STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 09/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND RETIREMENT	**752 E CENTER AVENUE MOORESVILLE, NC 28115**

(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 000	INITIAL COMMENTS 483.13 (F 226) at J Immediate jeopardy began on 09/17/14 when therapy staff member #1 failed to report an allegation of physical abuse to the nursing home's administration. Immediate jeopardy was removed on 09/26/14 at 6:39 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee and resident education and ensure monitoring systems in place are effective. 483.25 (F 323) at J Immediate jeopardy began on 12/10/13 when Resident #9 punched Resident #34 and the facility failed to monitor interventions to prevent reoccurrences to protect Resident #34. Immediate jeopardy was removed on 09/26/14 at 6:39 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee and resident education and ensure monitoring systems in place are effective.	F 000		
F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		10/16/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/17/2014

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F 226	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, a facility staff member failed to report her knowledge of resident to resident physical abuse to the nursing home's administration for 1 of 2 residents with a history of being physically abusive (Resident #9). Immediate jeopardy began on 09/17/14 when therapy staff member #1 failed to report an allegation of physical abuse to the nursing home's administration. Immediate jeopardy was removed on 09/26/14 at 6:39 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee and resident education and ensure monitoring systems in place are effective. The findings included: A document titled, "Abuse and Neglect Prohibition" revised June 2013 read in part: Any observations or allegations of abuse, neglect or mistreatment must be immediately reported to the Administrator and/or Director of Nursing. 1. Resident #103 was admitted to the facility on 05/09/13 with diagnoses that included history of a cerebral vascular accident with right sided paralysis. The most recent Minimum Data Set (MDS) dated 06/25/14 specified the resident did not have impaired cognition. On 09/22/14 at 1:38 PM Resident #103 was interviewed and asked if he saw any resident	F 226	Criteria #1 Therapy staff member #1 was suspended by Rehabilitation Director on 9/23/14 for failing to report an allegation of abuse. Therapy staff member #1 was re-educated on 9/23/14 by Rehabilitation Director on mandated reporting of abuse and neglect prohibition including resident to resident altercation. Resident #109 and #103 were re-educated on 9/25/14 by the Social Services Director on reporting observations of alleged abuse, suspected abuse or rumors of abuse to any facility employee. Resident #109 and #103 verbalized understanding to the Director of Social Services of reporting allegations of abuse. Criteria #2 All current employees were interviewed by the Director of Nursing (DON), Assistant Director of Nursing (ADON), or Staff Development Coordinator (SDC) on 9/26/14 to verify reporting of all allegations of abuse. All allegations and reports received as a result of these staff interviews have been investigated by the Administrator or DON according to the facility's policy and procedure regarding Abuse and Neglect Prohibition. Interviews conducted by the SDC, ADON, and Social Worker on 9/25/14 and completed on 9/26/14. Criteria #3 Beginning on 9/25/14, all facility	

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F 226	Continued From page 2 being abused. Resident #103 replied, "Yes." Resident #103 explained that he had observed Resident #9 hit Resident #34 on two separate occasions. Resident #103 explained that he was unable to recall exact dates because he had difficulty remembering dates but that "about 6 months ago" he was in bed and Resident #34 was in his wheelchair parked in the doorway. Resident #9 approached Resident #34 and slapped him across the face, knocking his hat off. Resident #103 stated he yelled for Resident #34 to get inside the room and Resident #9 left. Resident #103 described a second incident he witnessed 2-3 months ago in which he was in the hallway and watched as Resident #9 hit Resident #34 with a closed fist. Resident #103 propelled his wheelchair closer to the residents which caused Resident #9 to stop hitting Resident #34. Resident #103 stated he did not report either incident to a staff member. He offered no explanation why he did not report the incidents but stated that therapy staff member #1 was aware that Resident #9 was abusive toward Resident #34 because they had discussed it. Resident #103 reported that Resident #9 hated Resident #34 and was repeatedly mean to Resident #34. Resident #103 was unaware if any staff members had observed the incidents. On 09/23/14 at 3:45 PM the Director of Nursing (DON) was interviewed and reported that she was unaware of allegations of abuse involving Resident #9 and Resident #34. Resident #103's observed incidents were reported to the DON and she stated she was unaware and had not received reports of alleged abuse between Resident #9 and Resident #34. She stated she would have expected Resident #103 to tell a staff member immediately of any allegations of abuse.	F 226	employees were re-educated by the ADON or SDC on the Facility Policy for Abuse and Neglect Prohibition and mandated reporting of allegations of resident abuse and neglect to the Administrator, DON or the employees immediate supervisor. This re-education will also include reporting resident to resident altercation, providing separation and a safe environment for both residents involved in the altercation while the investigation is completed and appropriate interventions are care planned and implemented. No facility employees shall work after 9/25/14 without receiving this re-education. Beginning on 9/25/14, all newly hired facility staff will be educated prior to beginning work in the resident care area by the ADON or SDC on the Facility Policy for Abuse and Neglect Prohibition and mandated reporting of allegations of resident abuse and neglect to the Administrator, DON, or the employees immediate supervisor. This re-education will also include reporting resident to resident altercation, providing separation and a safe environment for both residents involved in the altercation while the investigation is completed and appropriate interventions are care planned and implemented. Beginning on 9/25/14, new resident admissions into the facility will be educated by the Social Services Director (SSD), Social Services Assistant (SSA) or the Admissions Coordinator (AC) during the admission process, on the facility policy for Prohibition of Abuse including	

