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 |
|---|---|---|---|
| | HAL011035 | A. BUILDING: _____ B. WING _____ | R 08/28/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BROOKDALE ASHEVILLE WALDEN RIDGE | 4 WALDEN RIDGE DRIVE ASHEVILLE, NC 28803 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey and follow-up survey on August 26, 2015 through August 28, 2015. | D 000 | See attached POC | |
| D 210 | 10A NCAC 13F .0604 (3) Personal Care And Other Staffing<br><br>10A NCAC 13F .0604 Personal Care And Other Staffing<br><br>(3) In addition to the staffing required for management and aide duties, there shall be sufficient personnel employed to perform housekeeping and food service duties.<br>(f) Information on required staffing shall be posted in the facility according to G.S. 131D-4.3(a)(5).<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to assure there was sufficient personnel employed to perform housekeeping and food service duties and resulted in direct care staff performing housekeeping on all three shifts and performing food service duties on first and second shift.<br><br>The findings are:<br><br>Confidential interview with 10 direct care staff during the survey revealed their duties in addition to providing direct resident care during first and second shift included:<br>-All resident laundry which included washing, drying, folding and storing personal clothing and bed linens.<br>-Immediately laundering any soiled bed linens.<br>-Laundering (wash, dry, and fold) table linens for | D 210 | | |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: DeRoth C Brooks RN — TITLE: Executive Director — (X6) DATE: 10/2/2015



POC approved 10/6/15

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| D 210 | Continued From page 1<br>all three meals.<br>-Setting the dining room tables with linens, flatware, pouring all beverages and serving plates to residents during the meals and clearing the table after the meals.<br>-Sweeping the dining room and cleaning the tables after each meal.<br>-Cleaning 2 resident rooms each shift.<br>-Preparing snack carts by placing snacks on plates, preparing beverages and serving snacks to residents in the morning, afternoon, and evening.<br>-Conducting 15 minutes of activity each shift.<br><br>Confidential interview with 10 direct care staff during the survey revealed:<br>-Management staff are not routinely scheduled to provide direct care duties or medication administration duties.<br>-"Almost the whole shift" is spent with duties other than direct resident care.<br>-If staff did not have to do laundry, housekeeping, and dining services, more time could be spent with each resident with oral care, cleaning their glasses, matching their socks, matching clothes, and would not have to "hurry through" their care.<br>-All the residents have a diagnosis of Alzheimers/dementia and are very slow to move and slow to respond to directing which requires a lot of time.<br><br>Interview with the one housekeeping staff on 8/26/15 at 11:10am revealed:<br>-She is scheduled to work as housekeeper 5 days per week but often gets pulled to provide direct resident care when staff do not show up or there is no other direct care staff available to put on the schedule.<br>-She has all the qualifications required to work as a personal care aide. | D 210 | | |

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| D 210 | Continued From page 2<br>-In the past year, she worked more as direct care staff than as housekeeper.<br>-There were no other housekeeping staff other than herself ever scheduled to work.<br>-Direct care staff do housekeeping routinely, but have to do more when she is pulled away from housekeeping duties.<br><br>Review of time cards for the Housekeeper revealed from 6/2515 through 7/9/15 the housekeeper worked as a direct care staff, not a housekeeper, 7 days out of 11 days.<br><br>Interview with the two food service staff during the survey revealed:<br>-Each staff works for 3 and 1/2 days each week by themselves.<br>-The facility has one dietary staff daily from 7:00am until 7:00pm.<br>-Dietary staff prepare three meals and three snacks per day for the more than 30 residents (and staff who choose to eat a meal), clean the kitchen, store all food items which come in, and wash all flatware, dishes, pots, and pans.<br>-The facility does not hire dietary aides to assist the cooks or serve in the dining room.<br>-They could not possibly do any more tasks than they are currently doing during the designated work time.<br>-They have asked for more help especially when the food truck arrives and food must be stored as quickly as possible.<br><br>Review on 8/27/15 of the Resident Care Associate job description, dated April 2009, revealed essential functions included:<br>-Serve meals to residents in the dining room or apartments.<br>-May assist in preparing meals following preplanned menus. | D 210 | | |

