PRINTED: 10/27/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345179	B. WING _			C <b>09/26/2014</b>
	ROVIDER OR SUPPLIER	TIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115	<b>,</b>	33/23/23 14
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR  ( (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE A  DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	therapy staff membe allegation of physical administration. Immeremoved on 09/26/12 implemented a credil The facility remains of scope and severity let the potential for more not immediate jeoparand resident education systems in place are 483.25 (F 323) at J Immediate jeopardy Resident #9 punched facility failed to monit reoccurrences to pro Immediate jeopardy 6:39 PM when the far allegation of complianof compliance at a lo D (no actual harm with minimal harm that is complete employee a ensure monitoring sy 483.13(c) DEVELOP ABUSE/NEGLECT, I	began on 09/17/14 when r #1 failed to report an l abuse to the nursing home's ediate jeopardy was 4 at 6:39 PM when the facility ble allegation of compliance. But of compliance at a lower evel D (no actual harm with eathan minimal harm that is redy) to complete employee on and ensure monitoring effective.  began on 12/10/13 when the tor interventions to prevent tect Resident #34 and the tor interventions to prevent tect Resident #34.  was removed on 09/26/14 at cility implemented a credible nce. The facility remains out wer scope and severity level the potential for more than not immediate jeopardy) to and resident education and restems in place are effective.  IMPLMENT ETC POLICIES		226		10/16/14
ADODATODY	NIRECTOR'S OR PROVIDED	SUPPLIER REPRESENTATIVE'S SIGNATUR	DE	TITI F		(X6) DATE

Electronically Signed 10/17/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
			7 50125111	<u> </u>		С	
		345179	B. WING			09/26/2014	
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
DDIAN OF	NITED HEALTH AND	PETIDEMENT		752 E CENTER AVENUE			
BRIAN CE	NTER HEALTH AND F	RETIREMENT		MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 226	by: Based on observa interviews and reco member failed to re resident to resident home's administrat history of being phy Immediate jeopard therapy staff member allegation of physic administration. Immediate a cree The facility remains scope and severity the potential for mo not immediate jeopand resident educat systems in place at The findings include A document titled, Prohibition" revised observations or alle mistreatment must Administrator and/or 1. Resident #103 of 05/09/13 with diagra cerebral vascular a paralysis. The most	tions, resident and staff ord review, a facility staff eport her knowledge of a physical abuse to the nursing ion for 1 of 2 residents with a sysically abusive (Resident #9).  By began on 09/17/14 when over #1 failed to report an exal abuse to the nursing home's mediate jeopardy was 14 at 6:39 PM when the facility dible allegation of compliance. Is out of compliance at a lower level D (no actual harm with one than minimal harm that is eardy) to complete employee atton and ensure monitoring are effective.  By began on 09/17/14 when over #1 failed to report an exal abuse to the nursing home's mediate jeopardy was 14 at 6:39 PM when the facility dible allegation of compliance. It is out of compliance at a lower level D (no actual harm with one than minimal harm that is eardy) to complete employee atton and ensure monitoring are effective.  By began on 09/17/14 when over #1 failed to report an exal a lower than minimal harm that is eardy) to complete employee atton and ensure monitoring are effective.  By began on 09/17/14 when over #1 failed to report an exal a lower than minimal harm that is eardy) to complete employee atton and ensure monitoring are effective.  By began on 09/17/14 when over #1 failed to report an exal abuse to the nursing home's mediately to complete employee atton and ensure monitoring are effective.  By began on 09/17/14 when over #1 failed to report an exal abuse to the nursing home's mediately exal a failed to report an exal abuse to the nursing home's mediately exal a failed to report an exal abuse to the nursing home's mediately exal a failed to report an exal abuse to the nursing home's mediately exal a failed to report an exal abuse to the nursing home's mediately exal abuse to the nursing h	F 2:		23/14 for abuse.  abilitation g of abuse g resident  Social suspected y facility #103 Director allegations  rviewed by Assistant Staff C) on allegations  ved as a lave been or or DON and I Neglect led by the r on		
	(MDS) dated 06/25 not have impaired On 09/22/14 at 1:3	5/14 specified the resident did		SDC, ADON, and Social Worke	r on /14.		

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				CIVID IVC	<del>7. 0930-0391</del>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(	c
		345179	B. WING _			09/	26/2014
NAME OF P	ROVIDER OR SUPPLIER			S1	FREET ADDRESS, CITY, STATE, ZIP CODE		
DDIAN OF	NTED HEALTH AND DE	TIDEMENT		75	52 E CENTER AVENUE		
BRIAN CE	NTER HEALTH AND RE	IIREMENI		M	OORESVILLE, NC 28115		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 226	Continued From pag	e 2	F 2	226			
		dent #103 replied, "Yes."	'-		employees were re-educated by the		
		ined that he had observed			ADON or SDC on the Facility Policy for	-	
	-	dent #34 on two separate			Abuse and Neglect Prohibition and		
		t #103 explained that he was			mandated reporting of allegations of		
		t dates because he had			resident abuse and neglect to the		
	difficulty remembering	ig dates but that "about 6			Administrator, DON or the employees		
	,	in bed and Resident #34			immediate supervisor. This re-educati	on	
	was in his wheelchai			will also include reporting resident to			
		thed Resident #34 and			resident altercation, providing separation	on	
	slapped him across t	the face, knocking his hat off.			and a safe environment for both reside	nts	
	Resident #103 stated	d he yelled for Resident #34			involved in the altercation while the		
	to get inside the roor	n and Resident #9 left.			investigation is completed and appropr	iate	
		ibed a second incident he			interventions are care planned and		
		is ago in which he was in the			implemented. No facility employees sh		
	-	d as Resident #9 hit Resident			work after 9/25/14 without receiving thi	S	
		t. Resident #103 propelled			re-education.		
