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	345318	A. BUILDING _____ B. WING _____	C 05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK COVE NURSING CENTER	1478 RIVER ROAD WINNABOW, NC 28479

(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 An unannounced complaint investigation was completed at this facility from 05/10/21 through 05/12/21. One of one of the allegations was substantiated with deficiency. Event ID #E0TE11	F 000		
F 600 SS=G	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- §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, staff and resident interviews, the facility failed to protect a resident ' s right to be free from mistreatment after notifying the Ombudsman of not getting showers for 1 of 1 residents (Resident #1) reviewed for abuse. Findings included: Resident #1 was admitted to the facility on 07/08/19. Diagnosis included stroke with left sided weakness to upper and lower extremities. The Minimum Data Set annual assessment dated 02/20/21 revealed the resident was cognitively	F 600	Resident #1 was visited by the Ombudsman and he was informed that she felt she was retaliated against by certain staff members during her shower. The WTN wrote a statement to the same effect but never reported it to the DON or Administrator until after the Ombudsman's visit. The Resident during an interview by the Administrator and DON stated that she felt safe and didn't want to change rooms or staff.	6/18/21

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

Electronically Signed | 06/14/2021

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F 600	Continued From page 1 aware, demonstrated no moods or behaviors, and required total dependence with two staff physical assistance with bed mobility, transfers, and bathing. Resident #1 had an impairment to one side to the upper and lower extremities and used a wheelchair. An observation of Resident #1 on 05/10/21 at 1:30 PM revealed an alert and oriented resident lying in her bed. Her hair was pulled back in a ponytail. An interview was conducted with Resident #1 on 05/10/21 at 1:30 PM. Resident #1 reported on 05/04/21 three nursing aides (NAs) came into her room yelling and were mad because it was the near the end of their shift and they had to give her a shower. Resident #1 stated one of the NAs stated, "We have to give you a shower because you went and called the Ombudsman!" Resident #1 stated they transferred her from her bed to the shower bed with a mechanical lift in a rushed and roughed manner and brought her to the shower room. Resident #1 stated she asked them to get her body wash, shampoo and cream rinse and was told "You won ' t need that!" Resident #1 stated while in the shower room she barely got wet and her ponytail holder was not taken out of her hair and she had requested cream rinse and was told "You ' re getting a shower, that ' s all you are entitled to, be grateful." Resident #1 reported she told the NAs the water temperature was scalding, and the response from one of the NAs was "You ' re getting a shower, be quiet." Resident #1 stated one of the NAs turned the water temperature down. Resident #1 stated she felt the NAs were being mean to her during her shower because she had called the Ombudsman about not getting showers and they were	F 600	The staff was educated on types of abuse and how/ who to report it to immediately. The staff members who were named in the complaint have been educated in addition to the general staff education regarding abuse and mistreatment. The Resident Council meeting will address with the Residents about their Rights and Abuse. They will also be advised of who to report allegations and the urgency of such a report. The Ombudsman's contact information is currently posted in various locations around the facility and available upon request. A census of alert and oriented Residents was used to interview randomly throughout the Facility to ensure there are not other Residents who have concerns regarding abuse/ mistreatment. Going forward the Facility will include this education to Residents at Care Plan meetings as well as monthly Resident Council Meetings. Any other grievances that include suspicion of abuse of any type will be reported to DHHS and the accused will be suspended pending investigation. The findings of the interviews will be reported monthly at our QAPI meeting for the next 3 months or longer if needed.	