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| D 210 | Continued From page 3<br>-Initiate and participate in leisure activities provided for residents as described in the activity calendar.<br>-Maintain a clean, safe and orderly environment for the residents. Perform general housekeeping; following cleaning schedules for resident laundry, bedrooms, dining area, living space, bathrooms, kitchen etc.<br>Interview with the Executive Director (ED) on 8/26/15 at 5:15pm revealed:<br>-Management included a Health and Wellness Director (HWD) who was designated as the Special Care Unit Coordinator and a Resident Care Coordinator (RCC).<br>-The RCC assisted staff on the floor when they asked for help.<br>-The RCC was not routinely scheduled for direct resident care.<br>-The RCC had worked as a medication aide when staff called out.<br>-The facility had an Activity Program Coordinator who also provided resident transportation.<br><br>Interview on 8/26/15 at 5:45pm with the Executive Director revealed:<br>-All of the staff are, by job description, "Universal Workers" which means they can all perform duties in dietary, laundry and housekeeping.<br>-There is one budgeted position in the dietary department.<br>-The RA's on the 7:00am-3:00pm and 3:00pm-11:00pm shifts had assigned dietary responsibilities which included wrapping silverware, serving drinks and food, clearing tables, scraping plates and serving snacks to their residents.<br>-There is one budgeted housekeeper position.<br>-The RA's on the 7:00am-3:00pm and 3:00pm-11:00pm shifts cleaned 2 rooms per day which involved cleaning the toilets, mopping the | D 210 | | |

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| D 210 | Continued From page 4<br>bathroom floors, vacuuming the carpets and assisting with activities.<br>-She had asked several day staff if deep cleaning 2 rooms per day until a housekeeper could be hired was workable and they had told her they felt it was.<br>-A deep cleaning schedule was posted in each laundry room.<br>-It had been difficult finding someone to fill the housekeeper position and the position was currently vacant.<br>-A Resident Assistant (RA) had been working (on and off) as the housekeeper.<br>-When the RA provided resident care, the housekeeping duties were divided among the three shifts.<br>-When the RA worked as the housekeeper, she did not do resident care.<br>-There was no budgeted position for a laundry person.<br>-The RA's were responsible for washing tablecloths, napkins, clothing protectors, the linen and clothing of the residents being showered that day and any linens soiled by incontinent episodes were to be washed immediately.<br><br>Review on 8/26/15 of a "Laundry Do's and Do Not's" posted in each laundry room revealed:<br>-Do resident sheets and laundry on their shower day.<br>-Wash one resident's laundry at a time.<br>-Laundry and linens were to be put away when clean.<br>-If the laundry was not free of odors, it was to be rewashed and dried separately.<br>-Make sure the washer and dryer are being used continually during the shift, as (we) have to keep up on (our) laundry.<br>-Wash tablecloths with ONLY tablecloths.<br>-Wash napkins with ONLY napkins. | D 210 | | |

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| D 210 | Continued From page 5<br>-Do not wash sheets and towels with clothing.<br>-Do not wash soiled linen or clothes (with urine, blood or feces) with other linen and clothes.<br><br>Observation of a facility direct care staff on 8/28/15 revealed:<br>-At 10:10am the staff was in the kitchen placing a tablecloth on a mobile cart, plating the snacks and getting beverages ready for resident snacks.<br>-At 10:35am, the staff was continuing to give snacks in the living room/activity room.<br><br>Random observations on 8/26/15 from 9:30am to 1:15pm during the survey revealed:<br>-Direct care staff in the laundry rooms doing laundry.<br>-Placing table linen on the dining room tables.<br>-Placing napkins and flatware on the tables.<br>-Pouring beverages for meals and bringing plated foods to table.<br>-Taking dirty dishes off dining room tables and taking them to dish area.<br>-Removing table linens and carrying them to the laundry areas.<br>-Folding resident clothes.<br><br>Review on 8/27/15 of the job description for the RCC revealed her duties included:<br>-Direct supervision, scheduling and education of resident care staff, medication management, safety and infection control and the quality improvement process.<br><br>Review of staff time cards from 7/24/15 through 7/31/15, from 8/8/15 through 8/9/15, and 8/15/15 through 8/16/15 revealed the facility usually did not have more than the required staffing (1 staff for 8 residents on first and second shift and 1 staff for 10 residents on third shift) for their census to perform housekeeping, laundry, and | D 210 | | |

