STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345318	A. BUILDING _____ B. WING _____	C 07/06/2023

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

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 07/05/23 through 07/06/23. Event ID# UMTP11. The following intake was investigated NC00203177. 5 of the 5 complaint allegations did not result in deficiency.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on record review and resident, family and staff interviews, the facility failed to speak to a resident in a respectful manner for 1 of 1 resident reviewed for dignity and respect (Resident #1). The findings included: Resident #1 was admitted to the facility on 04/27/23 with diagnoses which included, in part, acute ischemic heart disease, chronic obstructive pulmonary disease, congestive heart failure and weakness. Review of Resident #1's admission Minimum Data Set (MDS), dated 05/04/23, revealed she was cognitively intact and required the extensive	F 557	The Facility was made aware of the situation which occurred with the effected Resident and reacted immediately by going to the Resident and interviewing her to ensure she felt safe and secure within the Facility and had unmet needs. She recounted the incident and said because of her anxiety, the situation upset her but she did not feel abused. This interview was witnessed by this writer, the Social Worker and ADON. The Facility opened an investigation and filed a 24 hour report. The staff who were named in this investigation were suspended pending the outcome. Follow up was done with the Resident and her family who all felt that	7/10/23

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

Electronically Signed | 08/09/2023

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F 557	Continued From page 1 assistance of staff for bed mobility, toileting and personal hygiene. The MDS assessment indicated Resident #1 was always incontinent of her bowels and bladder. Review of Resident #1's Care Plan, dated 05/04/23, revealed she had an Activities of Daily Living (ADL) self-care performance deficit related to limited mobility. An interview was conducted with Resident #1 on 07/05/23 at 12:07 p.m. Resident #1's family member was present at the time of the interview. When asked if the staff treated her with dignity and respect, Resident #1 said, "sometimes and sometimes they are rude to me." When asked to explain further or to give an example, Resident #1 explained she did not want to get anyone in trouble or fired nor did she want anyone to come into her room at night to accuse her of getting them in trouble. At that time, Resident #1's family remarked to her that she should tell of an incident she had told him about during their visit - an incident that occurred that morning. Resident #1 stated she was not sure of the exact time, but thought it had been between the hours of 4:00 a.m. to 6:00 a.m. She explained she had pushed her call bell to request assistance for incontinent care and NA #1 had entered her room to provide care. Resident #1 explained NA #1 spoken rudely to her during the task. When asked if she had reported the incident to anyone, Resident #1 indicated she had informed Nurse #1 when he came in her room to give her medication and she thought he had reported it to the dayshift nurse, Nurse #2. During an interview with Nurse #2 on 07/05/23 at 12:56 p.m., Nurse #2 stated Nurse #1 reported	F 557	this was more a cultural difference with language barriers, the incident was more inappropriate and teachable but not abusive. None of them wanted law enforcement contacted as they felt no crime was committed. The 5 day investigation was filed indicating this information. All named staff returned after education was provided. Other Residents who are alert and oriented were interviewed to ensure there were no other interactions of this nature and that they all felt safe and cared for. No other Residents expressed concerns of this nature. All staff was educated again regarding the types of abuse, abuse policy and reporting instructions. Urgency of reporting abuse was stressed in this education. The 4 staff members named in the incident more more intensely educated regarding types of abuse, the facility policy and urgency of reporting suspected abuse immediately. Furthermore we discussed appropriate interaction, professional behavior and good customer service as well as taking the time to interact with Residents at the pace they prefer. Resident council meetings encourage discussion regarding Resident Rights and bringing any concerns to the Social worker, Administrator, DON or anyone they feel safe discussing with. Monthly staff meetings will also include discussion of same to ensure all staff is aware of Resident's Rights and abuse.	

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F 557	Continued From page 2 Resident #1 had complained about NA #1 being rude towards her. Nurse #2 explained NA #1 was from another country and had an accent when speaking. Nurse #2 explained Resident #1 might have perceived NA #1 was being rude because NA #1 sometimes spoke loudly when talking with residents in an effort to make herself better heard and understood. Nurse #2 further explained that Nurse #1 had reported to her that after he had spoken with NA #1 about the resident's complaint and how NA #1 then returned to Resident #1's room with two other nursing assistants (NA #2 and NA #3) and began questioning Resident #1, wanting to know why she had complained, that she had not been trying to hurt her, and asked the resident why she would have lied about the incident. During an interview with NA #1 on 07/05/23 at 3:22 p.m., NA #1 explained she entered Resident #1's room to provide incontinent care just before 6:00 a.m. After explaining to the resident the care she was going to perform, NA #1 stated Resident #1 consented and then she put the head of the bed down and asked the resident to turn. NA #1 explained Resident #1 has a lot of pain and instead of physically helping the resident turn to her side, she asked the resident to turn in the bed and then she provided the incontinent care. NA #1 stated she later heard the resident had complained against her and she went back to Resident #1's room and brought NA #2 and NA #3 with her to confront the resident and asked her, "why did you lie on me?" NA #1 stated she did not point her fingers at the resident, nor did she raise her voice. NA #1 further explained that Nurse #1 had told her Resident #1 had been crying and complained she had been rough with her during the care. NA #1 stated she probably	F 557	All incidents, concerns or grievances are discussed daily at the Administrative meeting and will be addressed immediately. These issues are reviewed at the weekly interdisciplinary team meeting. Any future issues will be reported and recorded at the QAPI monthly meetings for the next 3 months.	

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F 557	Continued From page 3	F 557		

should not have returned to Resident #1's room and also stated that she did not "bring" the two other nursing assistants with her, that they had followed her in.