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retaliating against her. Resident #1 stated after the shower, she was placed in the dining room to eat lunch and was left in the shower chair with wet hair. Resident #1 stated she asked for a towel for her head because her hair was still wet, and NA #3 brought the towel and just put it on top of her head. Resident #1 stated she asked for her glasses, her tea and her saltshaker and NA #3 brought her those items. Resident #1 reported she usually ate her meals in her room, but stated she felt the NAs brought her to the dining room instead of back to her room because they were punishing her for calling the Ombudsman. Resident #1 stated she had lunch in the dining room and remained there until about 3:00 PM when the Wound Treatment Nurse (WTN) came and put her back to bed. Resident #1 stated she told the WTN what happened to her while she was in the shower and the WTN assessed her and reported she had no burns or redness noted anywhere on her body. Resident #1 reported she did not have any pain after the shower on 05/04/21 and added that usually one only aid showered her, but she needed two aids to be transferred with the lift. Resident #1 stated she had a horrible day that day and she was very upset the aides were behaving that way.

A written statement by Nursing Assistant (NA) #1 on 05/05/21 revealed NA #1 gave Resident #1 a shower accompanied by two of her coworkers. The statement indicated at 11:15 AM entered resident ' s room with the mechanical lift and bath bed, entered the shower room at 11:30 AM, shampooed her hair and washed her body twice and rinsed her off from head to toe and then lifted her on mechanical lift and put her into the Geri chair and placed her in the dining room for lunch.

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An interview with NA #1 was not conducted. The Administrator reported NA #1 was on vacation and could not be reached.

A written statement by NA #2 on 05/05/21 revealed NA #2 went into Resident #1 ' s room to get her ready for a shower. The statement indicated we put her on a lift pad, then we transferred her to the shower bed, pushed her into the shower where we started her bath. We washed her twice, washed her hair, we then dried her, put her clothes on, put back on lift pad, and transferred her to a Geri chair. Brushed her hair, put it in a ponytail and Resident #1 took it out.

An interview with NA #2 was conducted on 05/11/21 at 9:26 AM. NA #2 reported on 05/05/21 she was doing her rounds and when she got finished about 11:15 AM, the nurse wrote NA #1 a note to give Resident #1 a bath. NA #2 stated she suggested to NA #1 since lunch trays were soon to come out maybe they could do the shower tomorrow and NA #1 told NA #2 "No, we need to do it now." NA #2 stated her, and NA #1 entered Resident #1 ' s room and we told her we were getting her up and giving her shower. NA #2 stated we did not fuss about it because we knew it had to be done. NA #2 reported that her and NA #1 did not say much while we were in the room and they just transferred the resident from her bed to shower bed. NA #2 added, we were not rough with the resident and we were not yelling at the resident. NA #2 stated we proceeded to roll her down the hall, and rolled her into the shower room, and the water was already turned on by NA #1. NA #2 stated we asked for NA #3 to help us because it would be quicker with the three of us and safer for the resident because one side of the shower bed did not lock so it

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helped to have 3 people. NA #2 reported the resident was in the shower stall on the left and when NA #3 started to shower the resident with the water, the Resident stated it was too hot and NA #3 turned it down, then she stated it was too cold and NA #3 adjusted it again it for her. NA #2 stated that they had the facility stock supplies in the shower room and would usually use those supplies. NA #2 stated she did not know if Resident #1 preferred to have her own supplies and did not recall the resident asking for her own supplies. NA #2 reported NA #1 took her ponytail out and washed her hair and she and NA #3 washed her body. She stated we washed her, rinsed her off and washed her again and rinsed her again. NA #2 reported when they were done, they dried her off and put a bath towel under her and over her and rolled her over to place the lift pad under her. They got her dressed in a gown because she chose to not to wear clothes and her hair was put back up in ponytail. NA #2 stated we then transferred her to the Geri chair and took her to the dining room. NA #2 stated they did not keep her in the shower chair when they brought her to the dining room. NA #2 stated the resident asked for a towel for her hair and was complaining that her was still wet and she took her ponytail out. NA #2 reported the resident complained about never getting out of bed, so we asked her if she wanted to eat in the dining room. NA #2 reported the resident seemed to enjoy being up and talking with the other residents in the dining room and eating having a good time. NA #2 stated she had asked for her tea and her saltshaker and a towel for her hair and NA #3 brought her those items. NA #2 reported that she did not speak to the resident in a derogatory way or treat her rough while transferring and showering her. She stated, "nothing like what the

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resident said happened." NA #2 added, the shower door was slightly opened and because we were in the shower room with water running, we may have had our voices raised, but we were not yelling at her.

