STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(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 A complaint survey was conducted from 08/24/23 through 08/25/23. The following intakes were investigated: NC00206243, NC00206148, NC00206023, NC00205446, NC00205256, NC00204873, NC00202417 and NC00200289. Intakes NC00206148 and NC00206023 resulted in immediate jeopardy. 2 of the 14 complaint allegations resulted in a deficiency. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity J. The tag F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 08/09/23 and was removed on 08/11/23. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		9/12/23

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

Electronically Signed | 09/12/2023

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F 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff, Responsible Party (RP) and law enforcement officer interviews, the facility failed to protect a cognitively impaired resident (Resident #1) from physical abuse from an employee when Nursing Assistant (NA) #1 was witnessed by another employee, Personal Care Assistant (PCA) #1, with both hands around Resident #1's neck in response to the resident being combative with care. Resident #1 did not have the cognitive capacity to express an adverse outcome. A reasonable person would have been traumatized by being physically abused by their caregiver in their home environment. This occurred for 1 of 2 resident reviewed for abuse. Immediate Jeopardy began on 08/09/23 when the facility failed to protect Resident #1's right to be free from abuse. The Immediate Jeopardy was removed on 08/11/23 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of a "D" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and that monitoring systems put into place are effective. The findings included: Resident #1 was admitted to the facility on 12/13/22 with diagnoses which included, in part, cerebral infarction, altered mental status, and	F 600	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation. Allegation-F-600—Freedom from Abuse, Neglect and Exploitation The facility failed to protect the resident from alleged physical abuse. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. •The resident #1 had a head-to-toe skin assessment completed by a licensed nurse to ensure that there were no negative outcomes incurred by the resident because of the staff to resident contact that was made on 08/09/2023. Resident #1 of focus is cared for and has their needs met by NA#1 who have been appropriately trained in the use of techniques and practices that are industry accepted and that have no potential for harm or abuse to be experienced by the resident during their care. The staff member of focus in the citation was immediately suspended upon the administrator's knowledge of the allegation and this staff member will not be returning to work at the facility. The police were notified as well as the physician and the family, and an initial report was made to the NCDHHS on	

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F 600	Continued From page 2 aphasia. The quarterly Minimum Data Set (MDS), dated 06/22/23, revealed Resident #1 had clear speech, was sometimes understood, and usually understood others. Resident #1 was assessed as severely cognitively impaired and required the total assistance of one staff member for transfers and toileting. The assessment indicated Resident #1 had rejection of care one to three days during the assessment period and no physical or verbal behavioral symptoms directed towards others and no other behavioral symptoms not directed toward others. A review of the facility's Incident Report, completed on 08/09/23 by the Administrator-in-Training (AIT), indicated the following, "Alleged Abuse, location resident's room. Description: this writer was informed that resident accused a staff member of grabbing her around the neck. Resident Description: staff put her hands around my neck. Immediate Action Taken: Resident was assessed by DON/ADON [Director of Nursing/Assistant Director of Nursing]. Injury Type: no injuries observed at time of incident. Mental Status: oriented to person, place, time. Injuries Report Post Incident: No injuries observed post incident." A review of the facility's investigation into a staff (NA #1) to resident (Resident #1) abuse allegation revealed a handwritten and signed statement from NA #1 on 08/09/23. It read as follows, "On 08/09/23 I was called into [Resident #1's room] to assist [Resident #1] off the toilet. Once I entered the bathroom, she immediately made a fist with her right hand and punched me in the neck. She continued to resist care, at	F 600	08/09/2023 with a 5-day report to follow the investigation is completed with findings 08/10/2023. APS was notified as well by police. The facility has been in ongoing cooperation with all authorities related to this incident. The Medical Director saw the resident on 08/18/2023. • Social Services Designee followed up with the resident daily x 3 for any signs of emotional upset that might be related to the allegation. There were none. •An Action Plan was rolled out in the facility that addressed allegations of Staff to Resident Abuse. The facility held an CQI meeting in the a.m. of 08/10/2023 to review and discuss the Action Plan rolled out 08/09/2023. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. •All residents who reside in the facility have the potential to be affected by this finding. Residents with a BIMS of 8 or greater were interviewed on 08/10/2023 to ensure that they had no concerns with any actions or speech used towards them or others that they feel are “abusive.” Residents with a BIMS of 7 or less, were assessed on 08/10/2023 for any new skin issues that could be related to physical “abuse.” There were no findings. •Going forward, the DON/ADON/SW will monitor 20 residents weekly for any indication of abuse. Ten residents will be interview able, ten will be skin assessed. This monitoring will continue for 4 consecutive weeks. After that, 10 residents will be monitored weekly for any	

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which point I left the bathroom and had another staff member assist [Resident #1].

