STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

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F 000	INITIAL COMMENTS Deficiencies were cited as a result of the complaint investigation. Event ID #Q6UP11. A complaint investigation survey was conducted from 01/07/19 through 01/10/19. Immediate Jeopardy was identified on 01/09/19. CFR 483.12 at tag F600 at a scope and severity IJ. The tag F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 12/12/18 and was removed on 01/10/19. An 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- §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 physician interview, resident interview,	F 600	Preparation and submission of this Plan	2/4/19

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

Electronically Signed | 01/31/2019

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F 600	Continued From page 1 staff interview, and record review the facility failed to protect the right to be free of verbal and physical abuse for 2 of 3 sampled residents (Resident #2 and #3) who were reviewed for abuse. Nursing Assistant (NA) #1 verbally cursed and insulted Resident #2, and physically grabbed Resident #2 by the genitals when she forcefully transferred the resident from his bed to a wheelchair. Resident #2 reported that he experienced embarrassment, fear, and anxiety created by the verbal and physical abuse inflicted on him by NA #1. Additionally, the facility failed to prevent NA #1 from verbally abusing Resident #3 as she cared for the resident. Resident #3 was visibly shaken and scared as a result of this abuse, requiring a staff member to sit with the resident for 15 minutes to calm her nerves. Immediate Jeopardy (IJ) began on 12/12/18 when NA #1 used profanity and insults and grabbed Resident #2 by the genitals when transferring the resident from his bed to his wheelchair. IJ was removed on 01/10/19 when the facility implemented an acceptable credible allegation of IJ removal. The facility remains out of compliance with this tag at a lower scope and severity level of "G" (actual harm that is not immediate jeopardy) for example number 2. Findings included: 1. Record review revealed that Resident #2 was admitted to the facility on 11/30/18. The resident's documented diagnoses included adjustment disorder with anxiety, congestive heart failure (CHF), atrial fibrillation (a-fib), cardiac pacemaker, diabetes, and unsteadiness of the feet.	F 600	of Correction does not constitute an admission of or an agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously implore the quality of care to comply with State and Federal requirements. verbal abuse allegation was made on 12/16/18 by resident #2 regarding staff member NA#1. Per resident on 12/12/18 NA#1 stated she spoke to him inappropriately saying the following "stop being so stubborn and stand up", "Jesus Christ, can't you do anything to help" and that she was "hateful". *A Facility Reportable Incident submitted on 12/16/18. *An investigation was initiated by the Administrator and Director of Nursing. *Following a thorough investigation, the 5 day final facility reportable was submitted on 12/21/18. * The allegation was substantiated. Employee had been suspended on 12/12/18 pending another investigation and was subsequently terminated. * Skin checks were completed on non-interviewable residents on 12/14/18 by the Director of Nursing and licensed nurses. No issues were identified. * Interviewable residents were questioned	

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F 600	Continued From page 2 Review of Resident #2's care plan revealed on 12/06/18 the following problem was added: "Resident has altered cardiac status r/t (in regard to) CAD (coronary artery disease), complete heart block, a-fib" was identified as a problem in Resident #2's care plan. Interventions to this problem included, "Note changes in sensorium: lethargy, confusion, disorientation, anxiety, and depression." The resident's 12/07/18 admission minimum data set (MDS) documented he had no impairment to his cognition, he exhibited no delirium/psychosis/behaviors including resistance to care, he required extensive assistance from two staff members with bed mobility and transfers, he required extensive assistance by a staff member with locomotion on and off the unit, he did not walk in the room or corridor during the look back period, he was not steady on his feet when transferring between the bed and chair and vice versa, he had range of motion impairment on both sides of his lower extremities, he used his wheelchair for mobility, he was 72 inches tall and weighed 240 pounds, and he experienced occasional moderate pain in last 5 days making it difficult to sleep and limiting his day-to-day activities. A nursing note written on 12/12/2018 at 6:03 PM documented, "Resident up in w/c (wheelchair) this AM & OOF (and out of facility) for MD (doctor's) (appointment) per orders. Resident left facility (at 9:55 AM), transported via _____ (name of contracted transport company), accompanied by NA (#2). Received report via telephone (at 10:20 AM) from NA that resident having c/o (complaints of) 'Not feeling right' (and) resident is also stating, 'I need you to take me to the hospital	F 600	on 12/14/18 on care and concerns by the DON, ADON, Social Service and/or designees. Concerns were shared regarding NA#1. She was terminated on 12/13/18. * Abuse re-education completed on 12/20/18 by the DON and/or designee for staff. The abuse education included the abuse policy, first ensuring the safety of the resident, an abuse quiz including types of abuse and notification to the Administrator and/or Director of Nursing immediately. A physical abuse allegation was made on 12/27/118 by resident #2 regarding NA#1. Per the resident on 12/12/18 NA#1 "forced him into a wheelchair", "put one hand on his groin and one hand on his back to transfer him into the wheelchair", "threw him into the wheelchair", refused to use the sliding board to transfer him back to bed", grabbed him around his chest tightly". Resident also signed statement that he did not report to staff initially. *A Facility Reportable Incident submitted on 12/27/18. *An investigation was initiated by the Administrator and Director of Nursing. *Brunswick County Sheriff's office was contacted by the resident and Social Worker on 12/27/18. No charges were filed. *A skin check was conducted on 12/27/18	

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F 600	Continued From page 3 instead of to my (appointment).' ___ (name of transport company) took resident to ED per resident's request." During a telephone interview with Nurse #11 on 01/10/19 at 11:23 AM she stated she was the nurse who discharged the resident on 12/12/18 for his surgical procedure in Wilmington. She reported the resident was alert and oriented, and he was a little forgetful the first couple of weeks in the facility. She commented the resident was reliable and could express his needs to staff. According to Nurse #11, Resident #2 was nervous about his upcoming surgery when he left the facility on 12/12/18. A 12/12/18 ED encounter note documented, "While in route to (Wilmington) the patient was diverted to this ED because he stated he felt he was too short of breath to continue his ride to (Wilmington)." A 12/15/18 hospital discharge summary documented Resident #2 was hospitalized between 12/13/18 and 12/15/18 for re-implantation of his pacemaker. "He (Resident #2) does admit that he is anxious to return back to Brunswick Health and Rehabilitation. He had considered going to a different (nursing home), but will return there as this is more convenient...Earlier today he had an episode of feeling overwhelmed with dyspnea, chest pain, and nausea. He thought this was due to a panic attack...." A 12/15/18 physician order started Resident #2 on as needed (prn) Ativan (anti-anxiety medication) 0.5 milligrams (mg) every six hours.	F 600	on resident #2 by the DON. There were no issues identified. *NA#1 was already terminated due to previous allegation on 12/13/18 *Following a thorough investigation the 5 day finial facility reportable was submitted on 1/2/19. *Resident had a planned discharge home on 1/2/19. Root Cause Analysis The facility failed to properly educate staff on the abuse policy including timeliness of reporting and the accuracy of statements including who, what, when, where how, and why. The Procedure for Implementing the Acceptable Plan of Correction for specific deficiency cited. All residents have the potential to be affected. The Administrator, Regional Director of Clinical Services and DON started in-house education on 1/9/19 related to F600 Abuse. The education was performed to ensure staff were properly trained on abuse, aware there is a "zero tolerance", reporting timely, as well as, accurately. Education will continue via telephone for staff not available on 1/9/19 and 1/10/19	