A written statement by NA #3 dated 05/06/21 revealed NA #3 was sitting at the desk charting on the computer when NA #1 and NA #2 came to the shower room with Resident #1 on the shower bed. NA #3 was asked to come and assist with turning her on the shower bed because the bed only locked on one side. During her shower, she stated it was warm and she turned it down and she stated it was cold, then she stated it was okay. The statement indicated after she was bathed twice and rinsed, NA #3 assisted with drying her off and getting her dressed and the other 2 aides helped to get her dressed and put the lift pad under her so she could be transferred to the Geri chair and placed at the table in the dining room for lunch. While at the table, Resident #1 requested a towel, her glasses, and her saltshaker from her room. All three things were given to her.

An interview was conducted with NA #3 on 05/10/21 at 2:30 PM on 05/10/21. NA #3 stated on 05/04/21, she was sitting at the nurse ' s station charting. NA #1 and NA #2 went to Resident # 1 ' s room to get her ready and transferred her onto the shower bed and while bringing the resident to the shower room had asked her to help so they could turn her safely. NA #3 stated when we got in the shower room, we took the lift pad out from under her and began her shower. NA #3 reported the Resident stated the water was too hot, so she turned the water down, then she said it was too cold, so she

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adjusted it again and she said that was fine. NA #3 reported the resident got washed, rinsed, washed again, and rinsed again. NA #3 stated they washed her hair with an all in one shampoo and conditioner and did not recall the resident asking for her specific shower products. NA #3 stated we usually used what was provided for us by the facility and it was kept in the shower room. NA #3 reported that the resident ' s hair was taken out of the ponytail before they washed it. NA #3 reported we placed bath blankets on the shower bed, placed the lift pad on the shower bed and blankets and used towels to dry Resident #1 and we put a towel on her hair. We got her dressed on the shower bed and then transferred her to the Geri chair. NA #3 stated we rolled Resident #1 to the dining room in the Geri chair. NA #3 stated we would never place a resident in the dining area in a shower bed. NA #3 believed that the resident thought because NA #1 combed her hair and put it back in the ponytail while it was still wet, that we never took the rubber band out of her hair. NA #3 stated when she was in the dining room either the resident or the nurse took the ponytail out because she saw that her hair was down when she asked for a towel for her head. NA #3 stated she wrapped the towel on the resident ' s head and tucked it in, and she did not just put it on top of her head. NA #3 stated she had asked for her tea, glasses and saltshaker from her room and she got them for her. NA #3 stated the resident had not been up for a while, so they offered to put her in the dining room, and she agreed. NA #3 added, Resident #1 did not say she didn ' t want to sit in the dining room. She stayed in there for a good little while and talked to other residents and ate her lunch. NA #3 denied telling the resident "she was lucky she was even getting a shower." NA #3 stated their

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voices may have been elevated in the shower room because they were talking over the running water, but they were not yelling or speaking to the resident in an inappropriate way.

A written statement by Nurse #1 on 05/05/21 revealed on 05/04/21 at approximately 12:00 PM, Nurse #1 observed Resident #1 exiting the shower room on the Geri chair. Skin was pale and dry and wet hair at shoulders. Hair was soft and easily placed in a ponytail with my fingers running through her hair. The shower room door was opened twice during the shower with the NA requesting a clean gown and Geri chair to another NA.