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F 226	Continued From page 3 2. On 09/23/14 at 2:52 PM therapy staff member #1 was interviewed and explained that she received regular training on prevention of abuse and neglect. She stated that she was trained to report any suspicion of abuse to her supervisor and/or Administrator. Therapy staff member #1 reported that on 09/17/14 she arrived for work and was greeted by Resident #9. Resident #9 reported to therapy staff member #1 that he had hit Resident #34. Therapy staff member #1 added that Resident #9 had a temper and was at times verbally abusive towards her and other staff members. Therapy staff member #1 stated she could tell when Resident #9 was getting mad and angry but that Resident #34 did not. She added that Resident #34 was unable to defend himself against Resident #9. Therapy staff member #1 admitted that she failed to report the allegation to the Director of Nursing or the Administrator because she didn't believe Resident #9 was telling the truth. On 09/23/14 at 3:45 PM the Director of Nursing (DON) was interviewed and reported she was unaware Resident #9 told therapy staff member #1 he had hit Resident #34. The DON stated she expected therapy staff member #1 to report the concern immediately to her or the Administrator. The DON added that the abuse policy did not allow staff the freedom to discern what was truthful; all allegations were to be reported. 3. Resident #109 was admitted to the facility on 08/30/13 with diagnoses that included cerebrovascular accident and hypertension. The most recent Minimum Data Set (MDS) dated 08/11/14 specified the resident had no impaired cognition. On 09/23/14 at 3:40 PM Resident	F 226	education on reporting observations of alleged abuse, suspected abuse or rumors of abuse to any facility employee. The Quality Assurance and Performance Improvement (QAPI) Committee met on 9/25/14 to discuss the findings identified by the surveyor and to review this action plan. DON, ADON, or Unit Manager will interview 10 staff members weekly for 12 weeks to verify reporting of all allegations of abuse and observed resident to resident altercations. SSD or SSA will interview 5 residents with BIMS higher than 10, weekly for 12 weeks to verify reporting of all allegations of abuse and observed resident to resident altercations. Administrator or DON will attend Resident Council monthly for 3 months to verify reporting allegations of abuse as well as review Resident Rights and Facility Policy on reporting Concerns and Issues, including reporting allegations of abuse and resident to resident altercations. Criteria #4 DON,SSD, and the Administrator will bring the findings of the interviews to QAPI Committee monthly for 3 months, at which time the QAPI Committee will determine if further interviews are needed.	

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#109 was interviewed and reported that 2 weeks ago he was peering outside his room and watched as Resident #9 slapped Resident #34. He explained that Resident #9 slapped Resident #34 a few times (defined as less that 5 times but more than 2 slaps). He explained that the incident occurred in the daytime but no staff were nearby to witness the incident. Resident #109 stated that he did not report the incident because he was concerned he would be blamed.

On 09/23/14 at 3:45 PM the Director of Nursing (DON) was interviewed and reported that she was unaware of a recent allegation of abuse involving Resident #9 and Resident #34. Resident #109's observed incident was reported to the DON and she stated she was unaware and had not received reports of alleged abuse between Resident #9 and Resident #34. She stated she would have expected Resident #109 to tell a staff member immediately of any allegations of abuse.

On 09/25/14 at 1:05 PM the Administrator was notified of immediate jeopardy for therapy staff member #1's failing to report allegations of physical abuse to the nursing home's administration so that appropriate investigation and follow up could be initiated. The facility provided an acceptable credible allegation of compliance on 09/26/14 at 4:56 PM. The following interventions were put into place to remove the immediate jeopardy.

Allegation of Compliance:

1. Therapy staff member #1 was suspended by Rehabilitation Director on 09/23/14 for failing to report an allegation of abuse.

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Therapy staff member #1 was re-educated on 09/23/14 by Rehabilitation Director on mandated reporting of abuse and neglect prohibition including resident to resident altercation.

Resident #109 and #103 were re-educated on 09/25/14 by the Social Services Director on reporting observations of alleged abuse, suspected abuse or rumors of abuse to any facility employee. Residents #109 and #103 verbalized understanding to the Director of Social Services of reporting allegations of abuse.