		r to the residents which			Beginning on 9/25/14, all newly hired		
		to stop hitting Resident #34.  d he did not report either			facility staff will be educated prior to beginning work in the resident care are		
		ember. He offered no			by the ADON or SDC on the Facility Po		
		did not report the incidents			for Abuse and Neglect Prohibition and	лісу	
		by staff member #1 was			mandated reporting of allegations of		
		#9 was abusive toward			resident abuse and neglect to the		
		se they had discussed it.			Administrator, DON, or the employees		
		ted that Resident #9 hated			immediate supervisor. This re-educati	on	
	Resident #34 and wa	as repeatedly mean to			will also include reporting resident to		
		lent #103 was unaware if any			resident altercation, providing separation	on	
	staff members had o	bserved the incidents.			and a safe environment for both reside	nts	
					involved in the altercation while the		
	On 09/23/14 at 3:45	PM the Director of Nursing			investigation is completed and appropr	iate	
		red and reported that she			interventions are care planned and		
	1	gations of abuse involving			implemented.		
		sident #34. Resident #103's			Beginning on 9/25/14, new resident		
		vere reported to the DON and			admissions into the facility will be		
		unaware and had not			educated by the Social Services Direct		
		lleged abuse between			(SSD), Social Services Assistant (SSA		
	Resident #9 and Res			the Admissions Coordinator (AC) durin	g		
		d Resident #103 to tell a staff			the admission process, on the facility		
	member immediately	of any allegations of abuse.			policy for Prohibition of Abuse including	3	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345179	B. WING _			l	26/2014
	ROVIDER OR SUPPLIER	ETIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115		1 00	20/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	#1 was interviewed received regular trai and neglect. She st report any suspicion and/or Administrator reported that on 09/ and was greeted by reported to therapy thit Resident #34. The added that Resident times verbally abusi members. Therapy could tell when Resident #34 wagainst Resident #35 (DON) was interview unaware Resident #41 he had hit Reside expected therapy st concern immediately The DON added the allow staff the freede truthful; all allegation 3. Resident #109 w 08/30/13 with diagnocerebrovascular accomost recent Minimul 08/11/14 specified the	2:52 PM therapy staff member and explained that she ning on prevention of abuse ated that she was trained to of abuse to her supervisor. Therapy staff member #1 17/14 she arrived for work Resident #9. Resident #9 staff member #1 that he had herapy staff member #1 that he had herapy staff member #1 stated she dent #9 was getting mad and tent #34 did not. She added as unable to defend himself. Therapy staff member #1 filed to report the allegation to ng or the Administrator believe Resident #9 was  PM the Director of Nursing wed and reported she was 9 told therapy staff member ent #34. The DON stated she aff member #1 to report the was 19 told therapy staff member was 19 told therapy st	F2	226	education on reporting observations of alleged abuse, suspected abuse or rumors of abuse to any facility employed. The Quality Assurance and Performance Improvement (QAPI) Committee met of 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 weeks to verify reporting of all allegation 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 altercation. Administrator or DON will attend Resid Council monthly for 3 months to verify reporting allegations of abuse as well a review Resident Rights and Facility Polyon reporting Concerns and Issues, including reporting allegations of abuse and resident to resident altercations.  Criteria #4  DON,SSD, and the Administrator will be the findings of the interviews to QAPI Committee monthly for 3 months, at whe time the QAPI Committee will determine further interviews are needed.	ce n d d n 12 ns f ns. ent s licy	

AND PLAN OF CORRECTION IDENTIFICA	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
	345179	B. WING _			09/2	; 26/2014	
NAME OF PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP	CODE			
DDIAN CENTED HEALTH AND DETIDEMENT			752 E CENTER AVENUE				
BRIAN CENTER HEALTH AND RETIREMENT			MOORESVILLE, NC 28115				
PREFIX (EACH DEFICIENCY MUST BE PREC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
F 226  Continued From page 4  #109 was interviewed and reported ago he was peering outside his row watched as Resident #9 slapped F He explained that Resident #9 slat #34 a few times (defined as less the more than 2 slaps). He explained incident occurred in the daytime be nearby to witness the incident. Restated that he did not report the inhe was concerned he would be blaced in the was concerned he would be blaced in the was concerned he would be blaced in the was unaware of a recent allegation involving Resident #9 and Resident Resident #109's observed incident to the DON and she stated she was had not received reports of alleged between Resident #9 and Resident stated she would have expected For to tell a staff member immediately allegations of abuse.  On 09/25/14 at 1:05 PM the Admir notified of immediate jeopardy for member #1's failing to report alleg physical abuse to the nursing hom administration so that appropriate and follow up could be initiated. The provided an acceptable credible allegations on 09/26/14 at 4:56 Pl following interventions were put intermove the immediate jeopardy.  Allegation of Compliance:  1. Therapy staff member #1 was a Rehabilitation Director on 09/23/14 report an allegation of abuse.	om and Resident #34. Oped Resident that 5 times but that the ut no staff were sident #109 cident because amed.  or of Nursing ed that she of abuse at #34. It was reported s unaware and I abuse t #34. She resident #109 of any  sistrator was therapy staff ations of e's investigation he facility legation of M. The op place to	F 2	26				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345179	B. WING		C 09/26/2014	