An interview was conducted with Nurse #1 on 05/11/21 at 10:02 AM. Nurse #1 reported on 05/04/21, the ADON had come out and told her that she had made an arrangement with the Ombudsman to make sure Resident #1 received a shower once a week and she was supposed to get it on Monday but there was only one aid on Monday and to make sure on Tuesday the resident got her shower. Nurse #1 reported on 05/05/21 she informed NA #1 and NA #2 to make sure Resident #1 got her shower now. NA #1 and NA #2 got the shower bed and the mechanical lift and went into Resident #1 ' s room. Once they got the resident on the shower bed and were transferring Resident #1 to the shower room, they asked NA #3 to help. Nurse #1 stated one of the aides opened the door twice during the shower to request a clean gown and then another time to request the Geri chair. Nurse #1 stated at about 11:45 AM they came out of the shower room with Resident #1 in her Geri chair and brought her to the dining area. Nurse #1 stated the resident did not seem to be in any emotional distress or upset

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when she came out of the shower room or while having lunch in the dining room. Nurse #1 stated Resident #1 had 12:00 medications to be given and when she brought them to her in the dining area she noticed Resident #1 ' s hair on her shoulders because it was long and curly. Nurse #1 stated the resident complained that they did not put cream rinse in her hair and the nurse touched her hair and stated to the resident "it ' s really soft, someone must have combed it." Nurse #1 added, at this time she put her hair up in a ponytail with the rubber band the resident provided her from her pocket. Nurse #1 stated the staff were speaking loudly while in the shower room, but she could not hear what they were saying, but it did not sound like yelling. Nurse #1 stated if it sounded like the aides were yelling or speaking inappropriately toward Resident #1, she would have gone into the shower room immediately. Nurse #1 stated Resident #1 reported to her the water was too hot in the shower, so she looked over her skin to see if she was reddened anywhere and her skin was noted to be pale and she did not have any complaints of pain. Nurse #1 reported she and the WTN assisted her back to her bed about 2:45 PM and Resident #1 never reported any kind of mistreatment or verbal abuse from the aides to her.

A written statement by the Wound Treatment Nurse (WTN) on 05/05/21 revealed on 05/04/21 at approximately 3:00 PM, the WTN arrived on station 4 and saw Resident #1 sitting slumped over to the left side in a Geri chair at the station 4 dining area. The WTN took Resident #1 back to her room via the Geri chair with Nurse #1 who assisted with transferring the resident from the Geri chair back to her bed utilizing the

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mechanical lift. The resident ' s skin was within normal limits.

A typed statement by the WTN dated 05/05/21 read: Complaint from Resident #1 as told to Wound Treatment Nurse, RN 05/05/21. On the morning of Tuesday, 05/04/21 sometime after 11:00 AM, three NAs, came into Resident #1 ' s room yelling and screaming at Resident #1 that she had called "the damn ombudsman" so they had to give her a shower. She was moved very roughly from her bed to the shower bed with a mechanical lift, all the while the NAs continued to scream and yell about the Ombudsman and having to give Resident #1 a shower. As she was being moved to the shower bed, Resident #1 asked them to get her body wash, shampoo, and cream rinse. It was stated that she wouldn ' t need them. Resident #1 stated that the shower lasted about 5 minutes, she barely got wet, the ponytail holder was not even taken out of her hair. Resident #1 requested cream rinse for her hair and was told "You ' re getting a shower, that ' s all you are entitled to, be grateful." She stated that the water was scalding, but when she protested she was told "you ' re getting a shower, be quiet." They continued to yell at Resident #1 throughout the shower. When the 5 minute shower was over, she was not dried off, a gown was put on her while she was still wet and she was transferred from the shower bed into the Geri chair without being told that she was not going back to her room or asking if she wanted to be in the Geri chair. She was wheeled into the station 4 dining area with no towel on her head and still wet. Resident #1 stated she was positioned with her back to the nurse ' s station but could hear the NAs talking among themselves. She asked to be taken back to her room on several

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occasions, but no one answered her. She requested water with no response, then out of nowhere Nurse #1 appeared with a cup of ice water for which she was very grateful. The resident felt she was brought into the dining room as punishment for requesting to have a shower. One of the comments a NA made was Resident #1 called the damn ombudsman and we got stuck. The resident requested her glasses so that she could see what she was eating and was told to "shut up." Eventually NA #3 brought her glasses, tea, and saltshaker.