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F 600	Continued From page 4 A statement written by Resident #2 on 12/16/18 documented, "Awakened from sleep had to get weighed. NA said to stand up. Had trouble moving from bed to wheelchair. No slide board used. Just pulled on a chair. Told her that legs ached. She was mumbling, but I could not understand. I asked for a Hoyer lift, but was told it was to be done her way. When back in room same procedure getting back to bed. Tried to lift me over the side of the chair and on bed. Started to lose control and tumbled on top of me at the same time uttering curses and taking the name of the Lord in vain. When...the end is near, having a procedure done, and in a total panic this is not good for the rehab facility, the family, or the patient...." An undated typed statement signed by Resident #2 documented, " (NA #1) forced (Resident #2) into wheelchair without sliding board and yanked him up out of the bed. Resident told NA that he did not need to be yanked. NA told him to get in chair by himself. NA grabbed him by the waist. She then put one hand on his back and one hand on his groin in order to transfer resident into the wheelchair from the bed. She threw him into the wheelchair and told him not to move. NA would not let resident use leg rest on wheelchair to transport down the hall to get weight. Resident had to hold his legs up the entire way down to get weighed. Resident could not get on the scale on his own, however, NA told him to get up on his own. NA pulled him up onto the scale. On the way back down the hall, the resident asked the NA to stop so he could rest his legs since he was having to hold legs up by his hands. NA did not stop when he asked her to. His heels were dragging. NA refused to use the sliding board to transfer resident back into bed from the	F 600	in person. These staff members will not be permitted to work until education is received. New hires will be educated on the abuse policy upon hire. The Regional Vice President of Operations re-educated the Licensed Nursing Home Administrator and DON on abuse, policy and procedures and conducting a proper/thorough investigation on 1/9/19. The Monitoring Procedure to Ensure the Plan of Correction is Corrected and the Specific Deficiency Cited Remains Corrected and in Compliance with Regulatory Requirements. On 1/10/19 random staff interview were being conducted related to abuse and reporting. On 1/10/19 facility resident interviews were conducted by Department Managers for those residents that were interviewable related to abuse. Questions included if the resident feels safe in the facility, if they feel they have been abused, and are they treated with dignity and respect. On 1/10/19 body checks were completed for those that were non-interviewable by licensed nurses. On 1/10/19 all interviewable residents were re-educated 1/10/19 by the Activity Director on residents rights including	

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F 600	Continued From page 5 wheelchair. She grabbed him around his chest tightly. She must have lost her balance in the process and they started to do down. Resident hit his back on the bed and the NA fell on top of the resident. This information was not reported initially to the staff." During a telephone interview with Resident #2 on 01/08/19 at 3:46 PM he stated before he was transported to an appointment in Wilmington for pacemaker re-implantation on the morning of 12/12/18, NA #1 entered his room where he was in bed, and told him that she needed to weigh him before he left the building. He reported because he tried to inform the NA that she was not transferring and transporting him correctly she became angry with him, stating, "We are going to do this my way." He also commented she called him a SOB (derogatory term), dirty old man, and stated he should be dead by now. According to Resident #2, NA #1 "groped" him during the transfer from the bed to the wheelchair with one hand around his waist and the other in his groin. He stated he did not share what happened to him on 12/12/18 until after his surgical procedure was completed because he was so stressed, anxious, fearful, and embarrassed about the way NA #1 treated him. However, he stated holding all this inside was very stressful, and he felt the way NA #1 talked to him contributed to having to detour to another hospital emergency department (ED) on the way to Wilmington, due to dizziness and feeling weak and faint. He explained this delayed his pacemaker re-insertion by a day. Resident #2 reported he finally shared how he was treated by NA #1 with a nurse because he was afraid other residents who could not speak for themselves were also abused by this same staff member.	F 600	immediately reporting any issues or concerns including abuse, dignity, and respect. The same education will be provided during monthly Resident Council Meetings x3 months. Facility Administrative/Department Managers will conduct abuse questionnaires with all staff beginning on 1/10/19 related to abuse and policy. The audits will be completed on 3 staff members 3x weekly. Any negative findings will be addressed immediately by the Administrator and/ or Director of Nursing. Ongoing monitoring of monthly Resident Council minutes and Department questionnaires 3x weekly will continue until 5/1/19. Findings will be brought to monthly QAPI meeting for review and further recommendations. The facility conducted an Ad Hoc QAPI meeting on 1/10/19 with the facility interdisciplinary team, Regional Vice President of Operations, Regional Director of Clinical Services, and the facility Medical Director to review corrective measures. The title of the person responsible for implementing the acceptable plan of correction is the Administrator.	

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F 600	Continued From page 6	F 600		

During a telephone interview with NA #1 on 01/09/19 at 1:20 PM she stated she needed to obtain a weight for Resident #2 on the morning of 12/12/18. She reported the resident was fully dressed and laying across his bed. She commented she used a sliding board to transfer the resident off the bed and to put him back on the bed after she weighed him in his wheelchair. According to NA #1, another staff member told her Resident #2 commented to her that NA #1 was very firm with him. She stated she was called in for a meeting with the Administrator and Director of Nursing (DON), and they accused her of abuse. She reported she never used profanity toward Resident #2, and she was only trying to motivate the resident to do as much for himself as possible. The NA commented she had never been accused of abusive behavior before so she quit her job.

During a telephone interview with the driver of the contracted transport van on 01/08/19 at 4:11 PM she stated she had transported Resident #2 before, but on 12/12/18 the resident was more anxious and fidgety than usual. She reported when she picked the resident up from the nursing home he complained of and exhibited signs and symptoms of excruciating pain in his legs. She stated the resident was wiggling and appeared miserable. In route to his Wilmington appointment she commented the resident complained of being dizzy, became short winded, stated he felt really hot, and the resident turned red and was very flushed. She stated she told the resident she needed to either call 911 or take him to an ED before continuing on to Wilmington.

During an interview with NA #7 on 01/09/19 at 10:52 AM she stated she traveled with Resident

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F 600	Continued From page 7	F 600		

#2 in the transit van on the morning of 12/12/18. She reported the resident was a little nervous and anxious about the long trip to Wilmington, and was frustrated because he wanted to be transported via stretcher rather than in a wheelchair. She commented not far into the trip the resident complained of dizziness and began looking pale and weak. According to NA #7, the resident requested to be taken to a local ED to be checked out.

A statement written by Nurse #6 on 12/16/18 documented, "(Resident #2) told this nurse that (NA #1) was rough when transferring him from bed to chair (with) 1 x assist, pt (patient) is a slide board. Pt told this nurse that (NA #1) told him 'it was her way and that he needed to stop being so stubborn and stand up.' Pt stated that (NA #1) was putting him back to bed and said, 'Jesus Christ, can't you do anything to help."