	ROVIDER OR SUPPLIER	TIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODE  752 E CENTER AVENUE  MOORESVILLE, NC 28115	03/20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 226	Continued From page	e 5	F 22	3		
	09/23/14 by Rehabilit reporting of abuse an including resident to a 109/25/14 by the Social reporting observations suspected abuse or a facility employee. Reverbalized understan Services of reporting 2. All current employ by the Director of Nur Nursing or Staff Deverous 2. All allegations and reporting abuse.  All allegations and reporting the Administrator or Expense and Neglect Producted by the SD 09/25/14 and completion of all observed resident to interviews were completion of the interviews were completion	resident altercation.  103 were re-educated on al Services Director on s of alleged abuse, umors of abuse to any esidents #109 and #103 ding to the Director of Social allegations of abuse.  The ees have been interviewed raing, Assistant Director of elopment Coordinator on orting of all allegations of abuse or ports received as a result of have been investigated by Director of Nursing according and procedure regarding and procedure regarding trohibition. Interviews C, ADON and SW on ted on 09/26/14.  IMS greater than 10 have the Social Services Director, stant or the Administrator to allegations of abuse and resident altercations. These beted on 09/26/14. At the				
	abuse.	ports received as a result of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345179	B. WING _				26/2014
	ROVIDER OR SUPPLIER	TIREMENT	1	STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 226	by the Administrator according to the faci regarding Abuse and Interviews conducted on 09/25/14 and cor 3. Beginning on 09/will be re-educated by Nursing or Staff Dev Facility Policy for Aband mandated reporabuse and neglect to of Nursing or the emsupervisor. This re-reporting resident to providing separation both residents involvinvestigation is compinterventions are car No facility employee without receiving this Beginning on 09/25/will be educated prioresident care area by Nursing or Staff Dev Facility Policy for Aband mandated reporabuse and neglect to of Nursing or the emsupervisor. This re-reporting resident to providing separation both residents involvinvestigation is compinterventions are car interventions ar	iews have been investigated or Director of Nursing lity's policy and procedure I Neglect Prohibition. In by the SDC, ADON and SW impleted on 09/26/14.  25/14 all facility employees by the Assistant Director of elopment Coordinator on the luse and Neglect Prohibition ting of allegations of resident of the Administrator, Director ployee's immediate education will also include resident altercation, and a safe environment for red in the altercation while the pleted and appropriate in the planned and implemented. Shall work after 09/25/14 is re-education.  14, all newly hired facility staff or to beginning work in the luse and Neglect Prohibition ting of allegations of resident of the Administrator, Director ployees immediate education will also include	F	226			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345179	B. WING		C 09/26/2014	
	ROVIDER OR SUPPLIER	TIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODE  752 E CENTER AVENUE  MOORESVILLE, NC 28115	33.23.11	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 226	Services Director, So Admissions Coordina process, on the facilit Abuse including educ observations of alleg or rumors of abuse to The Quality Assu Improvement Comming 9/25/14 to discuss the surveyor and to reaction plan.  Immediate Jeopardy 6:39 PM when the face additional training proon the importance of suspected and/or alled Interviews with alert a staff revealed they we whom to report allegates 483.25(h) FREE OF HAZARDS/SUPERV  The facility must ensenvironment remains as is possible; and eadequate supervision prevent accidents.	e educated by the Social ocial Services Assistant or ator during the admission ty policy for Prohibition of cation on reporting ed abuse, suspected abuse or any facility employee.  Tance and Performance of the met on some state findings identified by eview this  The was removed on 09/26/14 at collity provided evidence of covided to residents and staff reporting all observed, and oriented residents and ere trained on when and actions of abuse.  ACCIDENT ISION/DEVICES  The was removed on when and actions of accident hazards	F 22		10/16/14	
		ons, staff and resident d review the facility failed to		Criteria #1 The Assistant Director of Nursing (ADC	ON)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _			,	
		345179	B. WING				26/2014	
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
DDIAN CE	NTED HEALTH AND D	ETIDEMENT		7	52 E CENTER AVENUE			
BRIAN CE	NTER HEALTH AND R	ETREMENT		M	IOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 323	Continued From page	ge 8	F:	323				
	monitor and implem	ent interventions to protect			completed a head to toe nursing			
	one of one dependa	ant resident (Resident #34)			assessment of Resident #34 on 9/23/1	4		
	from other residents	s with physically violent			with no abnormal findings identified.			