An interview was conducted with the Wound Treatment Nurse on 05/11/21 at 10:18 AM. The WTN stated at 2:45 PM on 05/04/21 she had seen Resident #1 sitting in the dining room which was highly unusual because she was not usually out of her room. The WTN stated the resident was in a Geri chair, slumped over to the left side and was nodding off and on. The WTN stated she and Nurse #1 assisted the resident back to bed and when Nurse #1 left the room Resident #1 reported to her that she had a horrible day and informed the WTN the NAs were yelling at her and gave her a scalding hot shower. The WTN reported she assessed her skin immediately and there were no signs or symptoms of burns and the resident had no complaints of pain. The WTN nurse stated she took the residents ' statement and typed it up and left a copy on the Director of Nursing ' s (DON) desk. The WTN stated the resident was genuinely upset while she shared her experience about the shower and the way the 3 NAs treated her. The WTN stated she should have handed the typed statement to the DON to be sure the DON saw the allegation and not just have left it on her desk.

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An interview with the Ombudsman via phone on 05/11/21 at 10:36 AM revealed he had had many meetings with Resident #1 over the last couple of months due to her requesting showers over and over again and never receiving one. The Ombudsman reported the explanation he received from the DON was that she the resident would get cleaned up with every wound care dressing on Monday, Wednesday and Friday, but the resident stated it was just cleaning up and she would prefer to have a shower. The Ombudsman reported he spoke to the DON who had put Resident #1 on the schedule for Monday showers so it could be worked in around the time of the wound care. He stated he told Resident #1 to call him if she did not get her shower on Mondays. The Ombudsman stated he was notified by Resident #1 ' s Power of Attorney (POA) on Tuesday 05/05/21 that Resident #1 did not get a shower on Monday because she was told by the staff there was not enough staff on Monday so she would get a shower on Tuesday. The Ombudsman told the POA he would go and see the Resident. The Ombudsman stated when he arrived at the facility, the Resident had given him a written statement about the abusive tone, demands as to why did you call the "damn ombudsman" and about the shower water being scalding hot but the staff turned the water down, and how the aids gave such a quick shower, she did not feel like she even got a shower. Additionally, the statement noted that the Resident wanted to use her own products, but they would not let her, and they did not take out her ponytail, and left her in dining room until the end of shift. The Ombudsman reported he spoke to the DON and she said she was interviewing the staff involved and then the DON, ADON, and the Administrator showed him the written statements

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by NA #1 and NA #2 but stated they still had to interview one other person (NA #3). The Ombudsman stated the Administrator told him she was in the hallway on 05/04/21 when Resident #1 came out of the shower room and she did not notice anything wrong with Resident #1, nor did Resident #1 report anything to her.

An interview was conducted with the Director of Nursing on 05/11/12 at 1:25 PM. The DON reported when she became aware of the incident in the shower for Resident #1 by the Ombudsman, she asked the three NAs, the WTN, and Nurse #1 to complete a statement regarding Resident #1 and her shower. The DON stated she visited Resident #1 ' s room on 05/05/21 and asked if she was okay and the resident stated she was fine. The DON stated the resident never reported any of the concerns to her. The DON stated she changed the resident ' s shower day to Wednesday instead of Mondays because there was a particular NA who worked the 3 -11 shift on Wednesday that Resident #1 preferred to have do her showers. The DON added that herself, the Assistant Director of Nursing (ADON) or the assigned floor nurse were to be in the resident ' s presence whenever she was getting a shower or personal care.

