STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 11/28/23 through 11/29/23. Event ID# 62KE11. The following intake was investigated NC00209593. 1 of 1 compliant allegation did not result in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		12/27/23

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

Electronically Signed | 12/15/2023

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F 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, resident interview and outside transportation vendor, the facility failed to maintain a resident's dignity when a nurse yelled and spoke rudely towards 1 of 3 resident's (Resident #3) reviewed for abuse. The findings included: Resident #3 was admitted to the facility on 7/13/23. The 5- Day Minimum Data Set (MDS) assessment dated 7/20/23 indicated Resident #3 was cognitively intact. Review of the initial allegation report (24-hour working report) dated 8/9/23 revealed an allegation of abuse. The facility became aware of the allegation on 8/9/23. There was no date documented for the date of the incident. The allegation details revealed agency staff (Nurse #1) was reported not to honor Resident #3 wishes and spoke to the resident in a rude manner.	F 550	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. Nurse #1 was suspended on August 9, 2023, and her contract term ended during the suspension and investigation. By 12/18/2023, the Nursing Supervisor and Resident Liaison will meet with Resident #3 to ensure that the resident is currently being treated with dignity and respect. The IDT (Interdisciplinary Team) will review Resident #3 care plan and will update to include interventions for	

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F 550	Continued From page 2 Review of the investigation report (5-day) working report dated 8/16/23 stated the date of the incident was 8/3/23 and the facility became aware of the incident on 8/9/23. The incident involving Resident #3 occurred at the central nursing station. Resident #1's cognition was documented as intact. The accused staff was identified as Nurse #1 and one witness identified as Nursing Assistant (NA) #1. The actions taken revealed agency nurse (Nurse #1) was immediately suspended and her contract term ended during the suspension and investigation. The summary of the facility investigation stated Resident #3 was interviewed by the Resident Liaison and reported agency nurse (Nuse #1) to be rude. The witness to the incident also indicated that Nurse #1 was rude and exhibited poor customer service. A witness statement written by NA #1 on 8/10/23 stated on 8/3/23 on the way out to the van with Resident #3, NA #1 and the Transportation Aide were stopped by Nurse #1. Nurse #1 advised before Resident #3 left she needed to give Resident #3 her insulin. Resident #3 told Nurse #1 she was causing her to be late. The witness statement continued that Nurse #1 lifted Resident #3's shirt and said in a very rude tone, "I'm not causing you to be late. You can get your shot before you go or she could mark Resident #3 refused. Which one you want to do"? Resident #3 advised Nurse #1 to give her the shot so she could go. Nurse #1 gave Resident #3 the shot and walked off. NA #1, Resident #3 and the Transportation Aide proceeded to the van to leave for the appointment and were told was cancelled due to the doctor being sick. Once Resident #3 was back off the van and headed back to her room she stated the nurse was rude and hateful	F 550	evaluating the residents psycho/social adjustment as appropriate. Resident interviews will be completed by 12/18/2023 of alert and oriented residents to ensure that they were treated with dignity and respect. Interviews will be conducted by Nursing Supervisor or designee. All concerns will be immediately addressed and reported to the Administrator for appropriate follow-up. Beginning 12/15/2023, the Unit Coordinator and Resident Liaison or designee will educate all nursing staff on Dignity and Respect as it relates to Resident Rights. Any staff members who do not receive the training by 12/20/2023, (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. This education will be required during new hire orientation. Beginning 12/21/2023, the Unit Coordinator and Nursing Supervisor or designee will conduct weekly interviews with 5 nursing staff to assess compliance with Dignity and Respect as it relates to Resident Rights. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Beginning 12/21/2023, the Resident Liaison and Activity Director or designee will conduct weekly interviews with 5 alert	