2. All current employees have been interviewed by the Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator on 09/26/14 to verify reporting of all allegations of abuse.

All allegations and reports received as a result of these staff interviews have been investigated by the Administrator or Director of Nursing according to the facility's policy and procedure regarding Abuse and Neglect Prohibition. Interviews conducted by the SDC, ADON and SW on 09/25/14 and completed on 09/26/14.

All residents with a BIMS greater than 10 have been interviewed by the Social Services Director, Social Services Assistant or the Administrator to verify reporting of all allegations of abuse and observed resident to resident altercations. These interviews were completed on 09/26/14. At the completion of the interviews the residents verbalized understanding to report allegations of abuse.

All allegations and reports received as a result of

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these resident interviews have been investigated by the Administrator or Director of Nursing according to the facility's policy and procedure regarding Abuse and Neglect Prohibition. Interviews conducted by the SDC, ADON and SW on 09/25/14 and completed on 09/26/14.

3. Beginning on 09/25/14 all facility employees will be re-educated by the Assistant Director of Nursing or Staff Development Coordinator on the Facility Policy for Abuse and Neglect Prohibition and mandated reporting of allegations of resident abuse and neglect to the Administrator, Director of Nursing or the employee's immediate supervisor. This re-education will also include reporting resident to resident altercation, providing separation and a safe environment for both residents involved in the altercation while the investigation is completed and appropriate interventions are care planned and implemented. No facility employee shall work after 09/25/14 without receiving this re-education.

Beginning on 09/25/14, all newly hired facility staff will be educated prior to beginning work in the resident care area by the Assistant Director of Nursing or Staff Development Coordinator on the Facility Policy for Abuse and Neglect Prohibition and mandated reporting of allegations of resident abuse and neglect to the Administrator, Director of Nursing or the employees immediate Supervisor. This re-education will also include reporting resident to resident altercation, providing separation and a safe environment for both residents involved in the altercation while the investigation is completed and appropriate interventions are care planned and implemented.

Beginning on 09/25/14, new resident admissions

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F 226	Continued From page 7 into the facility will be educated by the Social Services Director, Social Services Assistant or Admissions Coordinator during the admission process, on the facility policy for Prohibition of Abuse including education on reporting observations of alleged abuse, suspected abuse or rumors of abuse to any facility employee. The Quality Assurance and Performance Improvement Committee met on 9/25/14 to discuss the findings identified by the surveyor and to review this action plan. Immediate Jeopardy was removed on 09/26/14 at 6:39 PM when the facility provided evidence of additional training provided to residents and staff on the importance of reporting all observed, suspected and/or alleged allegations of abuse. Interviews with alert and oriented residents and staff revealed they were trained on when and whom to report allegations of abuse.	F 226		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review the facility failed to	F 323	Criteria #1 The Assistant Director of Nursing (ADON)	10/16/14

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F 323	Continued From page 8 monitor and implement interventions to protect one of one dependant resident (Resident #34) from other residents with physically violent behaviors. Immediate jeopardy began on 12/10/13 when Resident #9 punched Resident #34 and the facility failed to monitor interventions to prevent reoccurrences to protect Resident #34. Immediate jeopardy was removed on 09/26/14 at 6:39 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee and resident education and ensure monitoring systems in place are effective. The findings included: Resident #34 was admitted to the facility on 04/29/13 with diagnoses that included cerebral palsy, speech disturbance, muscle disuse atrophy, intellect disability, aphasia and others. Resident #34's care plan initiated on 05/22/13 and last updated on 08/12/14 for behavior symptoms specified the resident had loud laughter and grunting. Approaches specified on the care plan included: - give simple, clear directions, repeat as needed - check for pain and discomfort - modify environment, situations and or treatment to minimize external stressors Resident #34 had a communication care plan initiated on 06/13/13 related to the resident's	F 323	completed a head to toe nursing assessment of Resident #34 on 9/23/14 with no abnormal findings identified. On 9/25/14, the Social Services Director (SSD), initiated a referral to Psychiatric Services for evaluation of Residents #34, #113, and #9. The evaluations were completed on 9/26/14. On 9/26/14 the psychologist determined that Resident #9 was not a danger to himself or others and was not appropriate for inpatient psychiatric services. On 9/26/14 the psychologist assessed Resident #113 to be stable. On 9/26/14 the psychologist was unable to assess Resident #34 due to his impaired cognition. On 9/26/14 at 11:00am the Director of Nursing (DON) scheduled continuous One on One direct supervision for Resident #9, provided by facility staff following completion of Psychiatric evaluation and implementation of recommendations. The one on one supervision continued through 9/29/14 as the resident did not have any physical outbursts for three days. After one on one supervision, the resident was placed on 15 minute checks until his discharge. On 9/26/14, the facility has initiated discharge planning for Resident #9 to an Assisted Living Facility. Resident #34 was assessed by the physician on9/26/14 and determined that a lower level of care was appropriate. Resident #9 was discharged to an ALF on 10/3/14. All facility staff will be re-educated on 9/26/14 by the ADON or Staff Development Coordinator (SDC) regarding keeping Resident #34 and Resident #9 separated during waking	