An interview was conducted with the Administrator on 05/11/12 at 1:25 PM. The Administrator reported after the Ombudsman reported the resident ' s allegation to her and the DON on 05/05/21, she had gone to Resident #1 ' s room to see if she was okay and felt safe. The Administrator reported Resident #1 told the Administrator on 05/05/21 she was fine and felt safe. The Administrator stated she had the

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Maintenance Director check the water temperatures of the shower room and the temperature was 105 degrees at the highest temperature for the shower on the right stall and 108 degrees at the highest temperature for shower stall on the left side which was the stall Resident #1 had her shower in. The Administrator reported she did not feel the resident was abused because she was alert and oriented and would have reported what had happened to her. The Administrator added, if the staff spoke to her the way the Ombudsman and the Resident were reporting they spoke to her, then it was inappropriate, but she did not see it as abuse.

A review of the hot water systems check list log revealed the temperatures for the shower room on station 4 on 05/05/21 revealed the water temperature was 105 degrees Fahrenheit for the shower on the right stall and 108 degrees Fahrenheit for the shower stall on the left side.

An interview with the Maintenance Director on 05/10/21 at 12:40 PM revealed the hot water temperature range should be between 105 degrees Fahrenheit to 120 degrees Fahrenheit. The Maintenance Director stated the water temperatures were checked and logged weekly.

An observation of the water temperatures for the station 4 shower room was conducted on 05/10/21 at 12:40 PM with the Maintenance Director. The water temperature was 105 degrees at the highest temperature for the shower on the right stall and 108 degrees at the highest temperature for the shower stall on the left side.

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F 600	Continued From page 14 A review of the In-Service Sign in Sheet dated 05/06/21 titled Resident Abuse revealed nurses, nursing assistants, medication technicians and therapy staff and administrative staff were in serviced to include Nurse #1, the Wound Treatment Nurse and NA #1, NA#2, and NA #3.	F 600		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to: 1) update the policy to be consistent with reporting requirements to include an abuse allegation must be reported immediately but not less than 2 hours after the allegation was made for 1 of 1 Residents (Resident #1), 2a) failed to identify abuse, report the allegation of abuse immediately to the administrator, and failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) by not submitting the Initial Allegation Report for abuse within 2 hours of the Director of Nursing being notified of abuse and by not submitting the 5 day Investigation Report within 5 working days for 1 of 1 residents (Resident #1),	F 607	Upon entrance of the Surveyor, she requested a copy of the Facility Abuse Policy. The Surveyor indicated it needed to be updated to include reporting requirements. The Administrator revised the policy to reflect the reporting requirements to include that all alleged violations of abuse must be reported immediately, but not later than 2 hours after the allegation was made if the event that caused the allegation involved abuse OR resulted in serious bodily injury to the Administrator of the facility and to the state agency in	6/18/21

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F 607	Continued From page 15 b) failed to protect 1 of 1 residents (Resident #1) from abuse, and; c) failed to conduct a thorough investigation for 1 of 1 resident (Resident #1) reviewed for abuse. Findings included: 1. The facility ' s ' Abuse Policy dated 12/23/2011 under "Employee Procedure to Report Abuse" read Report any alleged abuse by either employee or outside visitor immediately to the supervisor. Report the specific nature of the suspected abuse, the person involved, the resident affected, the time and the sequence of events observed. Notification of the accusation will be reported to the Complaint Investigation Branch within 24 hours or as soon as practical. The written report of the investigation must be postmarked or faxed to the Complaint Investigation Branch within 5 working days of the allegation. The facility ' s Abuse Policy dated 12/23/2011 did not include that all alleged violations of abuse must be reported immediately, but not later than 2 hours after the allegation was made if the event that caused the allegation involved abuse OR resulted in serious bodily injury to the Administrator of the facility and to the state agency in accordance with state law. 2a. The facility ' s ' Abuse Policy dated 12/23/2011 under "Employee Procedure to Report Abuse" read as follows: Report any alleged abuse by either employee or outside visitor immediately to the supervisor. Report the specific nature of the suspected abuse, the person involved, the resident affected,	F 607	accordance with state law. The updated Abuse policy has been shared with all staff and Residents to ensure they are all aware of the reporting requirements. The QAPI committee will review this updated policy to ensure everyone is aware of the timelines and reporting requirements.	