Further review of the investigation revealed a telephone interview with NA #1 was conducted by the AIT on 08/09/23 at 4:15 p.m. The interview was transcribed and read as follows, "I have not been involved with nor know of anyone in the facility that has been rough with [Resident #1]. At no point did I put my hands around [Resident #1's] neck. I was called to the room by her roommate, I noticed [Resident #1] in her bathroom sitting on the toilet. I did not want her to fall so I called for help at which time I asked [PCA #1] to come in the bathroom with stand-by for assist while I attempted to transfer back to her wheelchair. At that time, resident became aggressive towards me and by shaking her fist at me and then told [PCA #1] I will do this the resident and I walked out to get someone to come help her while [PCA #1] stayed with the resident and I walked out to get someone to come help her while [PCA #1] stayed with the resident. At no time did I put my hands around her neck."

An interview with Resident #1 was conducted on 08/25/23 at 10:16 a.m. The resident was observed sitting in her wheelchair in her room; she was awake and alert and very soft-spoken and difficult to hear when she answered questions asked of her. When Resident #1 was asked if she had ever been hurt at the facility, Resident #1 nodded her head yes and stated, "she was choking me" and at the same time she took her own hands and grabbed her neck and demonstrated the action. Resident #1 further stated that she had witness. Resident #1 was unable to name or describe the witness during

indication of abuse. Five will be interview able and five will be skin assessed. This will continue for a period of 6 months to ensure ongoing compliance.
•At the daily morning CQI (Clinical Quality Indicator), meetings, held M-F, the progress notes since the prior morning CQI meeting will continue to be reviewed as part of the meeting agenda. Any indications of new or increased behaviors will be reviewed and discussed and the SW will add these residents to a targeted list of residents with behaviors. These residents will be addressed by the SW/DON/ADON to see that the new or increased behavior is immediately addressed by the appropriate healthcare provider to include any necessary referrals. These will be followed up daily by the Administrator/DON/ADON/SW until resolved or managed. These residents will also be discussed at the monthly Behavior Management meetings ongoing.
3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.
A focused in-service on the Abuse Policy/Process was conducted by the Administrator as a review on 08/08/2023. The DON reviewed the Abuse Policy with the Administrator again on 08/10/2023.
•All staff in-servicing began on 08/09/2023-08/10/2023 on the following: The in-service(s) was conducted by the DON/ADON Administrator.
1) Abuse Policy to include identifying abuse, resident safety.
2) How to handle escalating resident

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F 600	Continued From page 4 this interview. An interview was conducted with Resident #1's RP on 08/24/23 at 3:58 p.m. The RP stated when she visited Resident #1 on 08/09/23 she had been notified of the incident. The RP explained the resident was very soft-spoken and at times it was difficult for her and staff to understand what she said. The RP said she asked Resident #1 about the incident and reported the resident put her hands around her neck and squeezed and then proceeded to describe NA #1. The RP stated Resident #1 indicated she had a witness and proceeded to describe PCA #1. Attempts made to contact NA #1 for a telephone interview on 08/24/23 and 08/25/23 were unsuccessful. An interview was conducted with PCA #1 on 08/24/23 at 1:43 p.m. The PCA explained she had been working on 08/09/23 during the 7:00 a.m. to 3:00 p.m. shift when she discovered Resident #1 in the bathroom on the toilet towards the end of the shift. The PCA explained she was not allowed to perform any patient care activities and sought out Resident #1's assigned NA, NA #1, to assist the resident off the toilet and back into her wheelchair. PCA #1 indicated NA #1 argued with Resident #1 and questioned why she was on the toilet as it appeared Resident #1 placed herself on the toilet instead of being assisted by staff as was usual. PCA #1 stated NA #1 left the bathroom at that time and explained she followed her out of the bathroom and remarked to NA #1 they probably should not leave her on the toilet and indicated they both returned to the resident's bathroom. PCA #1	F 600	behaviors—appropriate interventions/redirection 3) Staff “burn-out” ---how to recognize and address. •All newly hired employees will be educated by SDC/ADON during the orientation process on facility policy on Abuse and Neglect and How handle a combative resident. 4 How the corrective actions will be monitored to ensure the deficient practice does not recur- (i.e., what quality assurance program will be put into place and by what date the systemic change for the deficiency will be completed. • The Administrator/Designee will report monthly to the Quality Assurance committee and then randomly or as needed based on the QAC. • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Dates when corrective action will be completed: 09/29/2023.	