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F 323	Continued From page 9 inability to communicate due to cognitive impairment. Interventions included: - staff to make eye contact when communicating for the resident to be able to read lips - staff will speak clearly and slowly - staff will use gestures to assist in communication Resident #34's most recent Minimum Data Set (MDS) dated 07/14/14 specified the resident had severely impaired cognition but no mood or behaviors exhibited. 1a. Resident #9 was admitted to the facility on 11/27/12 with diagnoses that included psychosis, depressive disorder, bipolar disorder, insomnia, dementia, and others. Resident #9's care plan for behaviors initiated 11/12/13, updated on 02/19/14, 05/12/14 and 08/01/14 specified the resident exhibited verbal abuse, physical abuse and resisted care at times. The care plan identified behaviors that included threatening to hit other residents and hitting other residents. Interventions specified in the care plan included: - ignore verbal outbursts - allow choices within individual's decision making abilities - redirect as needed - be alert for triggers of potential evidence of pending behavioral episodes Review of Resident #9's medical record revealed a nurse's entry made by nurse #1 dated 12/11/13 at 7:00 PM that read in part, on 12/10/13 at 6:00 PM Resident #9 struck Resident #34 in the head because Resident #34 would not sit down.	F 323	hours, in the event Resident #34 and Resident #9 are in the same location staff will provide supervision to monitor for escalating behaviors and intervene as appropriate. No facility staff member shall work after 9/26/14 without receiving this re-education. No other residents in the facility were identified as having physical abusive behaviors. Resident #113's care plan was updated on 9/25/14 to reflect his history of being physically abusive toward Resident #34. Resident #34 and Resident #9 have refused room changes. Resident #9 remains on one to one supervision. Criteria #2 The DON,ADON, Unit Manager (UM), and MDS Coordinator completed an audit of the most recent MDS, active care plan and current medication administration records to identify those residents who have the potential to exhibit verbally abusive, physically abusive, and socially inappropriate or disruptive behaviors. All staff have been educated on 9/26/14 by the DON, ADON, SDC to increase vigilance when residents identified as having abusive behaviors are in close proximity to dependent residents. Following the identification of these residents each will be assessed by the DON, ADON, or UM for episodes of Behaviors, Psychiatric Services, appropriate care planning and implementation of recommended interventions. This was completed on 9/26/14. All Incident Reports (IR)completed during the last 30 days were reviewed by the	

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F 323	Continued From page 10 Resident #9 told nurse #1, "I don't give a _____. I do what the ____ I want to do." The residents were separated; the doctor and the Director of Nursing were notified. A document titled "Incident/Accident Report" dated 12/10/13 was reviewed and specified new interventions to address the incident included separating the Resident #9 and #34, and moving Resident #9's room, Resident #9 was referred to physician for medication review and Resident #34 was assessed for injury and none noted. Further review of Resident #9's medical record revealed an entry made by the Psychologist dated 01/06/14, "Patient displays episodic irritability aggressiveness when frustrated. There was no evidence of bizarre mentation. Patient was switched to another room. 'The (former) Social Worker told me that if I messed up again I would be out of here.' Initially he declined sharing the reason for changing rooms however; he described 'I punched Resident #34.' Patient initially attempted to soften the incident however; he acknowledged that he lost control of his anger." Resident #9's most recent MDS dated 08/02/14 specified his cognition was intact, no mood indicators present, verbal behaviors directed at others 1 to 3 days and the resident received antianxiety and antidepressant medications daily. Nurse #1 was unavailable for an interview. The Psychologist was unavailable for an interview. On 09/23/14 at 4:08 PM Resident #9 was	F 323	DON to validate a complete investigation was conducted and recommended interventions were care planned and implemented. These audits and any required interventions were completed on 9/26/14. Staff were notified of the care plan updates and changes. Criteria #3 Following this review, the Administrator, DON or Manager on Duty will ensure interventions as care planned and implemented to provide for the safety of residents while an investigation is completed and implement further interventions as required. Nurse aides care grids will be updated with all new changes. Nurse aides are given care grids daily. The ADON and SDC will re-educate all Nursing Staff to observe residents for signs of escalating behavior and appropriate interventions for management, to include reporting these observations to the DON, ADON, or Unit Manager. No Nursing Staff member shall work after 9/26/24 without receiving this re-education. This action was completed on 9/26/14. The Quality Assessment and Performance Improvement (QAPI) Committee met on 9/26/14 to discuss the findings identified by the surveyor and to review this action plan. The Interdisciplinary Team (DON,ADON,SSD,MDS Coordinator, Dietary Manager) will meet weekly for 12 weeks to review all Incident Reports to ensure investigations are complete and	