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| D 210 | Continued From page 6<br>food service duties.<br><br>Interview with the Executive Director on 8/28/15 at 3:10pm revealed it was her understanding Resident Care Staff could do laundry, housekeeping, and some food service duties as described in the Resident Care Staff job description. | D 210 | | |
| D 270 | 10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observation, interview, and record review, the facility failed to assure staff provided supervision for 1 of 5 sampled residents (#3) in accordance with the resident's assessed needs and current symptoms of assaulting staff and residents.<br><br>The findings are:<br><br>Review of current FL2, dated 7/6/15, for Resident #3 revealed diagnoses which included:<br>-Major neurocognitive disorder with behavior disturbance and corresponding mood disorder (dementia).<br>-Insomnia<br>-Concern for urinary tract infection | D 270 | | |

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| D 270 | Continued From page 7<br>-Hypertension<br><br>Review of Resident Register revealed Resident #3 was admitted to the facility on 7/6/15.<br><br>Review of physician orders on the hospital discharge dated 7/29/15 included:<br>-Seroquel 37.5 mg twice per day. Seroquel is used to treat the symptoms of of schizophrenia, bipolar disorder and major depressive disorder.<br>-Seroquel 75 mg at bedtime.<br>-Seroquel 25 mg as needed every 4 hours for agitation.<br>-Multivitamin, 1 per day.<br>-Diltiazem 240 mg 1 daily. Diltiazem is used to treat high blood pressure, angina and certain heart rhythm disorders.<br>-Atorvastatin, 20 mg, 1 daily (a cholesterol-lowering medication).<br>-Acetaminophen 325 mg, 2 tablets every 4 hours for pain.<br><br>Review of physician orders, dated 8/7/15, revealed an order for Depakote 125 mg three times per day.<br><br>Confidential interview with 11 facility staff during the survey revealed:<br>-Resident #3 had pinched a particular staff at least six times.<br>-Resident #3 gets agitated when she is redirected and instructed.<br>-Resident #3 punched a staff in the stomach in the dining room when staff removed another residents food from Resident #3.<br>-Staff observed Resident #3 kick a sitter when the sitter tried to assist Resident #3.<br>-Resident #3 resists help with dressing.<br>-Resident #3 resists showers and it has taken three staff to give Resident #3 a shower. | D 270 | | |

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| D 270 | Continued From page 8<br>-Resident #3 will grab a resident at bottom of neck "and push them down."<br>-Resident #3 hit Resident #7 on "top of head two weeks ago."<br>-Staff thought Resident #3 was a risk to the safety of other residents.<br><br>Review of Resident Progress Notes, dated 7/18/15, revealed:<br>-Resident #3 was in another resident's room and staff could not redirect Resident #3.<br>-Resident #3 "destroyed (male) resident's room. She put on his clothing and underwear."<br>-Staff called 911 and Resident #3 was transported and admitted to the hospital on the morning of 7/19/15.<br>-Resident #3 returned to the facility from the hospital on 7/29/15.<br><br>Review of the hospital discharge information, dated 7/29/15, revealed: upon admission, "For the past week, she has been combative, assaultive, and destructive of property at her SNF [skilled nursing facility]...She warranted impatient geriatric admission for crisis stabilization of behavioral disturbance, aggression, and corresponding mood instability."<br><br>Review of Incident Report for Resident #3, dated 8/20/15, revealed:<br>-Resident #3 "came up behind another resident [#5] who was sitting in her wheel chair on C hallway and started pushing her into the wall with her hands on the back of her neck. Staff quickly redirected both residents. No injuries noted."<br>-Approximate time of incident 10:00am.<br><br>Review of Incident Report for Resident #5, dated 8/20/15, revealed "no injuries noted." | D 270 | | |

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| D 270 | Continued From page 9<br><br>Interview with Staff Q on 8/27/15 at 9:45am revealed:<br>-On the morning of 8/20/15 before the above incident occurred, the staff were in one of the activity rooms for "stand-up" meeting.<br>-Staff Q observed Resident #3 pushing Resident #5 down the hall in the wheel chair with Resident #3's hands on the wheel chair.<br>-After the stand-up meeting, Staff Q walked down to B hall and saw Resident #3 with one hand on Resident #5's neck pushing her into the wall on the end of the hall.<br>-Resident #3 said "Oh, I'm sorry."<br>-Resident #5 does not talk but seemed to be very afraid of Resident #3 afterwards because she "cowers" when Resident #3 approaches her.<br>-Staff Q said she thought Resident #3 would have killed Resident #5 if there had been no interventions.<br><br>Review of Resident Log revealed facility staff contacted Resident #3's physician on 8/20/15 (after the incident) and the Seroquel 75 mg was increased to 100 mg nightly and Depakote was ordered to be increased to 250 mg three times per day.<br><br>Review of Incident Report for Resident #3, dated 8/26/15, revealed:<br>-"Resident was pushing another resident in wheelchair...Another resident [#6, who was ambulatory] came up and told her not to push the resident. Somehow" Resident #3 and Resident #6 "started fighting and [Resident #3] gave other resident a double skin tear. [Resident #3] had no injury."<br>-Approximate time of incident was 1:30pm.<br><br>Review of Incident Report, dated 8/26/15, for Resident #6 revealed: | D 270 | | |