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the time and the sequence of events observed. Notification of the accusation will be reported to the Complaint Investigation Branch within 24 hours or as soon as practical. The written report of the investigation must be postmarked or faxed to the Complaint Investigation Branch within 5 working days of the allegation.

Resident #1 was admitted to the facility on 07/08/19. Diagnosis included stroke with left sided weakness to upper and lower extremities. The Minimum Data Set annual assessment dated 02/20/21 revealed the resident was cognitively aware, demonstrated no moods or behaviors, and required total dependence with two staff physical assistance with bed mobility, transfers, and bathing. Resident #1 had an impairment to one side to the upper and lower extremities and used a wheelchair.

An interview was conducted with Resident #1 on 05/10/21 at 1:30 PM. Resident #1 reported on 05/04/21 three nursing aides (NAs) came into her room yelling and were mad. Resident #1 stated one of the NAs stated, "We have to give you a shower because you went and called the Ombudsman!" Resident #1 stated they transferred her from her bed to the shower bed with a mechanical lift in a rushed and roughed manner and brought her to the shower room. Resident #1 stated she asked them to get her body wash, shampoo and cream rinse and was told "You won ' t need that!" Resident #1 stated while in the shower room she barely got wet and her ponytail holder was not taken out of her hair and she had requested cream rinse and was told "You ' re getting a shower, that ' s all you are entitled to, be grateful." Resident #1 reported she told the NAs the water temperature was scalding,

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and the response from one of the NAs was "You ' re getting a shower, be quiet." Resident #1 stated one of the NAs turned the water temperature down. Resident #1 stated she felt the NAs were being mean to her during her shower because she had called the Ombudsman about not getting showers and they were retaliating against her. Resident #1 stated after the shower, she was placed in the dining room to eat lunch, but she usually ate her meals in her room, but stated she felt the NAs brought her to the dining room instead of back to her room because they were punishing her for calling the Ombudsman. Resident #1 stated she had lunch in the dining room and remained there until about 3:00 PM when the Wound Treatment Nurse (WTN) came and put her back to bed. Resident #1 stated she told the WTN what happened to her while she was in the shower and the WTN assessed her and reported she had no burns or redness noted anywhere on her body. Resident #1 reported she did not have any pain after the shower on 05/04/21.

An interview was conducted with the Wound Treatment Nurse on 05/11/21 at 10:18 AM. The WTN stated at 2:45 PM on 05/04/21 she had seen Resident #1 sitting in the dining room which was highly unusual because she was not usually out of her room. The WTN stated the resident was in a Geri chair, slumped over to the left side and was nodding off and on. The WTN stated she and Nurse #1 assisted the resident back to bed. The WTN stated Resident #1 reported she had a horrible day and informed the WTN the NAs were yelling at her. The WTN stated Resident #1 reported to her that her shower was scalding hot. The WTN reported she assessed her skin immediately and there were no signs or

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symptoms of burns. The WTN nurse stated she took the residents ' statement and typed it up and left a copy on the Director of Nursing ' s (DON) desk. The WTN stated the resident was genuinely upset while she shared her experience about the shower and the way the 3 NAs treated her. The WTN stated she should have handed the typed statement to the DON to be sure the DON saw the allegation and not just have left it on her desk.

An interview was conducted with the Director of Nursing on 05/11/21 at 9:10 AM. The DON reported she had become aware of Resident #1 ' s concern on 05/05/21 when the Ombudsman arrived around 2:30 PM. The DON stated the Ombudsman reported to her and the Administrator that Resident #1 complained she got a scalding hot shower on 05/04/21 and that Resident #1 felt it was due to retaliation because she called the Ombudsman about not getting showers. The DON reported the WTN left a typed statement on the DON ' s desk regarding the incident, but she did not see it until later on 05/05/21.