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BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 323	Continued From page 11 interviewed with the Director of Nursing and Assistant Director of Nursing (ADON) present. Resident #9 admitted he hit Resident #34 with a closed fist "about a year ago." Resident #9 stated he could not recall hitting Resident #34 any other times but recalled other incidents in which he got angry with other residents but denied becoming physical. Resident #9 explained that he had problems with his anger but knew to remove himself from upsetting situations. On 09/25/14 at 10:00 AM the Director of Nursing (DON) was interviewed. She reported that nurse #1 notified her of the incident on 12/10/13. The DON explained that the following day on 12/11/13 she investigated the incident and implemented every 15 minute checks for Resident #9 for 2 days, notified the physician to review for medication changes and notified Resident #9's psychologist. She added that Resident #34 was assessed and showed no injuries. She reported that Resident #9's physical behaviors were better but that he still had difficulty with verbally abusive behaviors. The DON explained that Resident #9 was not alert and oriented and had poor cognition and memory. 1b. Resident #113 was admitted to the facility on 01/10/14 with diagnoses that included depressive disorder, cerebellar ataxia and others. The most recent Minimum Data Set (MDS) dated 07/08/14 specified the resident had no impaired cognition and no mood or behaviors exhibited. Review of Resident #113's care plan initially dated 01/30/14 revealed he had a care plan to address insomnia and withdrawal. Interventions included monitoring for signs of behaviors and notifying the physician.	F 323	care plans and care grids are updated accordingly. Residents exhibiting physically, verbally, socially inappropriate or disruptive behaviors as identified by documentation, observation, psychotropic medication adjustment, as well as residents receiving psychiatric services will be reviewed by the IDT Team weekly. Criteria #4 The IDT team will report findings from the weekly reviews to QAPI Committee for next 3 months at which time the QAPI Committee will determine if further reviews are needed.	

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Review of Resident #113's medical records revealed an entry dated 04/09/14 that specified he had slapped Resident #34 in the face.

A document titled "Incident/Accident Report" dated 04/09/14 specified that Resident #34 was in the hallway when Resident #113 approached him and slapped Resident #34 across the face. Neither resident was able to communicate the reason for the incident. The incident was witnessed by an alert and oriented resident and staff. The residents were immediately separated and Resident #113 was placed on every 15 minute checks.

On 09/25/14 at 10:00 AM the Director of Nursing (DON) was interviewed and reported that staff notified her of the incident involving Resident #113 and Resident #34. She stated that the incident was isolated and she was unable to determine what caused Resident #113 to slap Resident #34. She reported that neither resident was able to describe the incident. The DON provided evidence of immediate actions taken to prevent a reoccurrence that included changing Resident #113's room, referring to psychology and notifying the physician. The DON added that there had been no further incidents of physical violence between Resident #113 and Resident #34.

1c. Resident #103 was admitted to the facility on 05/09/13 with diagnoses that included history of a cerebral vascular accident with right sided paralysis and others. The most recent Minimum Data Set (MDS) dated 06/25/14 specified the resident did not have impaired cognition. On 09/22/14 at 1:38 PM Resident #103 was interviewed and asked if he saw any resident

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being abused. Resident #103 replied, "Yes." Resident #103 explained that he had observed Resident #9 hit Resident #34 on two separate occasions. He described both of the incidents. Resident #103 explained that he was unable to recall exact dates because he had difficulty remembering dates but that "about 6 months ago" he was in bed and Resident #34 was in his wheelchair parked the doorway. Resident #9 approached Resident #34 slapped him across the face, knocking his hat off. Resident #103 stated he yelled for Resident #34 to get inside the room but Resident #9 left. Resident #103 described a second incident he witnessed 2 to 3 months ago in which he was in the hallway and watched as Resident #9 started hitting Resident #34 with a closed fist. Resident #103 propelled his wheelchair closer to the residents which caused Resident #9 to stop hitting Resident #34. Resident #103 stated he did not report either incident to a staff member. He offered no explanation why he did not report the incidents but stated that therapy staff member #1 was aware that Resident #9 was abusive toward Resident #34 because they had discussed it.

On 09/23/14 at 2:52 PM therapy staff member #1 was interviewed and explained that she received regular training on prevention of abuse and neglect. She stated that she was trained to report any suspicion of abuse to her supervisor and/or Administrator. Therapy staff member #1 reported that on 09/17/14 she arrived for work and was greeted by Resident #9. Resident #9 reported to therapy staff member #1 that he had hit Resident #34. Therapy staff member #1 added that Resident #9 had a temper and was at times verbally abusive towards her and other staff members. Therapy staff member #1 stated she

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could tell when Resident #9 was getting mad and angry but that Resident #34 could not. She added that Resident #34 was unable to defend himself against Resident #9. Therapy staff member #1 admitted that she failed to report the allegation to the Director of Nursing or the Administrator because she didn't believe Resident #9 was telling the truth.