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| D 270 | Continued From page 10<br>-Injury without outside treatment and/or observation.<br>-Applied first aid to the right forearm.<br>-"...a physical altercation resulted in resident having double skin tear on right forearm."<br><br>Interview with Staff B on 8/28/15 at 9:55am revealed:<br>-On 8/26/15, before the above incident, Staff B was in the Living Room when she heard screaming on D hall.<br>-When Staff B went down D hall, she observed Resident #3 had both her hands on Resident #6's arms and was pushing Resident #6 against the wall.<br>-Resident #6 was screaming and "out of breath and couldn't say anything."<br>-Resident #3 did not say anything but had a "blunt" expression.<br><br>Review of Resident Log revealed facility staff contacted Resident #3's family on 8/26/15 and discussed having a companion sitter for Resident #3 during her awake hours.<br>Observation on 8/27/15 at 12:45pm of Resident #6 revealed:<br>-A white bandage wrapped around approximately 6 inches of the resident's right forearm.<br>-A skin tear, approximately 3 inches long was noted under the dressing on the resident's right forearm.<br>-The skin edges had been well approximated (brought together).<br>-Thin strips of tape had been applied to keep the skin edges aligned.<br>-A non-stick dressing had been used to cover the area.<br>-There was an area of dark brown drainage approximately 3cm in diameter noted on the non-stick dressing. | D 270 | | |

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| D 270 | Continued From page 11<br>-One-half to one inch of dark blue and reddish purple bruising was noted around the skin tear.<br><br>Interview with the Executive Director on 8/27/15 at 10:20am regarding Resident #3 revealed:<br>-The resident had been admitted to the facility on 7/6/15.<br>-Due to changes in behavior, she was sent to the hospital on 7/19/15 and returned to the facility on 7/29/15.<br>-Changes had been made to her medications and she seemed better for awhile.<br>-Before 8/20/15, a sitter had been with the resident from 4:00pm until 8:00pm.<br>-After 8/20/15, a sitter had been with the resident from 2:00pm until 10:00pm.<br>-There was a sitter in training "who will be ready" on Friday at 8:00am.<br>-"I, as much as it is disruptive to the individual, probably need to have (her) evaluated by an in-patient stay".<br>-She had told the staff to keep her in sight.<br>-"My plan, staff 1:1 with her, immediately".<br><br>Observation on Friday morning of 8/28/15 at 6:30am revealed:<br>-Resident #3 was awake standing in her room and no staff were visible on the halls.<br>-Resident #3's sitter was in the facility at 7:00am on 8/28/15.<br><br>Interview on 8/28/15 with the three third shift staff who had worked the night of 8/27/15 revealed:<br>-They had not been given any different instructions for caring for Resident #3 when they came to work at 11:00pm on 8/27/15.<br>-Resident #3 woke up about 6:30am.<br><br>Review of the facility Resident Log from 7/6/15 to 8/26/15 revealed 6 incidences where Resident #3 | D 270 | | |

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| BROOKDALE ASHEVILLE WALDEN RIDGE | 4 WALDEN RIDGE DRIVE ASHEVILLE, NC 28803 |

| (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 |
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| D 270 | Continued From page 12<br>was up during the night (from 11:00pm to 7:00am) and refused to go to bed.<br><br>Interview on 8/28/15 at 10:55am and 3:15pm with the Executive Director and the Health and Wellness Director (HWD) revealed:<br>-They had been on the telephone that morning with Resident #3's Power of Attorney.<br>-The Power of Attorney did not want Resident #3 sent out to the hospital for evaluation.<br>-The physician had been contacted and a plan had been put in place.<br>-The plan included medication changes, evaluation of the effectiveness of those changes and transportation to the hospital if she demonstrated signs of aggression toward other resident(s) and/or staff.<br><br>Telephone interview on 8/28/15 at 2:45pm with Resident #3's physician revealed:<br>-He had spoken by telephone with the facility HWD and received an update on the resident's behavior.<br>-He had been, "working closely with the facility staff trying to make the facility an appropriate placement for the resident, safe for her, the other residents and staff."<br>-He had ordered medication changes and asked for staff to monitor the resident for response to those changes.<br>-He would get an update from the staff on Monday (8/31/15.)<br>-He had instructed the HWD to send the resident to the hospital if there were any safety issues with the resident and other residents and/or staff.<br>-Depending on the response to the medication changes, a more supervised environment may be necessary. | D 270 | | |

