involving Resident #145 on 12/16/12. The report stated an NA pulled Resident #145's right wrist up behind his back and with the assistance of a second NA pulled Resident #145 to the dayroom. The report was signed by the Assistant Director of the facility on 12/19/12 and faxed to the HCPR on 12/19/12.</p>	F 226	<p>As of 12/28/12, the Director/designee began daily monitoring of the status of all investigations on the "Administration Monitoring 24 Hour and 5 Day Report" form. A record of this review is being maintained by the Office Assistant responsible for Management investigation files. At any time monitoring identifies a problem, corrective action will be taken immediately.</p>	1/20/13
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F 226	<p>Continued From page 2</p> <p>An interview was conducted with RA #1 on 12/27/12 at 12:35 PM. RA #1 stated the abuse allegation involving Resident #145 on 12/16/12 was reported to her on 12/17/12 and she turned in her initial findings to the facility Director on 12/18/12. RA#1 further stated she did not substantiate the allegation based on her investigation.</p> <p>During an interview on 12/27/12 at 3:15 PM the Assistant Director stated several months ago the job of transmitting the 24-hour and 5 day reports to the HCPR was shifted to Administrative staff. The Assistant Director noted the Quality Assurance Nurse was the administrative staff member on call that weekend and came to the facility on 12/16/12 to take statements from all the staff working at the time of the incident. The interview revealed the initial findings from the RA were received on 12/18/12 and the 24-hour report was transmitted to the HCPR on 12/19/12. The Assistant Director further stated from a regulatory point of view the allegation should have been reported within 24 hours of the occurrence.</p>	F 226		
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