An interview was conducted with the Administrator at 11:15 on 05/11/21. The Administrator reported Resident #1 was alert and oriented and she spoke with the resident on 05/04/21 and the resident never said anything to her about being abused. The Administrator stated on 05/05/21, the Ombudsman came to the facility and met with Resident #1. The Administrator stated the Ombudsman spoke with the her and the DON and stated there should be criminal charges against the facility for what had happened with Resident #1. The Administrator stated she went to see Resident #1 on 05/05/21

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and she said she was fine and never reported any abuse to her regarding a scalding hot shower or verbal abuse. The Administrator reported she did not feel the resident was abused and that was why she did not complete an Initial Allegation Report or a 5-day Investigation and report it the HCPR.

b. The facility ' s ' Abuse Policy dated 12/23/2011 under "Employee Procedure to Report Abuse" read as follows:

Any employees suspected of abuse may be immediately removed from duty (suspended) by the Administrator and the Director of Nursing. The employee will be escorted off the assigned work area, asked to leave the facility premise and not return until a conference with the investigation committee has been arranged.

An interview was conducted with the Director of Nursing on 05/11/12 at 1:25 PM. The DON reported when she became aware of the incident in the shower for Resident #1 by the Ombudsman, she asked the three NAs, the WTN, and the Nurse to complete a statement regarding Resident #1 and her shower. The DON stated she did not assess other residents or interview and assess alert and oriented residents regarding verbal abuse, fear of retaliation, or getting scalding showers. The DON stated she visited Resident #1 ' s room on 05/05/21 and asked if she was okay. The DON stated the resident stated she was fine. The DON stated she did not ask Resident #1 specific questions or leading questions regarding her shower experience on 05/04/21. The DON stated herself, the Assistant Director of Nursing (ADON) or the assigned floor nurse was assigned to be in

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the resident ' s presence whenever she was getting a shower or personal care.

An interview was conducted with the Administrator and the Director of Nursing on 05/11/12 at 1:25 PM. The Administrator reported after the Ombudsman reported the resident ' s allegation to her and the DON on 05/05/21, she had gone to Resident #1 ' s room to see if she was okay and felt safe. The Administrator stated she had the Maintenance Director check the water temperatures of the shower room and the temperature was 105 degrees at the highest temperature for the shower on the right stall and 108 degrees at the highest temperature for shower stall on the left side which was the stall Resident #1 had her shower in. The Administrator reported Resident #1 told the Administrator on 05/05/21 she was fine and felt safe. The Administrator reported she did not feel the resident was abused and that was why she did not suspend the personnel involved or assess and interview the other residents in the facility. The Administrator added, she had conducted an in-service regarding types of abuse including physical, verbal, and emotional on 05/06/21. The Administrator stated she conducted the in service because of what the inappropriate behavior the Ombudsman reported to her.

c. The facility ' s ' Abuse Policy dated 12/23/2011 under "Employee Procedure to Report Abuse" read as follows:

The investigation committee will consist of the Administrator, DON, ADON, Social Worker, Department Head and other employees designated by the Administrator. The investigation committee would conduct a

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thorough investigation of alleged abuse and incident surrounding the initial report of abuse and once the investigation was completed, the investigation committee would hold a conference to review outcome findings.

An interview was conducted with the Administrator on 05/12/21 at 11:30 PM. The Administrator stated she checked in with the resident to see if she felt safe or if she wanted her room changed. The Administrator reported the resident declined a room change and reported she was safe. The Administrator stated she did not complete a full investigation because she did not feel there was abuse. The Administrator reported if the staff behaved as the Ombudsman and Resident #1 reported they did, then that was inappropriate behavior, but she did not feel it was abuse.