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F 550	Continued From page 3 to her and she didn't want her as a nurse anymore. Once Resident #3 was in her room NA #1 went to the Director of Nursing (DON) and explained the incident that took place. The DON advised she would follow up on the incident with both Resident #3 and Nurse #1 as Resident #3 had made these allegations before on staff and moving forward Nurse #1 would have someone in the room with her when caring for Resident #3 the remainder of the shift. A witness statement written by Transportation Aid on 8/15/23 stated Resident #3, the Transportation Aide and one of the NA's (name unknown) were walking towards the front door to get Resident #3 loaded for her appointment. Resident #3's nurse approached her as we were near the end of the nurse station. She told Resident #3 that she needed to give her one of her medications before we left. Resident #3 stated, can't I take it when we get back, you're going to make me late. The nurse got really irritated and yelled at Resident #3, "are you refusing? Because I can definitely document that!". Resident #3 told her to just go ahead and give her the medication and that she just didn't want to be late. Nurse #1 responded with, "it's not my fault you're late, you're the one that has 35 different medications to take!". Resident #3 went on to say how she had never had a nurse be so mean and argue with a patient. Nurse #1 responded, "Merry Christmas" and walked away!" A statement written by Nurse #1 dated 8/11/23 revealed Nurse #1 didn't recall the exact date, but she was assigned to be the nurse working on 400-hall. Resident #3 had an appointment around 9:00 AM so Nurse #1 medicated her. After getting through the regular routine with Resident	F 550	and oriented residents to assess compliance with Dignity and Respect as it relates to Resident Rights. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction date is 12/27/2023.	

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F 550	Continued From page 4	F 550		

#3, Resident #3 stated that she wasn't doing to make it to her appointment because the provider had the times mixed up. After checking with the scheduler, it was noted that Resident #3 was on time. Upon transport wheeling her to the front, Nurse #1 noticed that she hadn't given Resident #3 her insulin. The statement continued that nurse #1 met up with Resident #3 and the transportation aid at the nursing station. Nurse #1 let Resident #3 know that she didn't give her the last medication. Resident #3 stated Nurse #1 was making her late. Nurse #1 explained that she had the medications with her, but it was up to Resident #1 if she wanted to take it. Resident #3 stated yes so it was administered. A few minutes later Resident #3 was returning to her room because the appointment was canceled due to the provider getting sick. Resident #3 was upset and made comments that Nurse #1 was mean to her and nurse #1 informed her supervisor. Nurse #1's supervisor spoke with Resident #3 and soon after came and got me and we both went to speak to Resident #3 who stated, "I don't have a problem with the nurse, and I don't want to hear anything else about it." Nurse #1 finished her shift and was assigned to Resident #3 the next 2 days without any problems.

Interview with NA #1 on 11/28/23 at 12:52 PM revealed on the 8/3/23 she and the Transportation Aide were on the way out to the van when Nurse #1 stopped us because she wanted to give Resident #3 an injection. Resident #3 stated you are going to make me late to my appointment. Nurse #1 asked Resident #3 did she wanted the medication or not. Nurse #1 further stated she would document refuse if Resident #3 didn't want the medication (injection). Resident #3 stated to Nurse #1 to hurry up and

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give her the medication. NA #1 described Nurse #1 tone as very firm and if she was a resident, she wouldn't want to be talked to the way Nurse #1 talked to Resident #3. Following the incident Resident #3 told NA #1 she didn't like how Nurse #1 had spoken to her and she didn't want Nurse #1 working with her. NA #1 stated she told the Director of Nursing (DON) on 8/3/23 the day the incident occurred. The DON stated she would address the incident. She indicated the DON had spoken with Nurse #1.

Interview with Transportation Aide on 11/28/23 at 2:22 PM stated on 8/3/23 she was taking Resident #3 to an appointment with an NA (name unknown). She indicated a nurse came running up and stated she had forgotten to give Resident #3 one of her medications. Resident #3 stated she didn't want to take the medication because she didn't want to be late to her appointment. She stated the nurse told Resident #3 it wasn't her fault Resident #3 had 35 medications to take. Resident #3 stated she had never seen a nurse go back and forth with a patient. Nurse #1 told Resident #3 "Merry Christmas" and walked away. The Transportation Aide described Nurse #1's communication with Resident #3 as very rude. She further indicated Resident #3 appeared upset after the interaction with Nurse #1.

Interview with Resident #3 on 11/28/23 at 3:04 PM revealed she did not recall the incident.

Interview with the Director of Nursing (DON) on 11/28/23 at 1:49 PM indicated she recalled being approached on 8/3/23 by the nurse or a NA that Resident #3 and a nurse were arguing in the hallway. Resident #3 was going out for transport for a doctor's visit. Resident #3 was questioning

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F 550	Continued From page 6 whether she should take the insulin before the appointment. Nurse #1 and Resident #3 were interviewed, and the DON found Nurse #1 was inappropriate with her tone and she lacked empathy when speaking to Resident #3.	F 550		