STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345232	A. BUILDING _____ B. WING _____	05/29/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIAN CTR HEALTH & REHABI HICK	3031 TATE BOULEVARD SE HICKORY, NC 28602

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and witness interviews and record review the facility failed to prevent a nurse aide from physically abusing a resident for 1 of 2 abuse allegations (Resident #5). Immediate jeopardy began on 05/22/15 when nurse aide #1 abused Resident #5. Immediate jeopardy was removed on 05/29/15 at 12:25 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 #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set ((MDS) dated [DATE] specified the resident had short and long term memory impairment and severely impaired cognitive skills for decision making. The MDS also specified the resident had behavioral symptoms not directed towards others 1 to 3 days a week and required extensive assistance with activities of daily living (ADL). On 05/26/15 at 9:25 AM lab technician #1 was interviewed on the telephone and reported that on 05/22/15 at 5:40 AM she was in the facility walking through the 200 Hall intersection when she heard a loud, angry voice say, Didn't I tell you not to do that s***, huh, didn't I? The lab technician stated that she looked immediately toward the direction of the voice and observed nurse aide (NA) #1 standing over Resident #5 who was cowered down leaning to the left. The lab technician stated that Resident #5 was in her wheelchair positioned in the center of the 200 Hall and NA #1 had a tight grip on Resident #5's right wrist, as she spoke the NA shook Resident #5's right wrist to emphasize her words as NA #1 repeated, Didn't I, didn't I? Lab technician #1 stated that she watched as NA #1 flung Resident #5's right wrist down in the resident's lap and then slapped Resident #5's right shoulder twice as if she were spanking Resident #5. The lab technician stated that she immediately reported the incident to Nurse #1. The lab technician added that she reported to Nurse #1 that she had observed NA #1 manhandle Resident #5. The lab technician reported that after she spoke with Nurse #1 she left the facility and notified her immediate supervisor of the physical abuse. That afternoon, the lab technician stated that she was concerned regarding the incident she had observed and contacted the facility's Administrator. The lab technician stated that the Administrator requested that she email her the details of the witnessed abuse. On 05/26/15 at 12:20 PM the Administrator reported that the abuse allegation was substantiated. The Administrator explained that the incident was witnessed and a statement was obtained. Review of the facility's abuse investigation dated 05/22/15 revealed a document that was emailed to the Administrator on 05/22/15 at 2:49 PM that read in part: On Friday, May 22, 2015 at 5:40 AM I was walking through the facility to leave. As I approached the intersection of the 200 Hall, I heard a loud, stern feminine voice speaking very loud 'Didn't I tell you not to do that s***? Didn't I tell you that? Huh? Didn't I?' Naturally I looked to my left to see what was going on. I saw Resident #5 in a wheelchair wearing a pink or peach top with a dark sweater or jacket over it, she was cowering her head down towards her left. Nurse aide #1 was standing behind the wheelchair wearing blue scrubs. She had the resident's right wrist in a firm grasp and was shaking it to emphasize her words. NA #1 slung the Resident's arm downward and open hand slapped her twice on the upper arm as if she were spanking a child. I immediately went to tell Nurse #1. On 05/26/15 at 5:00 PM Nurse #1 was interviewed and reported that she was the charge nurse from 11 PM to 7 AM on the morning of 05/22/15. She added that around 6 AM a witness reported that NA #1 had abused Resident #5. Nurse #1 stated that she did not assess Resident #5 for sign or injury. Nurse #1 provided the text message delivered to the DON dated 05/22/15 at 8:23 AM that read in part, I need to let you know that the lab technician reported to me that she saw NA #1 manhandle a resident. On 05/27/15 at 9:40 AM NA #1 was interviewed and reported that she assisted Resident #5 the morning of 05/22/15 by getting her dressed and taking her to the dining room for breakfast. NA #1 reported that during care Resident #5 attempted to pinch her. NA #1 stated that she told Resident #5 not to do that. The NA explained that she took Resident #5 to the 200 Hall and left her in the hallway to speak to another resident, when she returned to Resident #5, the resident had pulled her shirt up. NA #1 stated that at times Resident #5 could be aggressive but she pulled the resident's shirt down and denied that she hit or used profanity during the incident. The NA added that after she assisted Resident #5 to the dining room, she was told that a witness made an allegation of abuse against her to Nurse #1. On 05/27/15 at 2:00 PM the Administrator was notified of immediate jeopardy. The facility provided an acceptable credible allegation of compliance on 05/29/15 at 12:25 PM. The following interventions were put into place to remove the immediate jeopardy. Allegation of Compliance F 223: 1. Residents identified to be affected by the alleged deficient practice. On 05/22/15 at 5:40AM, a contract employee reported to Nurse #1 that she had witnessed Nurse Aide #1 physically abuse Resident #5. At 8:23AM, Nurse #1 reported to the Director of Nursing an allegation of abuse involving Resident #5. The facility initiated a 24-hour Report and investigation at 2:50PM when the contracted employee contacted the Administrator. Nurse Aide #1 was suspended on 05/22/15 at 7:00PM. A 5-Working Day Report was submitted on 05/28/15. The findings of the investigation indicated that the allegation was substantiated. The Nursing Assistant was suspended on 05/22/15 at 7:00PM. Resident # 5 was assessed by the facility's Physician's Assistant on 05/27/15 and no injuries were identified as a result of the incident. The physician was notified on 05/27/15, and no additional orders were received as a result of the assessment. 2. Residents with the potential to be affected by the alleged deficient practice. Facility Residents have the potential to be affected by the alleged deficient practice. On 05/27/15, the Social Services Director and Social Services Assistant conducted interviews with those residents whose cognitive level score is 10 or greater to identify concerns related to care and services provided by the staff. Results of the audit revealed one additional allegation. The District Director of Clinical Services has initiated actions on 05/27/15 to include suspension of the identified employee, a 24-Hour Report has been completed, and an investigation has commenced. 3. Systemic Measures The Director of Nursing and Administrator will, upon notification, initiate actions to provide for a resident ' s safety in the event of an allegation of abuse or neglect, and conduct an investigation regarding the allegation according to the facility's Abuse & Neglect Policy and as follows: · Remove alleged staff member from resident care area · Supervisor to immediately notify the Director of Nursing or Administrator of the allegation · Licensed Nurse to assess the resident for potential injury and provide for safety and care · Inform MD if there are any signs/symptoms of injury The Division Director of Clinical Education and the Unit Coordinator have conducted training with facility staff beginning 05/27/15 regarding Abuse & Neglect Prohibition, the requirement that residents are to be free from abuse and neglect, and to report allegations to the Director of Nursing or Administrator to ensure that residents' needs are being met and interventions are put in place to ensure the resident's safety. Facility staff will not be allowed to work until the training is completed. Facility will be provided this education at least annually via the Director of Nursing or Social Services Director. This education will be included in the facility's new hire orientation and newly hired facility staff will not be permitted to assume their floor responsibilities until they have completed this education. On 05/27/15, the Administrator, District