	behaviors.				On 9/25/14, the Social Services Director			
					(SSD), initiated a referral to Psychiatric			
	, , ,	began on 12/10/13 when			Services for evaluation of Residents #3	4,		
		ed Resident #34 and the			#113, and #9. The evaluations were			
	,	itor interventions to prevent			completed on 9/26/14. On 9/26/14 the			
	reoccurrences to pro				psychologist determined that Resident			
	Immediate jeopardy			was not a danger to himself or others a	na			
	6:39 PM when the fa			was not appropriate for inpatient psychiatric services. On 9/26/14 the				
		ance. The facility remains out ower scope and severity level			psychologist assessed Resident #113	to		
		with the potential for more than			be stable. On 9/26/14 the psychologis			
	I	s not immediate jeopardy) to			was unable to assess Resident #34 du			
		and resident education and			to his impaired cognition.			
		systems in place are effective.			On 9/26/14 at 11:00am the Director of			
	Ŭ	•			Nursing (DON) scheduled continuous (	One		
	The findings include	ed:			on One direct supervision for Resident			
					provided by facility staff following			
	Resident #34 was a	dmitted to the facility on			completion of Psychiatric evaluation ar	ıd		
	04/29/13 with diagn	oses that included cerebral			implementation of recommendations.	Γhe		
	palsy, speech distur	rbance, muscle disuse			one on one supervision continued thro			
	atrophy, intellect dis	sability, aphasia and others.			9/29/14 as the resident did not have ar	-		
					physical outbursts for three days. After			
		e plan initiated on 05/22/13			one on one supervision, the resident w	as		
		08/12/14 for behavior			placed on 15 minute checks until his			
		the resident had loud			discharge. On 9/26/14, the facility has			
		ng. Approaches specified on			initiated discharge planning for Reside			
	the care plan includ	ea:			#9 to an Assisted Living Facility. Resid	ent		
	givo gimplo ele	par directions, repost se			#34 was assessed by the physician on9/26/14 and determined that a lower			
		ear directions, repeat as			level of care was appropriate. Resider			
	needed - check for pain a	and discomfort			#9 was discharged to an ALF on 10/3/			
		ment, situations and or			All facility staff will be re-educated on	. T.		
	_	ze external stressors			9/26/14 by the ADON or Staff			
		LO CALOTTIAI SILCOSOTO			Development Coordinator (SDC)			
	Resident #34 had a	communication care plan			regarding keeping Resident #34 and			
		3 related to the resident's			Resident #9 separated during waking			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(	С	
		345179	B. WING _			09/	26/2014	
NAME OF PI	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE			
				75	52 E CENTER AVENUE			
BRIAN CE	NTER HEALTH AND F	RETIREMENT		М	OORESVILLE, NC 28115			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE	
F 323	Continued From pa	ige 9	F3	323				
	·	icate due to cognitive			hours, in the event Resident #34 and			
	impairment. Interve	•			Resident #9 are in the same location s	aff		
					will provide supervision to monitor for			
	- staff to make e	eye contact when			escalating behaviors and intervene as			
		the resident to be able to read			appropriate. No facility staff member s	hall		
	lips				work after 9/26/14 without receiving thi	S		
		clearly and slowly			re-education. No other residents in the	:		
	_	estures to assist in			facility were identified as having physic			
			abusive behaviors. Resident #113's ca					
	D : 1 / //04				plan was updated on 9/25/14 to reflect			
		st recent Minimum Data Set			history of being physically abusive toward			
		/14 specified the resident had cognition but no mood or			Resident #34. Resident #34 and Resident #9 have refused room changes. Resident #34 and Resident #35 and Resi			
	behaviors exhibited	~			#9 remains on one to one supervision.	CIII		
		•			" o remaine on one to one capervision.			
	1a. Resident #9 wa	s admitted to the facility on			Criteria #2			
	11/27/12 with diagn	noses that included psychosis,			The DON, ADON, Unit Manager (UM),	and		
		r, bipolar disorder, insomnia,			MDS Coordinator completed an audit of	f		
		ers. Resident #9's care plan			the most recent MDS, active care plan			
		ed 11/12/13, updated on			and current medication administration			
		and 08/01/14 specified the			records to identify those residents who			
		verbal abuse, physical abuse			have the potential to exhibit verbally	l		
		It times. The care plan Is that included threatening to			abusive, physically abusive, and social inappropriate or disruptive behaviors. A	•		
		and hitting other residents.			staff have been educated on 9/26/14 b			
		fied in the care plan included:			the DON, ADON, SDC to increase	y		
	micorvonacino opoci	ned in the care plan included.			vigilance when residents identified as			
	- ignore verbal o	outbursts			having abusive behaviors are in close			
	_	within individual's decision			proximity to dependent residents.			