During an interview with Nurse #6 on 01/09/19 at 8:50 AM she stated on 12/16/18 as she was asking Resident #2 how his surgical procedure went he confided in her that NA #1 had been rude and crude to him after she (Nurse #6) checked on him the morning of 12/12/18. He explained to Nurse #6 that when NA #1 insisted on transferring him incorrectly she informed him, "You're going to break my f-----g (expletive) back, you're f-----g lazy. He also informed Nurse #2 that when he was unable to stand to be weighed NA #1 stated, "You're here for f-----g rehab, and you should be able to stand up on your f----g own." According to Nurse #6, she could tell by Resident #2's facial expressions that he was visibly upset and his hands were shaking while he was relaying the account to her. The nurse stated she and Resident #2 were asked to write statements

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

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F 600	Continued From page 8	F 600		

about what they were told or experienced. She reported Resident #2 did not say anything else to her about NA #1 until a couple of weeks later when the resident commented he was remembering more details about his ordeal with the NA. She reported the resident commented he was embarrassed to tell anyone, but NA #1 "grabbed his testicles" when she was attempting to stand him up from the bed. Nurse #6 stated she immediately informed her Administrator and DON. She reported Resident #2 was alert and oriented but could be forgetful at times. She also commented the resident had anxiety issues, and she felt he was afraid of dying. She remarked that the resident had a couple of near-panic attacks when he first arrived in the facility due to his health conditions with the resident reporting chest pain but having vital signs which were all within normal limits.

Review of Resident #2's care plan revealed on 12/21/18 the following problem was added: "Resident is on anti-anxiety therapy" was identified as a problem in Resident #2's care plan. Interventions to this problem included, "Implement non-pharmacological interventions specific for the resident."

During a 01/09/19 3:36 PM interview with the Administrator he stated that NA #1 was suspended on 12/12/18 after a nurse shared her 12/08/18 observation of NA #1 verbally abusing Resident #3 who had some cognitive impairment. He commented NA #1 did not work any more in the nursing home after 12/12/18. He reported NA #1 was terminated on 12/13/18 after verbally abusing Resident #3.

During an interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 9	F 600		

01/08/19 at 11:15 AM he stated when Resident #2 reported verbal abuse by NA #1 on 12/16/18 his complaint added even more validity to earlier accusations that NA #1 verbally abused Resident #3 (who had moderate cognitive impairment) since Resident #2's cognition was intact, and the staff considered him to be alert and reliable. However, he commented on 12/27/18 Resident #2 added to the recollection of his interaction with NA #1, stating she groped his crotch while transferring him incorrectly. According to the Administrator, he immediately contacted the sheriff's department, relaying to them Resident #2's account of what happened and the resident's desire to prosecute the NA for physical abuse. He explained the facility was waiting on the sheriff report before making a decision about the occurrence of physical/sexual abuse against Resident #2.

During a telephone interview with the sheriff investigator assigned to Resident #2's case on 01/08/19 at 1:55 PM he reported his investigation was still on-going. He stated he needed to talk to the resident's spouse and the accused NA, and he had not done so yet.

During a telephone conversation with the facility's Medical Director and Resident #2's primary physician on 01/09/19 at 11:16 AM she stated the resident had elevated levels of anxiety brought on by his health experiences and the severity of his illness. She reported she thought there was an emotional component that led to his detour to a local ED in route to his surgical appointment. She commented Resident #2 had shared with her how he was treated by NA #1, and she felt this treatment probably contributed to even more elevation in his anxiety levels. She explained

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F 600	Continued From page 10	F 600		

elevated levels of anxiety were not beneficial for a resident with a pacemaker because the resident's cortisol levels became elevated and tachycardia could develop. According to the Medical Director, after hearing about his interaction with NA #2, she had concerns about dignity, verbal abuse, and physical abuse. She stated Resident #2 was treated in a demeaning manner, and "what happened to him was a horrible thing, heartbreaking."

During an interview with the DON on 01/10/19 at 5:58 PM she stated the facility had zero tolerance for the abuse of residents by staff members. She reported the use of demeaning language and expletives when communicating with residents was a form of verbal abuse. She commented "groping" a resident in the crotch could be physical/sexual abuse or could be an example of poor transfer technique depending on the intent of the perpetrator.

During an interview with the Administrator at 6:02 PM on 01/10/19 he stated Resident #2 made significant progress with therapy and was discharged home on 01/02/19 with family. Upon being informed about the profanity NA #1 used against Resident #2, as reported by Nurse #6 during her interview, the Administrator reported this was the first time he had heard this information. He explained Nurse #6 should have informed the management team about the NA's use of the "F" word against Resident #2 because this elevated the level of the verbal abuse.

The Administrator and DON were notified of the Immediate Jeopardy on 01/09/19 at 6:05 PM.

On 01/10/19 at 5:36 PM the facility provided an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	9600 NO 5 SCHOOL ROAD ASH, NC 28420

(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	F 600		

acceptable credible allegation for IJ removal.

The facility's credible allegation for IJ removal for the deficiency at F600 included the following information:

A verbal abuse allegation was made on 12/16/18 by Resident #2 regarding staff member NA #1. Per resident on 12/12/18 NA #1 stated she spoke to him inappropriately saying the following "stop being so stubborn and stand up", "Jesus Christ, can't you do anything to help" and that she was "hateful".

*A Facility Reportable Incident submitted on 12/16/18.
*An investigation was initiated by the Administrator and Director of Nursing.
*Following a thorough investigation the 5 day final facility reportable was submitted on 12/21/18.
*The allegation was substantiated. Employee had been suspended on 12/12/18 pending another investigation and was subsequently terminated.
*Skin checks were completed on non-interviewable residents on 12/14/18 by the Director of Nursing and licensed nurses. No issues were identified.
*Interviewable residents were questioned on 12/14/18 on care and concerns by DON, ADON, Social Services and/or designees. Concerns were shared regarding NA#1. She was terminated on 12/13/18.
*Abuse re-education completed on 12/20/18 by the DON and/or designee for staff. The abuse education included the abuse policy, first ensuring the safety of the resident, an abuse quiz including types of abuse and notification to Administrator and/or Director of Nursing immediately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 12	F 600		

A physical abuse allegation was made on 12/27/18 by Resident #2 regarding staff member NA #1. Per the resident on 12/12/18 NA #1 "forced him into a wheelchair", "put one hand on his groin and one hand on his back to transfer him to a wheelchair", "threw him into the wheelchair", "refused to use a sliding board to transfer back in bed", "grabbed him around his chest tightly". Resident also signed statement that he did not report to staff initially.

*A Facility Reportable Incident submitted on 12/27/18.
*An investigation was initiated by the Administrator and Director of Nursing.
*Brunswick County Sheriff's office was contacted by the resident and social worker on 12/27/18. No charges were filed.
*A skin check was conducted on 12/27/18 on resident #2 by the DON. There were no issues.
*NA#1 was already terminated due to previous allegation on 12/13/18.
*Following a thorough investigation the 5 day final facility reportable was submitted on 01/02/19.
*Resident had a planned discharge home on 01/02/19.

Root Cause Analysis:

The facility failed to properly educate staff on the abuse policy including timeliness of reporting and the accuracy of statements including who, what, when, where, how and why.

The Procedure for Implementing the Acceptable Plan of Correction for the specific deficiency cited:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 13	F 600		

All residents have the potential to be affected.
The Administrator, Regional Director of Clinical Services and DON started in-house education on 01/09/19 related to F600 Abuse. The education was performed to ensure staff was properly trained on abuse, aware there is zero tolerance, reporting timely as well as accurately.
Education will continue via telephone for staff not available 01/09/19 or 01/10/19 in person. These staff members will not be permitted to work until education is received.
New hires will be educated to abuse policy upon hire.
The Regional Vice president of Operations re-educated the Licensed Nursing Home Administrator and DON on abuse, policy and procedures and conducting a proper/thorough investigation on 01/09/19.