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stated she stood just inside the bathroom door and indicated NA #1 was positioned on Resident #1's right side. PCA #1 described that NA #1 attempted to assist the resident off the toilet, but the resident became agitated and tried to hit NA #1 in the stomach. PCA #1 acknowledged the punch "never landed" which meant NA #1 did not get hit. PCA #1 explained NA #1 became upset, did not say anything to the resident at that moment and took both of her hands and placed them around Resident #1's neck and squeezed and choked her. PCA #1 said she yelled, "girl stop" at NA #1 while Resident #1 tried pulling NA #1's hands away from her neck. PCA #1 stated NA #1 did stop, removed her hands from Resident #1's neck and left the bathroom. PCA #1 indicated she got another NA to assist the resident off the toilet and into her wheelchair and then she pushed the resident in her wheelchair to the Director of Nursing's office to report the incident. The PCA stated the Director of Nursing (DON) was not in her office, so she reported it to the Assistant Director of Nursing (ADON).

An interview was conducted with the ADON on 08/24/23 a 1:11 p.m. The ADON explained she was in the DON's office on 08/09/23 around 3:00 p.m. when PCA #1 brought in Resident #1 and reported NA #1 had put her hands around Resident #1's neck and choked her. The ADON further explained because the DON and the AIT were both out of the facility at that time, she had called the AIT and received instruction from the AIT to place NA #1 in the conference room, obtain a written statement from her and then escort her out of the facility. The ADON indicated that once NA #1's statement was written, she escorted her out of the facility as instructed. The ADON explained she also obtained a statement

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from PCA #1 and contacted the police as per the AIT's instruction. The ADON explained that a deputy from the county sheriff's office arrived, interviewed PCA #1 and herself and told her the case would be referred to an investigator.

A telephone interview was conducted with the Deputy from the sheriff's office on 08/25/23 at 9:42 a.m. The Deputy explained when he arrived at the facility on 08/09/23 to complete an initial report, NA #1 had already been sent home, so he was not able to interview her, but indicated he interviewed Resident #1 and PCA #1. The Deputy stated during his interview with Resident #1, she had tried to explain what had occurred and described her repeatedly putting her hands on her neck and pulling at the skin on her neck. The Deputy indicated there were no signs of any bodily harm except for the redness on her neck which he admitted came from Resident #1's own hands pulling at her skin. The Deputy stated he turned the case over to the Lieutenant investigator.

An interview was conducted with the Lieutenant from the sheriff's office on 08/25/23 at 9:46 a.m. The Lieutenant explained NA #1 arrived at the sheriff's office where an interview was conducted and recorded. He further explained NA #1 denied the allegation of having choked Resident #1 and that she had described her interaction with the resident as an attempt to prevent the resident from falling off the toilet. The Lieutenant demonstrated how NA #1 described putting one of her forearms under one of the resident's arms and her other arm across her chest. The Lieutenant stated NA #1 was charged with a misdemeanor assault of an elderly individual with a disability and stated NA #1 was in court on this

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date, 08/25/23, related to the charge.

An interview was conducted with the AIT on 08/24/23 at 12:25 p.m. The AIT explained that she was out of the facility on 08/09/23 when she received a phone call from the ADON who informed her of the abuse allegation. The AIT further explained when she arrived at the facility on 08/09/23, the deputy had already interviewed Resident #1 in person and did a video interview with PCA #1 as she had left the facility for the day. The AIT stated she completed the Initial Report to the State and performed a skin assessment on Resident #1. The AIT described the resident's skin assessment as normal with no signs of injury and began the investigation which included skin assessments on all the residents in the facility as well as interviews with alert and oriented residents about staff to resident abuse and reported there were no significant findings from the skin assessments or resident interviews. When asked if she had completed any monitoring since the incident, she remarked that it was the first time she had an incident and investigation such as this and stated she did not know she needed to do anything else. The AIT stated she now knew that she should have done further monitoring and would do so if anything like this incident occurred again in the future. She confirmed NA #1's employment at the facility was terminated on 08/10/23 as it had been determined the incident did occur. She also stated a Lieutenant investigator with the sheriff's office came to the facility on 08/11/23 to begin an investigation. The AIT said she received a phone call from the Lieutenant on a later date and he had informed her NA #1 had gone to the sheriff's office, given her statement, and had been charged with a misdemeanor assault on an

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elderly person on 08/16/23.