On 09/23/14 at 3:45 PM the Director of Nursing (DON) was interviewed and reported that she was unaware of allegations of abuse involving Resident #9 and Resident #34 since 12/10/13. Resident #103's observed incidents were reported to the DON and she stated she was unaware and had not received reports of alleged abuse between Resident #9 and Resident #34. She stated she would have expected Resident #103 to tell a staff member immediately of any allegations of abuse. During the interview the DON reported that she was unaware Resident #9 told therapy staff member #1 he had hit Resident #34. The DON stated she expected therapy staff member #1 to report the concern immediately to her or the Administrator. The DON added that the abuse policy did not allow staff the freedom to discern what was truthful; all allegations were to be reported.

1d. Resident #109 was admitted to the facility on 08/30/13 with diagnoses that included cerebrovascular accident and hypertension. The most recent Minimum Data Set (MDS) dated 08/11/14 specified the resident had no impaired cognition. On 09/23/14 at 3:40 PM Resident #109 was interviewed and reported that 2 weeks ago he was peering outside his room and watched as Resident #9 slapped Resident #34. He explained that Resident #9 slapped Resident

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#34 a few times (defined as less that 5 times but more than 2 slaps). He explained that the incident occurred in the daytime but no staff were nearby to witness the incident. Resident #109 stated that he did not report the incident because he was concerned he would be blamed.

On 09/23/14 at 3:45 PM the Director of Nursing (DON) was interviewed and reported that she was unaware of a recent allegation of abuse involving Resident #9 and Resident #34. Resident #109's observed incident was reported to the DON and she stated she was unaware and had not received reports of alleged abuse between Resident #9 and Resident #34. She stated she would have expected Resident #109 to tell a staff member immediately of any allegations of abuse.

1e. on 09/22/14 at 3:30 PM Resident #9 and Resident #34 were together in the dining room for a group activity. During the activity Resident #9 was seated in his wheelchair behind Resident #34; Resident #9 gestured for Resident #34 to move out of his way. Resident #34 was not facing Resident #9 and was unable to propel his wheelchair. Resident #9 threw his hands up in the air, rolled his eyes and then swatted his hand in the air as to mimic slapping Resident #34. The activity assistant moved Resident #34 to the side of the room.

On 09/24/14 at 2:00 PM the Activity Assistant was interviewed and reported that she was unaware of any concerns with Resident #9 and Resident #34. She stated that they were allowed to interact with one another and that she was unaware of any additional monitoring or special precautions to take if the residents were in a group activity

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together.

On 09/24/14 at 3:05 PM Nurse #2 was interviewed and reported that Resident #9 was verbally and physically abusive towards staff cussing, kicking and trying to punch but denied that he was abusive towards residents. She reported that when Resident #9 became verbally abusive she implemented a "cool off period" which did not work. She explained that "cool off" meant she allowed the resident time to be alone and diffuse the anger in a safe place. She stated she was unaware of any interventions to keep him separated from other residents. Nurse #2 reported that Resident #9 stated he had been to prison and was not afraid to go back. Nurse #2 explained she believed Resident #9 was alert but not oriented but was aware of his actions.

On 09/25/14 at 1:05 PM the Administrator was notified of immediate jeopardy for failing to monitor and implement effective measures to keep Resident #34 safe from Resident #9 and Resident #113 after Resident #9 hit Resident #34 on 12/10/13. The facility provided an acceptable credible allegation of compliance on 09/26/14 at 4:56 PM. The following interventions were put into place to remove the immediate jeopardy.

Allegation of compliance:

1. The Assistant Director of Nursing completed a head to toe nursing assessment of Resident # 34 on 09/23/14 with no abnormal findings identified.

On 09/25/14The Social Services Director initiated a referral to Psychiatric Services for evaluation of Residents #34, #113, and #9. The evaluations

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were completed on 09/26/14. On 09/26/14 the psychologist determined that Resident #9 was not a danger to himself or others and was not appropriate for inpatient psychiatric services. On 09/26/14 the psychologist assessed Resident #113 to be stable. On 09/26/14 the psychologist was unable to assess Resident #34 due to his impaired cognition.

On 09/26/14 at 11:00 AM the Director of Nursing scheduled continuous One on One direct Supervision for Resident #9, provided by facility staff following completion of Psychiatric evaluation and implementation of recommendations. The one on one supervision will continue through 09/29/14 if the resident does not have any physical outbursts. If physical outbursts occur then the one on one supervision will continue until no physical outbursts are demonstrated for 3 days. After one on one supervision the resident will be placed on every 15 minute checks until discharge. On 09/26/14 the facility has initiated discharge planning for Resident #9 to an Assisted Living Facility. Resident #34 has been assessed by the physician and determined that a lower level of care was appropriate.