The monitoring procedure to assure the Plan of Correction is corrected and the specific deficiency cited remains corrected and in compliance with regulatory requirements:

On 01/10/19 random staff interviews are being conducted by Administrator related to abuse and reporting.
On 01/10/19 facility resident interviews are being conducted by Department Managers for those residents that are interviewable related to abuse. Questions include if resident feels safe in the community, if you feel as if you have been abused and have you been treated with dignity and respect.
On 01/10/19 body checks were completed for those residents that are not interviewable by licensed nurses.
On 01/10/19 all interviewable residents will be re-educated on 01/10/19 by the Activity Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	9600 NO 5 SCHOOL ROAD ASH, NC 28420

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F 600	Continued From page 14	F 600		

on resident rights including immediately reporting any issues of concern including abuse, dignity and respect. This same education will be provided during monthly resident council meetings x 3 months.
Facility Administrative/Department Managers will start abuse questionnaires with all staff on 01/10/19 related to abuse and policy. The audits will be completed on 3 staff, 3 x weekly. Any negative findings will be addressed immediately by the Administrator and/or Director of Nursing.
DON and/or ADON will conduct 3 skin checks on 3 non interviewable residents, 3 x weekly. Any negative findings will be addressed immediately by the Administrator and/or Director of Nursing.
On 01/10/19 resident questionnaires will be conducted with 3 residents weekly related to abuse. Any negative findings will be addressed immediately by Administrator and/or Director of Nursing.
The facility will conduct an Ad Hoc Quality Assurance Performance Improvement meeting on 01/10/19 with the facility interdisciplinary team, the Regional Vice President of Operations, Regional Director of Clinical Services the Medical Director to review the corrective measures.

The title of the person responsible for implementing the acceptable plan of correction is the Administrator.

Immediate Jeopardy removal date: 01/10/19

Validation:

Immediate Jeopardy (IJ) was removed on 01/10/19 at 5:36 PM. Validation of the credible allegation for IJ removal was completed as evidenced by interviews with 9 staff members

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	9600 NO 5 SCHOOL ROAD ASH, NC 28420

(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 15	F 600		

representing various disciplines and shifts to verify abuse and abuse reporting in-servicing and by interviews with 7 residents having intact cognition about whether they had ever been abused by facility staff. 28 skin checks were reviewed for residents who were unable to respond to questions about abuse, and none of those checks revealed documentation of skin impairment indicative of abuse infliction. Responses from 9 staff education questionnaires and 57 staff abuse quizzes were reviewed; revealing staff understood the in-servicing they received. Responses from 29 resident education questionnaires were reviewed; revealing residents understood how to report abuse if it happened to them. All questionnaires and quizzes were reviewed and the questions in them seemed appropriate to gauge understanding of the abuse education. The Administrator and DON confirmed they had been re-educated by the Regional Vice president of Operations on abuse, policy and procedures, and conducting a proper/thorough abuse investigation.

2. Resident #3 was admitted to the facility on 04/12/18 with multiple diagnoses including congestive heart failure (CHF), edema, anxiety, major depression, and chronic obstructive pulmonary disease (COPD).

Resident #3's quarterly Minimum Data Set (MDS) dated 09/15/18 revealed the resident had mild cognitive impairments. The resident needed extensive assistance with toilet use, personal hygiene, and was independent with eating.

Resident #3's care plan goals dated 08/21/18: revealed the resident needed oxygen and diuretic therapy related to chronic obstructive pulmonary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	9600 NO 5 SCHOOL ROAD ASH, NC 28420

(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 16	F 600		

disease (COPD), edema, and congestive heart failure (CHF). Resident had behaviors, refused care, refused showers, and was verbally abusive to staff as evidenced by yelling.

Review of the facility incident reports from 12/08/18 through 12/11/18 revealed there was no incident report for alleged verbal abuse of Resident #3 by Nursing Aide (NA) #1 on 12/08/18.

Review of the nurse's notes from 12/08/18 through 12/12/18 revealed no documentation of Nurse #1or Nurse #2 or NA #2 having concerns that NA #1 had been verbally abusive to Resident #3 on the night of 12/08/18.

Review of the facility 5 day Abuse Summary dated 12/18/18 revealed on 12/12/18 at or around 8:00 AM Nurse #1 reported to the Administrator and DON that on 12/08/18 she heard Nursing Aide (NA) #1 tell Resident #4 that she was "hateful and she could ring her call bell, but she wasn't going to answer it". The DON and Administrator interviewed the other nurse on duty Nurse #2 and she also stated that she didn't hear the exchange, but said the resident was anxious throughout the night. The Administrator and DON also interviewed the other NA on duty NA #2. She stated that she heard Resident #3 yelling out and went to her room. NA #1 told her to "get out, and said Resident #3 doesn't need any company tonight because she's hateful". On 12/16/18 Resident #2 said NA #1 told him, during a transfer, "Jesus can't you do anything yourself", and considered it abusive. After investigating the incident the facility substantiated abuse. An abuse in-service was initiated with staff, and NA #1 was terminated from employment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 17	F 600		

Three incident/accident witness statement reports were provided by the Administrator on 01/07/19. The first report from Nurse #1 revealed on 12/08/18 during the night shift she was sitting at the nurses station and overheard NA #1 say to Resident #3 "you are a hateful woman, and you can ring your call light all night, and I don't have to come back into your room." The second report from NA #2 revealed on 12/08/18 during the night shift she heard Resident #3 yelling, and she immediately went to Resident #3's room to check on the cause of the yelling, and was told by NA #1 to "get out of Resident #3's room, she didn't need any company tonight because Resident #3 was being hateful." NA #2 said she came out of Resident #3's room, walked to the nursing station and spoke to Nurse #1 whom NA #2 stated heard the whole conversation." NA #2 stated that NA #1 repeated the same statement to Nurse #2. NA #2 said Resident #3 was fearful of NA #1. The third report from NA #1 revealed on 12/08/18 during the night shift Resident #3 yelled to "get my stuff off of floor." NA #1 told Resident #3 "there's nothing on the floor, calm down." NA #1 then stated she told resident, she was being mean, and to stop being mean. NA #1 told NA #2 to leave resident's room, so she could calm down, that she was having one of her episodes.

An interview conducted on 01/07/19 at 3:50 PM with Resident #3 revealed she could not remember anything that happened on 12/08/18. She said she did not remember staff being mean or hateful to her. Resident #3 said she was treated well at the facility, and had no staff concerns.

An interview conducted on 01/08/19 at 3:43 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	9600 NO 5 SCHOOL ROAD ASH, NC 28420

(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 18	F 600		

with NA #2 revealed, on the night of 12/08/18 she heard Resident #3 screaming. She said when she went into Resident #3's room to check on the cause of the screaming, NA #1 told her that Resident #3 had been mean and hateful, and did not need any company or visitors. NA #1 told NA #2 that Resident #3 was hateful, didn't need visits, and threatened to take away the resident's call bell. NA #2 said she went to the nursing station, which was only 2 doors away, and relayed the verbal event to Nurse #1 and Nurse #2, who both heard it.