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|---|---|---|---|
| | HAL011035 | A. BUILDING: _____ B. WING _____ | R 08/28/2015 |

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| D 270 | Continued From page 13<br><br>A Plan of Protection provided by the facility on August 28, 2015 revealed:<br>-The facility had communicated their current safety concerns for Resident #3 to the physician.<br>-Orders for medication changes had been received.<br>-Resident #3 would be transferred to the Emergency Room for evaluation of any incident(s) of aggressive behavior.<br>-The facility would provide one-on-one coverage for Resident #3 until a contracted sitter service could confirm 24 hour sitters.<br>-The physician would be updated on Resident #3's condition on August 31, 2015.<br><br>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 28, 2015. | D 270 | | |
| D 465 | 10A NCAC 13F .1308(a) Special Care Unit Staff<br><br>10A NCAC 13F .1308 Special Care Unit Staff<br>(a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to assure minimum | D 465 | | |

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| D 465 | Continued From page 14<br>staffing was present at all times on third shift.<br><br>The findings are:<br><br>Confidential interview with 8 facility staff revealed the facility only schedules one medication aide/supervisor and two direct care staff for third shift.<br><br>Observation of the facility on 8/28/15 revealed:<br>-The building surrounded an outside patio with the dining and kitchen in the back area and the management and a living room in the front area.<br>-An additional living room/activity room was located off the left main hall of the outside patio.<br>-An activity room was located off the right main hall of the outside patio.<br>-The 4 resident halls (A, B, C, and D) were off the four different corners of a H shaped building.<br>-The 4 resident halls extended from the main building and had to be assessed by turning a corner from the common hall areas.<br>-Staff can observe only one hall at a time when staff were in that particular hall, A, B, C, or D.<br>-The two living rooms, activity room, and main halls could not be observed if staff were on any of the resident room hallways.<br><br>Review of daily census for July and August, 2015 revealed:<br>-7/24 -7/27: census of 35 with occupancy of 32.<br>-7/28: census of 35 with occupancy of 31.<br>-7/29-7/31: census of 35 with occupancy of 32.<br>-8/8-8/9: census of 35 with occupancy of 34.<br>-8/15-8/16: census of 35 with occupancy of 33.<br>-8/26-8/28: census of 35 with occupancy of 34.<br><br>Review of time cards for 7/24/15 through 7/31/15 revealed one medication aide and two direct care staff worked third shift when the occupancy | D 465 | | |

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| D 465 | Continued From page 15<br>ranged from 31 to 32.<br><br>Review of time card for the week-end of 8/8/15 and 8/9/15 revealed one medication aide and two direct care staff worked third shift when the occupancy was 34.<br><br>Review of time card for the week-end of 8/15/15 and 8/16/15 revealed one medication aide and two direct care staff worked third shift when the occupancy was 33.<br><br>Review of the staff schedule for 8/24/15 and 8/25/15 for the survey revealed 3 staff on third shift for the occupancy of 34.<br><br>Confidential interview with five staff who had worked third shift revealed the third shift duties included:<br>-Making resident rounds every 2 hours.<br>-Sometimes rounds took so long it is time to start rounds again when one is completed.<br>-All the residents have a diagnosis of Alzheimers/dementia and are very slow to move and slow to respond to directing which requires a lot of time.<br><br>-Fifty percent of the 8 hours is spent on duties not related to resident care.<br>-Third shift duties include assuring table cloths on dining room table, emptying trash cans, resident laundry and linens, cleaning the outside patio and porch areas, cleaning and mopping the break room, laundry rooms, dining room, and vacuuming the living room and common areas.<br>-There are 4 resident halls and three staff.<br>-If staff are in the laundry room with door propped open, they sometimes cannot hear the residents.<br>-The facility has no laundry staff and the housekeeper is often pulled away from | D 465 | | |