All facility staff will be re-educated on 09/26/14 by the Assistant Director of Nursing or Staff Development Coordinator regarding keeping resident #34 and Resident #9 separated during waking hours, in the event Residents #34 and #9 are in the same location staff will provide supervision to monitor for escalating behaviors and intervene as appropriate. No facility staff member shall work after 09/26/14 without receiving this re-education. No other residents in the facility were identified as having physical

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abusive behaviors. Resident #113's care plan was updated on 09/25/14 to reflect his history of being physically abusive. All staff were notified of Resident #113's potential to be physically abusive toward Resident #34. Resident #34 and Resident #9 have refused room changes. Resident #9 remains on one to one supervision.

2. The Director of Nursing, Assistant Director of Nursing, Unit Manager, and MDS Coordinator completed an audit of the most recent MDS, active care plans and current medication administration records to identify those residents who have the potential to exhibit verbally abusive, physically abusive, and socially inappropriate or disruptive behaviors. All staff have been educated on 09/26/14 by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator to increase vigilance when residents identified as having abusive behaviors are in close proximity to dependant residents.

Following the identification of these residents each will be assessed by the Director of Nursing, Assistant Director of Nursing or Unit Manager for episodes of Behaviors, Psychiatric Services, appropriate care planning and implementation of recommended interventions. This was completed on 09/26/14.

All Incident Reports completed during the last 30 days were reviewed by the Director of Nursing to validate a complete investigation was conducted and recommended interventions were care planned and implemented. These audits and any required interventions were completed on 9-26-14. Staff were notified of the care plan updates and changes.

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3. Following this review the Administrator, Director of Nursing, or Manager on Duty will ensure interventions are care planned and implemented to provide for the safety of residents while an investigation is completed and implement further interventions as required. Nurse aides care grids will be updated with all new changes. Nurse aides are given care grids are given daily.

The Assistant Director of Nursing and Staff Development Coordinator will re-educate all Nursing Staff to observe residents for signs of escalating behavior and appropriate interventions for management, to include reporting these observations to the Director of Nursing, Assistant Director of Nursing or Unit Manager. No Nursing Staff member shall work after 09/26/14 without receiving this re-education. This action was completed 09/26/14.

The Quality Assessment and Performance Improvement Committee met on 9/26/14 to discuss the findings identified by the surveyor and to review this action plan.

Immediate Jeopardy was removed on 09/26/14 at 6:39 PM when the facility provided evidence of discharge planning for Resident #9, one on one supervision for Resident #9, frequent monitoring of Resident #34's location to ensure he was safe. The facility also provided evidence of completion of audits that included auditing incident reports, MDS assessments and care plans. Interviews and observations revealed staff were aware of Resident #9's behaviors and the need for one on one supervision; and the need to monitor Resident #34. Medical records for residents were reviewed and revealed updated care plans were

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F 323	Continued From page 20 in place.	F 323		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to follow a recipe for pureeing turkey by adding water to thin the entrée. The findings included: On 09/22/14 at 8:45 AM observations were made of the facility's kitchen. On 09/22/14 at 9:00 the kitchen manager proceeded to prepare puree turkey for the lunch meal. She was observed pureeing cut up pieces of cooked turkey using a food processor. The mixture resembled crumbled meat. The kitchen manager added water to the turkey mixture and re-processed the meat to a thinner consistency. The kitchen manager added water two more times before the pureed turkey resembled smooth "mashed potato" consistency. During the observations, the kitchen manager was interviewed and reported that she added about ½ - 1 cup of water each time to the puree turkey mixture to get the right consistency, similar to mashed potatoes. She explained that sometime	F 364	Criteria #1 The kitchen manager was re-educated on following the recipe for puree diets on 9/25/14 by the Dietary Manager. Criteria #2 All residents who receive a puree diet have the potential to be affected. However, all residents receiving puree diet were assessed by the dietician 10/1/14 to ensure there were no negative outcomes for residents receiving puree food made with water rather than using recipe guidelines which called for broth and thickener. Criteria#3 The kitchen manager was inserviced by the Dietary Manager on 9/25/14 on following the recipe for puree diets. All other dietary employees who are responsible for making puree meals were also inserviced by the Dietary Manager on 9/25/14 on following the recipe for puree diet. The Dietary Manager will observe	10/16/14