An interview conducted on 01/08/19 at 4:42 PM with the DON revealed the first time she heard of Resident #3's verbal abuse allegation was from NA #2, which was after their 12/12/18 staff town hall meeting.

An interview conducted on 01/09/19 at 11:50 AM with Nurse #1 revealed, on the night of 12/08/18 after NA #1's verbal interaction with Resident #3, and after the resident yelled "get me out of here" Nurse #1 observed Resident #3 was visibly shaken and scared. The nurse said, after NA #1's verbal confrontation with Resident #3, she felt it was necessary for her to sit with the resident for about 10 minutes, verbally reassuring her that it was going to be okay. She said, after the 10 minutes, she left to get the resident warm juice, which the resident liked, and sat with her for an additional 5 minutes. Nurse #1 said after sitting with the resident, and giving her the juice, the resident was more relaxed and calm. Nurse #1 said she told the resident that she would be right at the nursing station, two doors down, if she needed anything else. Nurse #1 said she again checked on the resident when NA #1 was in the resident's bathroom, and the resident pointed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	9600 NO 5 SCHOOL ROAD ASH, NC 28420

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F 600	Continued From page 19 NA #1, and nodded yes 3 times to Nurse #1 that it was NA #1 who was verbally hateful to her. An interview conducted on 01/10/19 at 6:05 PM with the Administrator revealed the statements made to Resident #3 on 12/08/18 by NA #1, calling her a mean old lady, was verbal abuse, and would not be tolerated. He said it was his expectation that the night staff should have immediately called either the DON or himself, when they thought there was any indication of possible abuse, and they did not.	F 600		
F 607 SS=D	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 follow their abuse policy and procedure by not reporting allegation of abuse immediately to the Director of Nursing (DON) or Administrator/Abuse Coordinator for 1 of 4 sampled residents reviewed for abuse and neglect (Resident #3). Findings included:	F 607	Preparation and submission of this Plan of Correction does not constitute an admission of or an agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously implore the quality of care to comply with State and Federal requirements.	2/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 607	Continued From page 20 The facility's abuse policy and procedure with the revised date of 03/03/17 was reviewed. Under policy, the policy indicated that "Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy." Under definitions, the policy indicated verbal abuse "is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability comprehend, or disability. Examples of verbal abuse included but are not limited to: threats of harm; saying things to frighten a resident". Resident #3 was admitted to the facility on 04/12/18 with multiple diagnoses including congestive heart failure (CHF), edema, anxiety, major depression, and chronic obstructive pulmonary disease (COPD). Resident #3's quarterly Minimum Data Set (MDS) dated 09/15/18 that resident had mild cognitive impairments. The resident needed extensive assistance with toilet use, personal hygiene, and was independent with eating. Resident #3's care plan goals dated 08/21/18: revealed the resident needed oxygen and diuretic therapy related to chronic obstructive pulmonary disease (COPD), edema, and congestive heart failure (CHF). Resident had behaviors, refused care, refused showers, and was verbally abusive to staff as evidenced by yelling. Review of the nurse's notes from 12/08/18	F 607	1. Resident #3 continues to reside in the facility. At this time Resident #3 does not recall any events on 12/8/2018 and there were no negative outcomes. Resident #2 was discharged home on 1/2/19. Once the allegation was given to the Administrator and Director of Nursing, a facility reportable incident was completed and fax to the NCDHHS on 12/12/2019. An investigation was conducted and NA#1 was terminated. 2. Skin checks were completed on all non-interviewable residents on 12/14/2018 by the DON and licensed nurses. No issues were identified. Interviewable residents were questioned on 12/14/18 on care and concerns by DON, ADON, Social Services and or/designee. Concerns were shared regarding NA#1. Again NA#1 was terminated on 12/13/18. On 1/10/19 facility resident interview were conducted by Department Managers for those residents that were interviewable related to abuse. No issues were identified. On 1/10/19 body checks were completed for those residents that are not interviewable by licensed nurses. No issues were identified. 3. Abuse re-education was completed on 12/20/18 by the DON and/or designee for staff. The abuse education included the abuse policy, first ensuring safety of the resident, an abuse quiz and to notify the Administrator and/or DON immediately. The Administrator, DON, and Regional Director of Clinical Services started	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 607	Continued From page 21 through 12/12/18 revealed no documentation of Nurse #1or Nurse #2 or NA #2 having concerns that NA #1 had been verbally abusive to Resident #3 on the night of 12/08/18. Review of the facility incident reports from 12/08/18 through 12/12/18 revealed there was no incident report for alleged verbal abuse of Resident #3 by Nursing Aide (NA) #1 on 12/08/18. Review of the facility 5 day Abuse Summary dated 12/18/18 revealed on 12/12/18 at or around 8:00 AM Nurse #1 reported to the Administrator and DON that on 12/08/18 she heart Nursing Aide (NA) #1 tell Resident #4 that she was "hateful and she could ring her call bell, but she wasn't going to answer it". The DON and Administrator asked Nurse #1 why she didn't immediately report the incident and she said she at first didn't feel it was abusive, but after thinking about it, she felt like she had to report. The DON and Administrator interviewed the other nurse on duty Nurse #2 and she also stated that she didn't hear the exchange, but said the resident was anxious throughout the night. The Administrator and DON also interviewed the other NA on duty NA #2. She stated that she heard Resident #3 yelling out and went to her room. NA #1 told her to "get out, and said Resident #3 doesn't need any company tonight because she's hateful". On 12/16/18 Resident #2 said NA #1 told him, during a transfer, "Jesus can't you do anything yourself", and considered it abusive. After investigating the incident the facility substantiated abuse. An abuse in-service was initiated with staff, and NA #1 was terminated from employment. Like residents were interviewed and skin checks were performed.	F 607	in-house re-education on 1/9/19. The education was performed to ensure staff are appropriately trained on abuse, aware of the "zero tolerance", reporting timely, and the accuracy of the report. The Regional Vice President of Operation re-educated the Administrator, DON, and ADON on abuse and conducting a thorough investigation on 1/9/19. On 1/10/19 all interviewable residents were re-educated by the Activity Director on resident rights including reporting issues of concerns with abuse, dignity, and respect. The Administrative/Department Managers will complete 3 random abuse questionnaires to staff x3 weekly until 5/1/19. DON and/or designee will conduct x3 skin checks on non-interviewable residents x3 weekly until 5/1/19. Questionnaires regarding abuse will be conducted with 3 residents weekly until 5/1/19. Education regarding abuse reporting abuse issues will be presented at Resident Council x3 months until 5/1/19. Any negative findings will be addresses immediately by the Administrator and/or DON. The Administrator and/or designee will present audit results in QAPI each month for review and any recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 607	Continued From page 22	F 607		

An interview conducted on 01/07/19 at 3:50 PM with Resident #3 revealed she could not remember anything that happened on 12/08/18. She said she did not remember staff being mean or hateful to her. Resident #3 said she was treated well at the facility, and had no staff concerns.