	making abilities				Following the identification of these			
	- redirect as nee				residents each will be assessed by the			
	- be alert for triggers of potential evidence of				DON, ADON, or UM for episodes of			
	pending behavioral	episodes			Behaviors, Psychiatric Services,			
	Davidson of Davidson	t #0  di			appropriate care planning and			
		t #9's medical record revealed			implementation of recommended			
		de by nurse #1 dated 12/11/13			interventions. This was completed on			
		d in part, on 12/10/13 at 6:00 ruck Resident #34 in the head			9/26/14. All Incident Reports (IR)completed duri	na		
		#34 would not sit down.			the last 30 days were reviewed by the	''9		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
						С	
		345179	B. WING _			09/26/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	CODE		
				752 E CENTER AVENUE			
BRIAN CE	NTER HEALTH AND I	RETIREMENT		MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	DER'S PLAN OF CORRECTION PRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLET DATE		
F 323	Continued From pa	age 10	F 3	23			
F 323	Resident #9 told not do what the I were separated; th Nursing were notificated 12/10/13 was interventions to add separating the Resident #9's room physician for medicated an entry rounder of the revealed an entry rounder of bizarres witched to anothe Worker told me that be out of here.' In reason for changin described 'I punched initially attempted to the acknowledged to an entry rounder.'  Resident #9's most specified his cognitindicators present,	urse #1, "I don't give a I want to do." The residents e doctor and the Director of	F3	DON to validate a complet was conducted and recom interventions were care pla implemented. These audit required interventions were 9/26/14. Staff were notified plan updates and changes.  Criteria #3 Following this review, the ADON or Manager on Duty interventions as care planrimplemented to provide for residents while an investig completed and implement interventions as required. Care grids will be updated changes. Nurse aides are grids daily.  The ADON and SDC will re Nursing Staff to observe resigns of escalating behavior appropriate interventions for management, to include reobservations to the DON, Amanager. No Nursing Staff work after 9/26/24 without re-education. This action on 9/26/14.  The Quality Assessment and Performance Improvement	mended anned and anned and anned and any e completed on d of the care and		
	antianxiety and ant	vailable for an interview.		Committee met on 9/26/14 findings identified by the sureview this action plan. The Interdisciplinary Team (DON,ADON,SSD,MDS Concepted Manager) will mee weeks to review all Incider	to discuss the urveyor and to oordinator, t weekly for 12		
	On 09/23/14 at 4:0	8 PM Resident #9 was		ensure investigations are of	•		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345179	B. WING _			09/2	26/2014
NAME OF P	ROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CODE		, 00/2	0,2011
				752 E CENTER AVENUE			
BRIAN CE	NTER HEALTH AND RE	IIREMENI		MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	I	(X5) COMPLETION DATE
F 323	Assistant Director of I Resident #9 admitted closed fist "about a ye he could not recall hit times but recalled oth angry with other resid physical. Resident #8 problems with his anghimself from upsetting On 09/25/14 at 10:00 (DON) was interviewed.	Director of Nursing and Nursing (ADON) present. he hit Resident #34 with a ear ago." Resident #9 stated ting Resident #34 any other er incidents in which he got ents but denied becoming 9 explained that he had ger but knew to remove	F3	care plans and care grids are used accordingly. Residents exhibiting physically, verbally, socially into or disruptive behaviors as idented documentation, observation, permedication adjustment, as well residents receiving psychiatric will be reviewed by the IDT Teator Criteria #4  The IDT team will report finding weekly reviews to QAPI Comment 3 months at which time the Committee will determine if fur	ng appropria atified by sychotrol I as services am week gs from to nittee for e QAPI	pic s sly.	
	DON explained that the she investigated the investigated the investigated the investigated the phymedication changes are psychologist. She ad assessed and shower that Resident #9's phymedications. The DON was not alert and ories and memory.  1b. Resident #113 was 01/10/14 with diagnost disorder, cerebellar arecent Minimum Data specified the resident and no mood or behar Resident #113's care revealed he had a carand withdrawal. Inter	ne following day on 12/11/13 ncident and implemented ks for Resident #9 for 2 sician to review for and notified Resident #9's ded that Resident #34 was d no injuries. She reported ysical behaviors were better fficulty with verbally abusive explained that Resident #9 anted and had poor cognition us admitted to the facility on ses that included depressive taxia and others. The most Set (MDS) dated 07/08/14 had no impaired cognition viors exhibited. Review of plan initially dated 01/30/14 re plan to address insomnia		reviews are needed.	iner		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
		345179	B. WING _			C <b>09/26/2014</b>
	ROVIDER OR SUPPLIER	ETIREMENT		STREET ADDRESS, CITY, STATE, 752 E CENTER AVENUE MOORESVILLE, NC 28115	, ZIP CODE	00/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 323	revealed an entry dhe had slapped Res  A document titled "I dated 04/09/14 spein the hallway when him and slapped Res Neither resident wareason for the incidwitnessed by an ale staff. The residents and Resident #113 minute checks.  On 09/25/14 at 10:0 (DON) was interview notified her of the in #113 and Resident incident was isolated determine what cau Resident #34. She was able to describ	ge 12 #113's medical records ated 04/09/14 that specified sident #34 in the face.  ncident/Accident Report" cified that Resident #34 was Resident #113 approached esident #34 across the face. s able to communicate the ent. The incident was at and oriented resident and a were immediately separated was placed on every 15  00 AM the Director of Nursing wed and reported that staff acident involving Resident #34. She stated that the d and she was unable to sed Resident #113 to slap reported that neither resident e the incident. The DON of immediate actions taken to	F	323	oeno)	