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| D 465 | Continued From page 16<br>housekeeping leaving a lot of housekeeping duties other than laundry for the direct care staff on all shifts.<br>-Some residents require a three person assist if they have to do showers on third shift and from 7 to 10 residents always require a two person assist for transferring and toileting.<br>-Third shift does not have enough staff.<br>-They worry that if a fire were to occur, all 7 exit doors would automatically unlock and with the mental acuity of the residents and with 7 to 10 residents who required a two person assist, they could not monitor exits and evacuate safely.<br><br>Interview with the Executive Director on 8/28/15 at 3:10pm revealed:<br>-They had only been scheduling a total of three staff for third shift.<br>-They had not been scheduling for more than three staff because the census used to remain at 30 or below and three staff met third shift requirements.<br>-The census had "changed so quickly" and they had not had any staff who could cover third shift.<br>-The Health and Wellness Director comes in at 6:00am some mornings during the week-day but she is also considered the Special Care Unit Coordinator.<br>-They do not have documentation which shows the Health and Wellness Director (Special Care Unit Coordinator) works more than 40 hours per week. | D 465 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with | D912 | | |

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| D912 | Continued From page 17<br>relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision.<br><br>The findings are:<br><br>Based on observation, interview, and record review, the facility failed to assure staff provided supervision for 1 of 5 sampled residents (#3) in accordance with the resident's assessed needs and current symptoms of assaulting staff and other residents. [Refer to 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).] | D912 | | |

The following is the Plan of Correction for Clare Bridge of Asheville related to the DHHS Site Visit conducted **August 28, 2015** resulting in citations. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation of finding, nor have we identified mitigating factors.

## 10A NCAC 13F .0604 Personal Care and Staffing

- Resident Assistants will provide assistance to residents who need help eating, carrying plates, trays, and beverages as well as deliver meals to the residents at their tables.
- Dining Services staff will clean utensils, dishes and the kitchen as assigned.
- Hours will be reallocated to allow for a designated Dining Services associate to setup the Dining Room for all meals.
- Adjustments will also be made to allow for a designated Dining Services associate to clean the Dining Room after all meals.
- There will be a dedicated Housekeeper to perform routine housekeeping duties and to assist with daytime laundry needs. Resident Assistants will assist with housekeeping and laundry during the hours of 9pm to 7am hours. In doing so, these responsibilities will not hinder the care, sleep or lifestyle of the resident. Additionally, hours above the required hours of direct care between 7am and 9pm will be allocated to the performance of housekeeping and/or laundry tasks when needed. In doing so this will not hinder the care of the residents.
- Staff will receive re-training related to care, laundry, housekeeping and the allocation of applicable responsibilities.

**Date of Correction---October 28, 2015**

## 10A NCAC 13F .0901(b) Personal Care and Supervision

- Resident #3 was admitted to the hospital on August 29, 2015
- Resident was discharged on September 14, 2015 after Geri-Psych hospitalization due to no improvement in behavioral expressions
- Residents will be reviewed at bi-weekly Collaborative Care review meeting by ED (Executive Director), HWD (Health and Wellness Director), RCC (Resident Care Coordinator), applicable department heads and associates for aggression and behaviors which compromise the safety of residents and associates. In addition, behaviors and change in condition will be reviewed during twice daily stand up meetings and through daily review of 24 hour shift report and resident record reviews.by the Health and Wellness Director or designee.
- If such behaviors are determined, the ED, HWD, and RCC will collaborate with the resident's physician and family regarding assessment, immediate safety

interventions up to and including a private companion and appropriate placement based on needs.

- Associates will be re-trained on reporting responsibilities regarding change in condition and behavioral expressions and documentation of same, and redirection and interventions to implement when residents are demonstrating behavioral expressions.

**Date of correction—September 28, 2015**

## 10A NCAC 13F .1308(a) Special Care Unit Staffing

Staffing was increased effective August 28, 2015 during the 11pm to 7am hours by .8 hours of associate time for census exceeding 30 residents. The community will staff associates to meet or exceed staffing regulations and with additional staff based on needs and acuity of residents.

**Date of Correction—August 28, 2015**

## G.S. 131D-21(2) Declaration of Resident Rights

Residents will receive care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations.

**Date of Correction—August 28, 2015**

**Respectfully Submitted,**
**Dee Brooks, RN, Executive Director**

POC approved
10/6/15
[signature], RN