Three incident/accident witness statement reports were provided by the Administrator on 01/07/19. The first report from Nurse #1 revealed on 12/08/18 during the night shift she was sitting at the nurses station and overheard NA #1 say to Resident #3 "you are a hateful woman, and you can ring your call light all night, and I don't have to come back into your room." The second report from NA #2 revealed on 12/08/18 during the night shift she heard Resident #3 yelling, and she immediately went to Resident #3's to check on cause of the yelling, and was told by NA #1 to "get out of Resident #3's room, she didn't need any company tonight because Resident #3 was being hateful." NA #2 said she came out of Resident #3's room, walked to the nursing station and spoke to Nurse #1 whom NA #2 stated heard the whole conversation." NA #2 stated that NA #1 repeated the same statement to Nurse #2. NA #2 said Resident #3 was fearful of NA #1. The third report from NA #1 revealed on 12/08/18 during the night shift Resident #3 yelled to "get my stuff off of floor." NA #1 told Resident #3 "there ' s nothing on the floor, calm down." NA #1 then stated she told resident, she was being mean, and to stop being mean. NA #1 told NA #2 to leave resident's room, so she could calm down, that she was having one of her episodes.

An interview conducted on 01/08/19 at 3:43 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	9600 NO 5 SCHOOL ROAD ASH, NC 28420

(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 607	Continued From page 23	F 607		

with NA #2 revealed, on the night of 12/08/18 she heard Resident #3 screaming. She said when she went into Resident #3's room to check on the cause of the screaming, NA #1 told her that Resident #3 had been mean and hateful, and did not need any company or visitors. NA #1 told NA #2 that Resident #3 was hateful, didn't need visits, and threatened to take away the resident's call bell. NA #2 said she went to the nursing station, which was only 2 doors away, and relayed the verbal event to Nurse #1 and Nurse #2, who both heard it. NA #2 said she was told by Nurse #2 to write out her statement, which she said she typed out that night, and placed it in the white locked box at the DON's office. NA #2 said she heard nothing from the Administrator or the DON about her typed written statement, until she confronted the DON after the 12/12/18 staff meeting. NA #2 said on 12/12/18 the Administrator and DON asked her to write-up another statement, which she did. She said, she never saw again her 10/08/18 typed up statement.

An interview conducted on 01/08/19 at 4:42 PM with the DON revealed she had received no typed or hand written statement from NA #2, and that no typed statement was placed in her white locked box. The DON said the first time she heard of Resident #3's verbal abuse allegation was from NA #2, which was after their 12/12/18 staff town hall meeting. The DON said it was her expectation that if facility staff witness abuse in any form, they were required by facility policy to immediately report it by phone to the DON or the Administrator, and not just write it down on a note and put it in her white box, or wait days later to notify her verbally after a staff meeting, to bring it up. The DON said, on 10/08/18 her staff should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 607	Continued From page 24	F 607		

have called her or the Administrator immediately as required by policy, and they did not.

An interview conducted on 01/09/19 at 11:50 AM with Nurse #1 revealed, on the night of 12/08/18 after NA #1's verbal interaction with Resident #3, and after the resident yelled "get me out of here" Nurse #1 observed Resident #3 was visibly shaken and scared. The nurse said, after NA #1's verbal confrontation with Resident #3, she felt it was necessary for her to sit with the resident for about 10 minutes, verbally reassuring her that it was going to be okay. She said, after the 10 minutes, she left to get the resident warm juice, which the resident liked, and sat with her for an additional 5 minutes. Nurse #1 said after sitting with the resident, and giving her the juice, the resident was more relaxed and calm. Nurse #1 said she told the resident that she would be right at the nursing station, two doors down, if she needed anything else. Nurse #1 said she again checked on the resident when NA #1 was in the resident's bathroom, and the resident pointed to NA #1, and nodded yes 3 times to Nurse #1 that it was NA #1 who was verbally hateful to her.

An interview conducted on 01/10/19 at 6:00 PM with the Administrator revealed, on the night of 12/08/18 he was not called or informed of the verbal abuse allegation incident with NA #1 until after the morning staff meeting on 12/12/18. The allegation was that NA #1 was verbally abusive to Resident #3. He indicated that he considered the NA's verbal statements as abuse allegations. The Administrator stated that he did not report the allegations of abuse because the two night nursing staff (Nurse #1 and NA #2) on 12/08/18 failed to report the verbal abuse incident to the Administrator or DON until after the 12/12/18 staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	9600 NO 5 SCHOOL ROAD ASH, NC 28420

(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 607	Continued From page 25 meeting. An interview conducted on 01/10/19 at 6:00 PM with the Director of Nursing revealed she was never informed of the incident between Resident #3 and NA #1 until 12/12/18. She stated she should have been informed immediately by phone that night; so, that an investigation could have been started and the 24-hour 5-day reports could have been started and sent to the state agency, according to their facility abuse protocol. An interview conducted on 01/10/19 at 6:05 PM with the Administrator revealed the statements made to Resident #3 on 12/08/18 by NA #1, calling her a mean old lady, was verbal abuse, and would not be tolerated. He said it was his expectation that the night staff should have immediately called either the DON or himself, when they thought there was any indication of possible abuse, and they did not.	F 607		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review and family, resident, and staff interviews the facility failed to provide daily showers as ordered by the physician for 1 of 3 dependent residents (Resident #5) reviewed for the provision of Activities of Daily Living (ADLs) care. Findings included: Resident #5 was admitted to the facility on	F 677	Preparation and submission of this Plan of Correction does not constitute an admission of or an agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously implore the quality of care to comply with State and Federal requirements.	2/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 677	Continued From page 26 05/22/18 and had diagnoses of muscle weakness, diabetes, and a history of urinary tract infections (UTIs). Review of the quarterly Minimum Data Set (MDS) dated 10/30/18 revealed that Resident #5 did not reject care and was totally dependent on one person for the tasks of bathing and showering. Resident #5 was moderately cognitively impaired. Review of the 11/02/18 Urologist note revealed an order for the facility to shower Resident #5 daily. Review of the Nursing Note dated 11/06/18 revealed a family member of Resident #5 provided the facility with the order to shower Resident #5 daily on 11/06/18. The order was entered into the computer that day. Review of the November 2018 Nursing Notes and the Shower/Tub Bath/Bed Bath Sheets revealed Resident #5 received showers on 11 of the 24 days after the order for daily showers was received. Review of the Care Plan updated 11/14/18 revealed Resident #5 was at risk for infections due to a history of UTIs and was to be showered every day as allowed. Review of the December 2018 Nursing Notes and the Shower/Tub Bath/Bed Bath Sheets revealed Resident #5 received showers on 9 of the 29 days (Resident #5 was out of the facility on 2 days) that month. Review of the January 2019 Nursing Notes and the Shower/Tub Bath/Bed Bath Sheets revealed Resident #5 received showers on 3 of the 9 days	F 677	Based on physician interview, resident interview, and record review the facility failed to provide daily showers as ordered by the Physician for 1 of 3 dependent residents. 1. Resident #5 received a shower on 1/9/19 by her assigned CNA. 2. The DON/Designee audited current physician orders to identify other residents that may have a physician ordered shower schedule. No other shower schedule orders were identified. 3. The DON/ADON provided education for the nursing staff regarding following physician orders and expectations for validating resident showers are completed as requested. 4. The DON/and or designees will review shower sheets to identify the residents who were bathed, showered, or refused their schedule to ensure completion and appropriate documentation. 3 residents a week will be interviewed /observed to validate they are receiving showers and documented. The ongoing audits will be completed daily for 4 weeks and then weekly for 8 weeks. The DON and/or designee will present audit results in QAPI each month for review and any recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	9600 NO 5 SCHOOL ROAD ASH, NC 28420

(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 677	Continued From page 27	F 677		

in January.