	prevent a reoccurre Resident #113's roc and notifying the ph there had been no f violence between R #34. 1c. Resident #103 v 05/09/13 with diagn cerebral vascular ac paralysis and others Data Set (MDS) dat resident did not hav 09/22/14 at 1:38 PM	om, referring to psychology ysician. The DON added that urther incidents of physical esident #113 and Resident was admitted to the facility on oses that included history of a ecident with right sided s. The most recent Minimum ed 06/25/14 specified the e impaired cognition. On M Resident #103 was teed if he saw any resident				

		) DATE SURVEY COMPLETED				
		345179	B. WING _			C 99/26/2014
NAME OF F	ROVIDER OR SUPPLIER	0.00		STREET ADDRESS, CITY, STATE, ZIP CODE		19/20/2014
				752 E CENTER AVENUE		
BRIAN CI	ENTER HEALTH AND RE	ETIREMENT		MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COME (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From pag	ge 13	F 3	23		
F 323	being abused. Resi Resident #103 expla Resident #9 hit Resi occasions. He deso Resident #103 expla recall exact dates be remembering dates ago" he was in bed a wheelchair parked th approached Resider face, knocking his ha he yelled for Reside but Resident #9 left. second incident he w in which he was in th Resident #9 started closed fist. Residen wheelchair closer to Resident #103 state incident to a staff me explanation why he but stated that thera aware that Resident Resident #34 becau  On 09/23/14 at 2:52 was interviewed and regular training on p neglect. She stated any suspicion of abu Administrator. There that on 09/17/14 she greeted by Resident therapy staff membe #34. Therapy staff r Resident #9 had a te	dent #103 replied, "Yes." ained that he had observed ident #34 on two separate cribed both of the incidents. ained that he was unable to ecause he had difficulty but that "about 6 months and Resident #34 was in his ne doorway. Resident #9 nt #34 slapped him across the at off. Resident #103 stated nt #34 to get inside the room Resident #103 described a witnessed 2 to 3 months ago ne hallway and watched as hitting Resident #34 with a	F 3			

			3) DATE SURVEY COMPLETED				
		345179	B. WING _		,	C 09/26/2014	
	ROVIDER OR SUPPLIER	ETIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	angry but that Resident added that Resident himself against Resimember #1 admitted allegation to the Dir Administrator because Resident #9 was te On 09/23/14 at 3:45 (DON) was interviewas unaware of alles Resident #9 and Resident #9 and Resident #103's ob reported to the DON unaware and had not abuse between Resident #103 to tell a staffinallegations of abuse DON reported that told therapy staffinallegations of abuse DON reported that to report the administration of the DON staffinallegation of abuse DON reported that to report the abuse policy did discern what was trong the abuse pol	ident #9 was getting mad and dent #34 could not. She t #34 was unable to defend ident #9. Therapy staff d that she failed to report the ector of Nursing or the use she didn't believe ling the truth.  5 PM the Director of Nursing wed and reported that she egations of abuse involving esident #34 since 12/10/13. Served incidents were and she stated she was not received reports of alleged esident #9 and Resident #34. Ind have expected Resident hember immediately of any es. During the interview the she was unaware Resident #9 amber #1 he had hit Resident ed she expected therapy staff to the concern immediately to ator. The DON added that I not allow staff the freedom to was admitted to the facility on was admitted to the facility on	F3	323			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345179	B. WING		C 09/26/2014
	ROVIDER OR SUPPLIER	TIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115	1 03/20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 323	#34 a few times (defined more than 2 slaps). incident occurred in the nearby to witness the stated that he did not he was concerned he on 09/23/14 at 3:45 (DON) was interview was unaware of a reginvolving Resident #8 Resident #109's obset to the DON and she had not received rep between Resident #8 stated she would have to tell a staff member allegations of abuse.  1e. on 09/22/14 at 3: Resident #34 were to a group activity. Dur was seated in his wh #34; Resident #9 gemove out of his way. facing Resident #9 a wheelchair. Resident the air, rolled his eye in the air as to mimic activity assistant move of the room.  On 09/24/14 at 2:00 interviewed and report any concerns with Resident and that additional monitoring	He explained that the he daytime but no staff were incident. Resident #109 the report the incident because it would be blamed.  PM the Director of Nursing and reported that she cent allegation of abuse incident was reported stated she was unaware and corts of alleged abuse in and Resident #34. She we expected Resident #109 immediately of any	F 32	23	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		ATE SURVEY OMPLETED
		345179	B. WING _			C 09/26/2014
	ROVIDER OR SUPPLIER	TIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115	•	00/20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	verbally and physica cussing, kicking and that he was abusive reported that when Fabusive she implemed which did not work. The meant she allowed the and diffuse the anges she was unaware of him separated from reported that Reside prison and was not a explained she believed not oriented but was On 09/25/14 at 1:05 notified of immediate monitor and implemed keep Resident #34 separated from 12/10/13. The facredible allegation of 4:56 PM. The followinto place to remove	PM Nurse #2 was orted that Resident #9 was ally abusive towards staff trying to punch but denied towards residents. She Resident #9 became verbally ented a "cool off period" She explained that "cool off" he resident time to be alone in a safe place. She stated any interventions to keep other residents. Nurse #2 https://example.com/stated/any/stated/he had been to offraid to go back. Nurse #2 ed Resident #9 was alert but aware of his actions.  PM the Administrator was a jeopardy for failing to ent effective measures to afe from Resident #9 and Resident #9 hit Resident #34 cility provided an acceptable of compliance on 09/26/14 at ing interventions were put the immediate jeopardy.	F3	23		
	a head to toe nursing 34 on 09/23/14 with identified.  On 09/25/14The Soc	g assessment of Resident # no abnormal findings sial Services Director initiated				
		ric Services for evaluation of , and #9. The evaluations				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		(X3) DATE COMP	SURVEY
		345179	B. WING _				<b>26/2014</b>