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F 364	Continued From page 21 she used broth, milk or gravy but she did not have broth to add to the turkey so she used water. The pureed turkey mixture was served to the 11 residents on pureed diets for the lunch meal on 09/22/14 starting at 12:30 PM. On 09/24/14 at 11:45 a follow-up interview was conducted with the kitchen manager. She explained that she used recipes when preparing food for residents. The facility's recipe for pureed turkey was reviewed and specified chicken broth and food thickener was to be combined to make a slurry and used to thin pureed turkey meat. The kitchen manager reported she did not make slurry with chicken broth and food thickener as specified in the recipe.	F 364	dietary employees daily for five days, then three times weekly for 12 weeks to ensure employees are following the recipe for puree diets. The Dietary Manager will review the menus and food orders weekly to ensure all ingredients are available for puree diet. Criteria #4 The Dietary Manager will provide findings of observations and menu review results to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months at which time, the QAPI Committee will determine if further monitoring is needed.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to ensure the dish machine reached proper wash temperatures and failed to maintain proper sanitizing solution in the	F 371	Criteria #1 All breakfast dishes were rewashed on 9/22/14 at the proper temperature. Dietary Aide #1 was inserviced by the	10/16/14

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F 371	Continued From page 22 3-comparment sink. The findings included: 1. An initial tour of kitchen was made on 09/22/14 at 8:45 AM with the kitchen manager. During the tour, observations were made of the dish machine in use. Two dietary aides were in the dish room cleaning dishware from the breakfast meal service. Observations of the dish machine were made that revealed the following wash temperatures: - At 8:56 AM wash temperature reached 142 degrees Fahrenheit - At 9:00 AM wash temperature reached 150 degrees Fahrenheit - At 9:02 AM wash temperature reached 150 degrees Fahrenheit On 09/22/14 at 9:05 AM dietary aide #1 was interviewed and reported that she was trained to monitor the temperature gauges of the dish machine while in use. She explained that she recorded rinse and wash cycle temperatures on a daily log. The dietary aide reported that she was unaware of any concerns with the machine's temperatures. The dietary aide stated that the rinse cycle was to be at 180 degrees Fahrenheit or hotter and the wash cycle was supposed to reach 150 degrees Fahrenheit. The dietary aide reported that if the machine's cycles did not reach the proper temperature she was supposed to report the problem to the kitchen manager. On 09/22/14 at 9:10 AM dietary aide operated the dish machine. The wash cycle reached 146 degrees Fahrenheit. The dietary aide reported that she was unaware the machine was not	F 371	dietary manager on proper dishwashing procedures, including not turning off the dish machine and monitoring for proper temperatures during wash/rinse cycles on 9/25/14. The morning cook and kitchen manager were inserviced by dietary manager on 9/25/14 on monitoring sanitizing solution for proper Parts Per Million (PPM) in 3 compartment sink prior to use. Criteria#2 All residents have the potential to be affected, however all breakfast dishes were rewashed at the proper temperatures, and the sanitizer solution was brought to proper PPM, and no resident was negatively affected. Criteria#3 All dietary staff were inserviced on proper dishwashing procedures, including not turning off the dish machine, and monitoring for proper temperatures by checking gauges before, during, and after wash/rinse cycles. All dietary staff were inserviced on using test strips for sanitizer solution to ensure proper PPM in 3 compartment sink. Dietary Manager will observe dietary staff for proper dishwashing procedures to ensure dishwasher temperatures are maintained throughout the dishwashing process. Dietary Manager will test sanitizer for 3 compartment sink to ensure proper PPM for sanitizing solutions daily for 5 days, then 3 times per week for 12 weeks.	

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BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 371	Continued From page 23 reaching the required temperate to sanitize dishware. She notified the kitchen manager who reported that the wash temperature should be 160 degrees Fahrenheit. She proceeded to notify the facility's Maintenance Director. On 09/22/14 at 9:15 AM the Maintenance Director observed the dish machine. He contacted the dish machine manufacturer. A technician for the dish machine was able to come on site and observed the dish machine in use. He determined that dietary aide #1 was turning the machine off between cycles which caused the machine to not reach proper wash temperatures for sanitizing dishware. 2. An initial tour was made of the kitchen on 09/22/14 at 8:45 AM with the kitchen manager. During the tour, observations were made of the 3-comparment sink in use. The morning cook was interviewed at 8:50 AM and reported that she was responsible setting up the sink. She explained that after completing the setup she tested the sanitizing solution to ensure there was proper sanitizing solution. She reported that there was to be 200ppm (parts per million) sanitizing solution. On 09/22/14 at 8:52 AM the kitchen manager tested the 3-comparment sink's sanitizing solution to be 100ppm. She reported that the sink did not have the proper amount of sanitizing solution to clean the dishware. She explained that because the sink had been set up earlier that day the solution became "weaker." The kitchen manager reported that the morning cook should have re-tested the sanitizing solution before she resumed using the 3-compartment sink.	F 371	Criteria#4 Dietary Manager will provide findings of observations and sanitizer test results to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months at which time, the QAPI Committee will determine if further monitoring is needed.	