During an interview with Nurse #1 on 07/05/23 at 4:49 p.m., Nurse #1 stated he had entered Resident #1's room around 6:00 a.m. to give her medication. He explained the resident was upset, anxious and tearful and when he had asked her what had happened to upset her, she told him NA #1 had been rude with her during care and she was not used to being treated that way. Nurse #1 indicated he told her he would speak with NA #1. Nurse #1 stated he went on down the hall to continue his medication pass when he saw a group of nursing assistants down the hall by the other nurses' station. He stated as he was explaining to them that "one size does not fit all" in regard to the type of care they provide different residents, NA #1 came out of a resident's room and told him the resident had lied to him about her having treated the resident rudely. He stated after their meeting, he saw NA #1 walk down the hall with NA #2 and NA #3 and clarified he did not know they were on their way to Resident #1's room, that he just thought the three of them were going on a break together. Nurse #1 stated he continued his medication pass when he heard NA #1 yelling from inside of Resident #1's room and he immediately walked back down the hall to the resident's room. He explained NA #2 was standing in the doorway of Resident #1's room and NA #1 and NA #3 were standing over the resident's bed and NA #1 was yelling at the resident, "what are you lying for, what are you lying for, you're lying" and stated NA #1 just kept yelling and repeating the same statements over and over to the resident. Nurse #1 stated he

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F 557	Continued From page 4	F 557		

thought Resident #1 was frightened and he called the nursing assistants to come out of the resident's room. When asked if he had ever had any in-service trainings on abuse, Nurse #1 said he knew what he saw and heard was verbal abuse and reiterated "it was definitely verbal abuse." Nurse #1 stated the yelling by NA #1 was so loud that another resident (Resident #2) had come out of his room to see what the commotion was about and when he saw the nursing assistants coming out of Resident #1's room he told them, "you're getting paid to take care of the residents, not yell at them."

A second interview was conducted with Resident #1 on 07/06/232 at 9:06 a.m. Resident #1 stated she had a good night. The resident also remarked that she was in "her right mind" and said she was not scared of the nursing assistants, but they had hurt her feelings. Resident #1 explained the way she had been yelled at by NA #1 was just rude and that Nurse #1 had told her their behavior was unacceptable. Resident #1 stated she does not like anyone treating her like "dirt."

An interview was conducted with Resident #2 on 07/06/23 at 9:16 a.m. Resident #2's MDS, dated 06/09/23, indicated he was cognitively intact. Resident #2 explained he did not see the nursing assistants, but he heard them. He stated he left his room to go and get his medications from Nurse #1 and stated he heard NA #1 "screaming, not yelling" at Resident #1 from within Resident #1's room. Resident #2 stated when the nursing assistants left Resident #1's room, he told them (as they passed him going back up the hall), "they pay to stay here, and you get paid to take care of them and if you were to ever talk to me that way

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F 557	Continued From page 5	F 557		

you wouldn't have a job." Resident #2 indicated the nursing assistants did not respond to him.

An interview was conducted with NA #2 on 07/06/23 at 9:41 a.m. NA #2 explained she had only gone to Resident #1's room to gather the trash from the room and the bathroom. NA #2 stated NA #1 was just talking with the resident, asking her why she would lie and say the things she did to Nurse #1. NA #2 indicated NA #1 used her normal tone of voice but did keep repeating her questions to the resident. NA #2 stated Resident #1 was "hysterical" and that she kept changing her story to NA #1. NA #2 explained that she thought Resident #1 thought they were going to do something to her "because she saw all of us in there." NA #2 stated she felt it might have been intimidating to the resident because she might have thought we were going to do something to her but indicated they were not planning on doing anything to the resident, that NA #1 just wanted to know why the resident thought she had been rude with her during the care. NA #2 stated she told NA #1 to "come on, we've got other residents to get changed" as they work together to help each other make rounds. NA #2 stated the other nursing assistant involved, NA #3, had been standing beside NA #1 at the resident's bed and indicated that NA #3 did not say anything to the resident and had told NA #1, "come on, let's go."

An interview was conducted with NA #3 on 07/06/23 at 10:09 a.m. NA #3 explained she was assigned to take care of Resident #1 from 11:00 p.m. to 7:00 a.m. on 07/04/23. NA #3 explained she had gone to the resident's room to get her sister (NA #1) out of the room because she knew that "in this line of care, we are not supposed to

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F 557	Continued From page 6	F 557		

argue with residents." NA #3 explained after NA #1 kept asking the questions over and over, it got loud, and she did not want the situation to escalate and stated she grabbed NA #1's hand and between her and NA #2, they got NA #1 out of Resident #1's room. When asked to describe their positions in the room in relation to the resident lying in her bed, NA #2 explained Resident #1's bed faced the door, with the head of the bed against the wall where the window was. She further explained the resident's right side of the bed was against the wall and NA #1 was on the left side of the bed by the foot of the bed. NA #3 explained she was just inside the door to the room until she went up to NA #1 and took her by the hand and encouraged her to walk away. NA #3 stated she felt that NA #1 was not upset, that she just wanted to know why the resident told the nurse what she did.

During an interview with the Administrator on 07/06/23 at 9:25 a.m., the Administrator explained NA #1 is not from the United States and speaks with an accent that can sometimes be difficult to understand. The Administrator felt the way she spoke with Resident #1 on the morning of 07/05/23 was secondary to her sociocultural perspective in that she spoke loudly to the resident to make herself better understood. The Administrator indicated that she will be doing one-to-one training with NA #1 as well as sensory training with all of her staff.