	ROVIDER OR SUPPLIER	TIREMENT		STREET ADDRESS, C 752 E CENTER AVEN MOORESVILLE, N		, 00.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	psychologist determination and anger to himself of appropriate for inpation 09/26/14 the psychoward was unable to assess impaired cognition.  On 09/26/14 at 11:00 scheduled continuous Supervision for Resistaff following complevaluation and implerecommendations. Will continue through not have any physical outbursts occur then will continue until not demonstrated for 3 coupervision the resident will continue until not demonstrated for 3 coupervision the resident #3 to an Assesident #3 to an Assession to an Asse	one of the provided by facility etion of Psychiatric ementation of The one on one supervision of physical outbursts. If physical the one on one supervision physical outbursts are lays. After one on one lent will be placed on every still discharge. On 09/26/14 ed discharge planning for esisted Living Facility. En assessed by the mined that a lower level of experience on the provided ending event Residents #34 and #9	F	323			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345179	B. WING _			1	C <b>26/2014</b>
	ROVIDER OR SUPPLIER			752 E	ET ADDRESS, CITY, STATE, ZIP CODE CENTER AVENUE DRESVILLE, NC 28115	<u>1 09/</u>	20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	abusive behaviors. F was updated on 09/2 being physically abus Resident #113's pote toward Resident #34 #9 have refused roor remains on one to or  2. The Director of N Nursing, Unit Manage completed an audit of active care plans and administration record who have the potenti physically abusive, a disruptive behaviors. educated on 09/26/14 Assistant Director of Coordinator to increat identified as having a close proximity to de  Following the identified each will be assesse Assistant Director of episodes of Behavior appropriate care plan	Resident #113's care plan 5/14 to reflect his history of sive. All staff were notified of ntial to be physically abusive Resident #34 and Resident n changes. Resident #9 e supervision.  Aursing, Assistant Director of er, and MDS Coordinator of the most recent MDS, I current medication s to identify those residents al to exhibit verbally abusive, and socially inappropriate or All staff have been by the Director of Nursing, Nursing, Staff Development se vigilance when residents busive behaviors are in	F	323			
	on 09/26/14.  All Incident Reports of days were reviewed by validate a complete in and recommended in planned and implement required interventions.	completed during the last 30 by the Director of Nursing to envestigation was conducted terventions were care ented. These audits and any is were completed on notified of the care plan					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG		COMPLETED
		345179	B. WING			C <b>09/26/2014</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115	I	09/20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	3. Following this revolute of Nursing, and the second support of Nursing, and the second support of Nursing Staff to observations to the Director of Nursing Staff to observations to the Director of Nursing Staff to observations to the Director of Nursing Staff member shall vice of Nursing Staff to observations to the Director of Nursing Staff member shall vice of Nursing Staff to observations to the Staff member shall vice of Nursing Staff to observations for Nursing Staff to observations for Nursing Staff to observations for Mursing Staff to observations for Nursing Staff to observatio	riew the Administrator, or Manager on Duty will are care planned and ide for the safety of residents in is completed and rerventions as required. It is aides are given care grids or of Nursing and Staff inator will re-educate all rerve residents for signs of and appropriate interventions include reporting these Director of Nursing, Assistant or Unit Manager. No Nursing work after 09/26/14 without cation. This action was	F 3	23		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION  NG	(X3) DATE SU COMPLE	
		345179	B. WING _		09/26	/2014
	ROVIDER OR SUPPLIER	TIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115	•	.2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From pag in place.	e 20	F3	323		
F 364 SS=E	•	FRITIVE VALUE/APPEAR, R TEMP	F3	364	10	)/16/14
	food prepared by me	es and the facility provides thods that conserve nutritive pearance; and food that is and at the proper				
	by: Based on observation record review the fact	r is not met as evidenced ons, staff interviews and cility failed to follow a recipe y adding water to thin the		Criteria #1 The kitchen manager was re-efollowing the recipe for pureefollowing the Dietary Manager	diets on	
	of the facility's kitched On 09/22/14 at 9:00 proceeded to preparameal. She was obset of cooked turkey using mixture resembled commanager added watere-processed the mean The kitchen manage times before the pure smooth "mashed pot observations, the kitcher interviewed and report of the pure smooth to be a compared to the pure smooth to the pure smooth to be a compared to the pure smooth to the pur	AM observations were made n.  the kitchen manager e puree turkey for the lunch erved pureeing cut up pieces ng a food processor. The rumbled meat. The kitchen er to the turkey mixture and at to a thinner consistency. It is added water two more eved turkey resembled ato" consistency. During the		Criteria #2 All residents who receive a purhave the potential to be affect. However, all residents receiving diet were assessed by the diet 10/1/14 to ensure there were coutcomes for residents receiving food made with water rather the recipe guidelines which called and thickener.  Criteria#3 The kitchen manager was insected the Dietary Manager on 9/25/16 following the recipe for pure cother dietary employees who are responsible for making puree also inserviced by the Dietary 9/25/14 on following the recipe diet. The Dietary Manager will	ed. ng puree tician no negative ng puree nan using for broth  erviced by 14 on diets. All are meals were Manager on e for puree	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		PLETED
		345179	B. WING _				C <b>26/2014</b>
	ROVIDER OR SUPPLIER	TIREMENT		75	TREET ADDRESS, CITY, STATE, ZIP CODE  2 E CENTER AVENUE  OORESVILLE, NC 28115	03/	20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 364		e 21 or gravy but she did not he turkey so she used	F	364	dietary employees daily for five days, the three times weekly for 12 weeks to ensemployees are following the recipe for		
		xture was served to the 11 diets for the lunch meal on 2:30 PM.			puree diets. The Dietary Manager will review the menus and food orders wee to ensure all ingredients are available f puree diet.		