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

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.

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F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Director of Clinical Services, and Division Director of Clinical Education provided education for the Director of Nursing regarding what constitutes an allegation of abuse, removal of the accused individual, ensuring the safety of the resident, submitting a 24-Hour Report, and completing a thorough investigation. Beginning on 05/27/15 all facility employees will be re-educated by the Director of Nursing, Director of Clinical Education, ADON and Unit Coordinator on the Facility Policy for Abuse and Neglect Prohibition and mandated reporting of allegations of resident abuse and neglect. This re-education will also include: · Providing separation and a safe environment for residents while the investigation is completed · Appropriate interventions are care planned and implemented based on the resident's assessment. · No facility employee shall work without receiving this re-education. The Administrator and Director of Nursing will be retrained by the District Director of Clinical Services regarding the facility's Abuse & Neglect policy and the investigative process to include: · Reporting via the 24-Hour Report and 5-working day Report of allegations of abuse or neglect · Interview notes/Statements of staff and residents related to the allegation · Assessment of the resident for potential injuries · Notification of the physician for injuries The following methods of monitoring, tracking, and trending will be implemented as of 05/28/15: · The Director of Nursing will identify individuals who have had two or more allegations of abuse submitted within a calendar year, will monitor care provided and interactions with residents three times per week for four weeks after the second allegation. · The Administrator will review Ambassador Rounds and Concern Forms daily during the morning meeting for any allegations of abuse and will follow up immediately. Immediate Jeopardy was removed on 05/29/15 at 12:25 PM when the facility provided evidence of additional training provided to residents and staff on the importance of preventing all observed, suspected and/or alleged allegations of abuse. Interviews with staff and alert and oriented residents revealed they were trained on when and whom to report allegations of abuse and what actions were required by supervisory nursing staff to protect residents allegedly abused.