In an interview on 01/09/19 at 11:00 AM a family member indicated that Resident #5 had a physician's order for daily showers and that the showers were not being provided. The family member stated Resident #5 had not had a shower that morning. Resident #5's family member indicated that the reason daily showers were ordered was because Resident #5 had a history of UTIs and it was felt this would help with cleanliness of the peri-area.

In an interview on 01/09/19 at 1:28 PM Nurse #3 indicated Resident #5 had a shower that morning. She indicated she looked at the Shower/Tub Bath/Bed Bath Sheet the aide filled out and then documented that the shower had been provided. Nurse #3 indicated that was the process for documenting that showers were given. Nurse #3 looked for, but was unable to locate, the Shower/Tub Bath/Bath Sheet for Resident #5 for that day. Nurse #3 did not realize Resident #5 was not receiving daily showers as ordered or the reason for the daily showers.

In an interview on 01/09/19 at 1:31 PM Nursing Assistant (NA) #11 stated she had provided a shower for Resident #5 that morning but had not filled out the Shower/Tub Bath/Bed Bath Sheet for the nurse yet. NA #11 indicated that a Shower/Tub Bath/Bed Bath Sheet was filled out each time a resident was bathed and if there were missing sheets the bathing task may not have been done.

In an interview on 01/09/19 at 1:33 PM Resident #5 stated she had not received a shower that day. She indicated she had received a bed bath.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 677	Continued From page 28 Resident #5 indicated she received showers on some days but could not remember which days they had been given. In an interview on 01/09/19 at 1:42 PM Nurse #3 stated she was now aware that Resident #5 had not received a shower that day after all and that she would correct her documentation. In an interview on 01/10/19 at 3:46 PM the Director of Nursing (DON) stated she expected orders to be followed. She indicated she expected showers to be provided daily if ordered and that the nurses not sign an order as completed unless they knew it was done.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on physician interview, resident interview, staff interview and record review the facility failed to utilize therapy recommendations to transfer a resident from the bed to a chair and to transport a resident in a wheelchair for 1 of 3 sampled residents (Resident #2) reviewed for accidents. Findings included: Record review revealed that Resident #2 was admitted to the facility on 11/30/18. The	F 689	Preparation and submission of this Plan of Correction does not constitute an admission of or an agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously implore the quality of care to comply with State and Federal requirements. Based on physician interview, resident	2/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	9600 NO 5 SCHOOL ROAD ASH, NC 28420

(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 689	Continued From page 29 resident's documented diagnoses included adjustment disorder with anxiety, congestive heart failure (CHF), atrial fibrillation (a-fib), cardiac pacemaker, diabetes, and unsteadiness of the feet. Review of Resident #2's Resident Mobility/Transfer Profile, dated 12/01/18 and good through readmission to the facility from the hospital on 12/15/18, revealed Resident #2 was to be transferred with a sliding board and two-person assist. The resident's 12/07/18 admission minimum data set (MDS) documented he had no impairment to his cognition, he exhibited no delirium/psychosis/behaviors including resistance to care, he required extensive assistance from two staff members with bed mobility and transfers, he required extensive assistance by a staff member with locomotion on and off the unit, he did not walk in the room or corridor during the look back period, he was not steady on his feet when transferring between the bed and chair and vice versa, he had range of motion impairment on both sides of his lower extremities, he used his wheelchair for mobility, he was 72 inches tall and weighed 240 pounds, and he experienced occasional moderate pain in last 5 days making it difficult to sleep and limiting his day-to-day activities. A nursing note written on 12/12/18 at 6:03 PM documented Resident #2 left the facility at 9:55 AM on 12/12/18 for surgery in Wilmington, was transported by a contracted transport company, and was accompanied by nursing assistant (NA) #2. At 10:20 AM the NA reported that the resident complained of "not feeling right" and the	F 689	interview, and record review the facility failed to utilize therapy recommendations to transfer a resident from the bed to a chair and to transport a resident in a wheelchair for 1 of 3 sampled residents. 1. Resident #2 was discharged home on 1/2/19. 2. An audit was completed on 1/29/19 of the current resident's physician orders, care plan, and kardex to validate resident transfer status is correct. Any residents identified with a change in transfer status will be referred to Therapy for evaluation. 3. The DON/Designee will provided licensed Nurses and CNA's with education regarding expectations to follow the transfer status for all residents per the kardex. Nursing staff will complete resident handling training to validate understanding od different types of transfers. 4. The DON/Designee will observe nursing staff transferring residents to ensure they are following the plan of care. This will be documented for 4 residents daily x7 days, then 4 residents 5 days a week x 3 weeks, then 4 resident for 8 weeks. The DON and/or designee will present audit results in QAPI each month for review and any recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	9600 NO 5 SCHOOL ROAD ASH, NC 28420

(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 689	Continued From page 30	F 689		

resident stated, "'I need you to take me to the hospital instead of to my (appointment)." The transport company took the resident to the ED (emergency department) per the resident's request.

A 12/12/18 ED encounter note documented, "...but during his ambulance ride to ___ (name of Wilmington hospital) (Resident #2) developed severe right knee, right leg, and right foot pain. Had nausea and vomiting, and was brought to our emergency room. Evaluation in the emergency room found him volume compensated (hydrated) and in no acute distress except for his knee and leg complaints. His right knee was warm and exquisitely tender. Right foot especially across the MTPs (metatarsophalangeals--toe joints) and especially the right first MTP was exquisitely tender and warm."

A statement written by Resident #2 on 12/16/18 documented, "Awakened from sleep had to get weighed. NA said to stand up. Had trouble moving from bed to wheelchair. No slide board used. Just pulled on a chair. Told her that legs ached. She was mumbling, but I could not understand. I asked for a Hoyer lift, but was told it was to be done her way. When back in room same procedure getting back to bed. Tried to lift me over the side of the chair and on bed. Started to lose control and tumbled on top of me..."

An undated typed statement signed by Resident #2 documented, " (NA #1) forced (Resident #2) into wheelchair without sliding board and yanked him up out of the bed. Resident told NA that he did not need to be yanked. NA told him to get in chair by himself. NA grabbed him by the waist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	9600 NO 5 SCHOOL ROAD ASH, NC 28420

(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 689	Continued From page 31	F 689		

She then put one hand on his back and one hand on his groin in order to transfer resident into the wheelchair from the bed. She threw him into the wheelchair and told him not to move. NA would not let resident use leg rest on wheelchair to transport down the hall to get weight. Resident had to hold his legs up the entire way down to get weighed.... On the way back down the hall, the resident asked the NA to stop so he could rest his legs since he was having to hold legs up by his hands. NA did not stop when he asked her to. His heels were dragging. NA refused to use the sliding board to transfer resident back into bed from the wheelchair. She grabbed him around his chest tightly. She must have lost her balance in the process and they started to do down. Resident hit his back on the bed and the NA fell on top of the resident. This information was not reported initially to the staff."

During a telephone interview with Resident #2 on 01/08/19 at 3:46 PM he stated before he was transported to an appointment in Wilmington for pacemaker re-implantation on the morning of 12/12/18, NA #1 entered his room where he was in bed, and told him that she needed to weigh him before he left the building. He reported he informed the NA that she was not transferring and transporting him correctly, but she stated, "We are going to do this my way."