A telephone interview was conducted with the Administrator on 08/24/23 at 3:19 p.m. The Administrator explained he was not at the facility at the time of the incident on 08/09/23 and that he had received a phone call from the AIT who informed him of the abuse allegation. The Administrator stated he gave instruction to the AIT in regard to safeguarding the resident, calling law enforcement, reporting to the State, and beginning an investigation of the incident. The Administrator indicated he felt this was not just an assault but was elder abuse. He clarified that despite having done background checks on NA #1 prior to employment there was no way they could have predicted what NA #1 would do to a resident, he insisted charges be filed as one does not "accidentally put their hands around someone's neck." The Administrator commented he did not know what they could have done differently and felt, after the incident, they had done everything correctly in regard to reporting to law enforcement and to the State and completing their investigation.

On 08/24/23 at 5:30 p.m., the AIT was informed of immediate jeopardy. The facility provided a credible allegation of immediate jeopardy removal. The allegation of immediate jeopardy removal indicated:

Identify those recipients who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:
- NA #1 was removed from the floor following the observation of abuse. She was terminated on 08/10/2023.
- The Administrator-in-Training submitted the

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24-hour initial report to State Agency on 08/09/2023 and investigation report on 08/10/2023 pertaining to incident involving Resident #1 and NA # 1.
- Resident #1 was interviewed by the Administrator-in-Training and DON/ADON 08/09/2023 and indicated that she is feeling safe at facility. On 08/10/2023 the Administrator-in-Training completed a skin assessment on Resident #1, and on 08/10/2023 a skin assessment was completed again by the Management Nurse. Skin assessments conduct on 08/09/2023 and 8/10/2023 showed no injuries.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from the occurring or recurring, and when the action will be completed:
- All residents have potential to be affected by the alleged deficient practice.
- All interviewable residents were interviewed by Social Worker on 08/10/2023. The question asked was, has a staff member or anyone else abused you, physical, verbal or mentally. All residents have the right to be free from abuse. The interviews revealed no results of concern.
- 100% of all residents had a skin assessment completed on 08/10/2023 by the DON and no concern of injuries were noted.
- 08/09/2023, the Administrator-in-Training initiated an in-service to all facility staff to be conducted by Director of Nursing/ADON on the facility policy on "Abuse and Neglect" immediately to ensure the safety of all residents. On 08/09/2023 the staff was in-service on following abuse, verbal, physical, and mental. Any staff not in-serviced by 08/09/2023, will be in-serviced prior to next scheduled shift.
- All newly hired employees will be educated by

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Staff Development Coordinator/ADON during the orientation process on facility policy on Abuse and Neglect and How handle a combative resident.
- On 08/10/2023 100% of licensed, and unlicensed nursing staff, dietary staff, activity staff, housekeeping staff, rehabilitation staff and social services staff were educated by the Staff Development Coordinator (SDC) on the protocol regarding residents with behaviors. The protocol in-service topic was on, how to recognizes changes in behavior that indicate psychological change, maintain your composure and be aware of your emotions, tone voice, and body language, and consider taking a short break or time-out if the resident becomes agitated. Any staff not in-serviced will be in-serviced prior to next scheduled shift.

Alleged date of Immediate Jeopardy removal will be 08/11/2023.

The credible allegation of immediate jeopardy removal was verified on 08/25/23 as evidenced by review of the documentation of Resident #1's skin assessment completed on 08/09/23, skin assessments of all other the residents in the facility completed on 08/10/23, interviews conducted with alert and oriented residents in the facility on 08/10/23, and in-service education on 08/09/23 and 08/10/23 to all the staff at the facility related to the facility's abuse policy and procedures and how to provide care to residents with behaviors. Interviews conducted with staff on 08/25/23 confirmed they had received the in-service education. The validation further verified that the facility had no evidence of monitoring implemented following the 08/09/23 physical abuse of Resident #1 and the facility made no decision to take this non-compliance to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(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 600	Continued From page 11 the Quality Assurance and Performance Improvement committee prior to the suvey. The facility's immediate jeopardy removal date of 8/11/23 was validated.	F 600		