F 371 SS=F	conducted with the ki explained that she us food for residents. The turkey was reviewed and food thickener was a slurry and used to the The kitchen manager	DD PROCURE, F 371		ich	10/16/14		
	considered satisfacto authorities; and	sources approved or ry by Federal, State or local stribute and serve food ions					
	by: Based on observation record review the fact machine reached pro	ns, staff interviews and lility failed to ensure the dish per wash temperatures and per sanitizing solution in the			Criteria #1 All breakfast dishes were rewashed on 9/22/14 at the proper temperature. Dietary Aide #1 was inserviced by the		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION		E SURVEY PLETED
		245470	D MING			С
		345179	B. WING _		•	/26/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
BRIAN CE	NTER HEALTH AND I	RETIREMENT		752 E CENTER AVENUE		
DIVIAN OF	ALIII AIID I	C I II CIN CIV		MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 371	09/22/14 at 8:45 A During the tour, ob dish machine in us the dish room clea breakfast meal ser machine were mac wash temperatures  - At 8:56 AM wa degrees Fahrenhe - At 9:00 AM wa degrees Fahrenhe - At 9:02 AM wa degrees Fahrenhe On 09/22/14 at 9:0 interviewed and re monitor the temper machine while in u recorded rinse and daily log. The dieta unaware of any co temperatures. The rinse cycle was to or hotter and the w reach 150 degrees reported that if the the proper tempera report the problem	kitchen was made on M with the kitchen manager. servations were made of the e. Two dietary aides were in ning dishware from the vice. Observations of the dish le that revealed the following s: ash temperature reached 142 it ash temperature reached 150 it ash temperature reached 150	FS	dietary manager on proper procedures, including nor dish machine and monitor temperatures during was 9/25/14. The morning commanager were inserviced manager on 9/25/14 on manager elements have the position of the proper Presidents have the position of the proper temperatures, and the sawas brought to proper President was negatively at Criteria#3  All dietary staff were insertioned in the dish mach monitoring for proper temperature on using test solution to ensure proper compartment sink. Dietary Manager will obsfor proper dishwashing pensure dishwasher temperature dishwasher temperature of 3 compartments of 3 compa	er dishwashing t turning off the oring for proper th/rinse cycles on ook and kitchen d by dietary monitoring oper Parts Per ortment sink prior  tential to be akfast dishes oper unitizer solution PM, and no affected.  erviced on proper including not ine, and operatures by during, and after etary staff were estrips for sanitizer PPM in 3  erve dietary staff rocedures to eratures are the dishwashing er will test ent sink to ensure	
	dish machine. The degrees Fahrenhe	wash cycle reached 146 it. The dietary aide reported		for 5 days, then 3 times pweeks.		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE COMP	
		345179	B. WING _			09/:	26/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	1 00//	20/2014
DDIAN CE	NTER HEALTH AND RE	TIDEMENT		752 E CENTER AVENUE			
DRIAN CE	INTER HEALTH AND RE	IREMENT		MOORESVILLE, NC 2811	15		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRI EFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From page	e 23	F 3	71			
F 371	reaching the required dishware. She notified reported that the was 160 degrees Fahrenh the facility's Maintenath on 09/22/14 at 9:15 A observed the dish madish machine manufadish machine was abobserved the dish mathat dietary aide #1 who between cycles which reach proper wash tedishware.  2. An initial tour was 09/22/14 at 8:45 AM During the tour, obse 3-comparment sink in was interviewed at 8: was responsible settil explained that after cotested the sanitizing sproper sanitizing solu was to be 200ppm (phonounce) on 09/22/14 at 8:52 A tested the 3-comparment to be 100ppm. She rehave the proper amono clean the dishware. Sthe sink had been set	temperate to sanitize d the kitchen manager who h temperature should be neit. She proceeded to notify ance Director.  AM the Maintenance Director achine. He contacted the acturer. A technician for the le to come on site and achine in use. He determined was turning the machine off in caused the machine to not imperatures for sanitizing  made of the kitchen on with the kitchen manager. rvations were made of the in use. The morning cook 50 AM and reported that she	F 3	Criteria#4 Dietary Manager will observations and sa the Quality Assurand Improvement (QAPI for 3 months at whic Committee will deter monitoring is needed	nitizer test results be and Performand ) Committee month th time, the QAPI rmine if further	to e	
	reported that the mor re-tested the sanitizin resumed using the 3-						