During a telephone interview with NA #1 on 01/09/19 at 1:20 PM she stated she needed to obtain a weight for Resident #2 on the morning of 12/12/18. She reported the resident was fully dressed and laying across his bed. She commented she used a sliding board to transfer the resident off the bed and to put him back on the bed after she weighed him in his wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	9600 NO 5 SCHOOL ROAD ASH, NC 28420

(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 689	Continued From page 32	F 689		

According to NA #1, there were already foot rests on the resident's wheelchair when she transported him to be weighed.

During a telephone interview with the driver of the contracted transport van on 01/08/19 at 4:11 PM she stated on 12/12/18 when she picked Resident #2 up from the facility to be transported to Wilmington the resident complained of and exhibited signs and symptoms of excruciating pain in his legs.

A statement written by Nurse #6 on 12/16/18 documented, "(Resident #2) told this nurse that (NA #1) was rough when transferring him from bed to chair (with) 1 x assist, pt (patient) is a slide board. Pt told this nurse that (NA #1) told him 'it was her way and that he needed to stop being so stubborn and stand up.'"

During an interview with Nurse #6 on 01/09/19 at 8:50 AM she stated on 12/16/18 as she was asking Resident #2 how his surgical procedure went he confided in her that NA #1 had refused to transfer and transport him correctly on the morning of 12/12/18 before he departed the facility for Wilmington. She reported she could tell by Resident #2's facial expressions that he was visibly upset, and his hands were shaking while he was relaying the account to her. The nurse stated she and Resident #2 were asked to write statements about what they were told or experienced.

During an interview with Therapist #1, the Director of Rehabilitation, on 01/09/19 at 9:21 AM, she stated therapy worked with Resident #2 on transfers and dynamic standing balance. She reported the resident's legs were very weak so

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	9600 NO 5 SCHOOL ROAD ASH, NC 28420

(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 689	Continued From page 33	F 689		

before having his surgery in Wilmington he was transferred using a sliding board. She also commented she thought therapy was just beginning to trial the use of the sit-to-stand lift when transferring the resident to a shower chair. She explained the resident complained of right knee weakness and pain so staff should not have allowed the resident to stand and pivot during transfers. She commented by not using the sliding board for transfers the resident was put at risk for falling. According the Therapist #1, staff were educated during orientation that unless residents were able to wheel themselves in their wheelchairs, foot rests were supposed to be on the wheelchair. She stated Resident #2 preferred for staff to push his wheelchair outside of his room. She commented that without foot rests Resident #2 could have injured his feet or fallen out of his wheelchair.

During an interview with Therapist #2, Resident #2's primary provider of Occupational Therapy, on 01/09/19 at 9:35 AM, he stated before having surgery in Wilmington Resident #2 should have been transferred in and out of the bed by two staff members using a sliding board. He reported he thought a sliding board was kept in Resident #2's room, and there was a back-up sliding board kept in the unlocked gym all the time. According to Therapist #2, Resident #2's primary NA received review and demonstration of the sliding board technique when transferring, and she would have passed this review on to the rest of the staff who cared for the resident. Since Resident #2 could barely move his swollen legs and he had a larger frame, Therapist #2 explained that if the sliding board was not used by two staff members during transfers, Resident #2 was placed at high risk for falls. The therapist commented Resident #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345575	A. BUILDING _____ B. WING _____	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK HEALTH & REHAB CENTER	9600 NO 5 SCHOOL ROAD ASH, NC 28420

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F 689	Continued From page 34	F 689		

could not hold his feet up for long due to weakness, and having him do so increased the risk the resident could sustain skin tears or experience a foot/ankle fracture.

During an interview with Therapist #3, Resident #2's primary provider of Physical Therapy, on 01/09/19 at 9:53 AM, she stated during the first half of December 2018 the resident should have been transferred in and out of the bed by two staff members utilizing a sliding board which was kept in his room. She reported if staff had tried to stand and pivot the resident his weak knees could have buckled, and he could have fallen and sustained a fracture. According to Therapist #3, there should have been foot rests on Resident #2's wheelchair at all times due to the weakness in his legs. Without them she commented the resident could have broken his ankle. She reported the transfer status of residents was documented in a notebook kept at the nursing station. According to Therapist #3, if staff were unsure of how to care for residents, they were supposed to consult this notebook to facilitate safe resident transfers.

During an interview with NA #6, who cared for Resident #2, she stated the resident was alert and oriented and reliable. She reported prior to his 12/13/18 surgery the resident was transferred by two staff members using a sliding board. She also commented when the resident went outside of his room there were always supposed to be foot rests on his wheelchair. According to NA #6, the transfer status of all residents was documented on therapy forms stored in a notebook at the nursing station.

During a telephone conversation with the facility's

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F 689	Continued From page 35	F 689		

Medical Director and Resident #2's primary physician on 01/09/19 at 11:16 AM she stated the resident shared with her that on 12/12/18 NA #1 would not transfer and transport him the way in which therapy had instructed staff. She reported because this NA did not follow therapy recommendations, the NA placed Resident #2 at risk for falls and injuries such as skin tears, head trauma, and fractures.

During a telephone interview with Nurse #11 on 01/10/19 at 11:23 AM she stated Resident #2 was alert and oriented, and he was a little forgetful the first couple of weeks in the facility. She commented the resident was reliable and could express his needs to staff.
She reported she was the nurse who discharged the resident on 12/12/18 as he left for surgery in Wilmington, and at that time, the resident should have been transferred by two staff members using a sliding board, and his foot rests should have been on his wheelchair. According to Nurse #11, these transfer and transport techniques were necessary because Resident #2's legs were weak. She explained that the resident could have sustained skin tears without the foot rests, and could have fallen without the sliding board since his legs could not support his weight.

During an interview with the DON on 01/10/19 at 5:58 PM she stated the facility depended on therapy's expertise for the safest transfer techniques. She reported when NA #1 did not use the sliding board and foot rests for Resident #2 on 12/12/18 she created the potential for falls, fractures, and skin tears. She also commented not using the recommended transfer techniques made residents fearful of staff and increased resident anxiety levels.

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F 689	Continued From page 36 During an interview with the Administrator at 6:02 PM on 01/10/19 he stated Resident #2 made significant progress with therapy after returning to the facility on 12/15/18, and was discharged home on 01/02/19 with family.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's	F 690		2/4/19

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F 690	Continued From page 37 comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and physician and staff interviews the facility failed to follow-up on a urine culture which caused a delay in treatment for 1 of 1 sampled residents (Resident #5) reviewed for urinary tract infections (UTIs). Findings included: Resident #5 was admitted to the facility on 05/22/18 and had diagnoses of muscle weakness, diabetes, and a history of urinary tract infections (UTIs). Review of the quarterly Minimum Data Set (MDS) dated 10/30/18 revealed that Resident #5 was frequently incontinent of bowel and bladder and required the extensive assistance of one person for hygiene. Resident #5 was moderately cognitively impaired and did not reject care. Review of the 11/02/18 Urologist note revealed an order for the facility to collect a catheterized urine specimen and to send it to the laboratory for a culture and sensitivity analysis. Review of the Nursing Note dated 11/06/18 revealed a family member of Resident #5 provided the facility with an order to collect a urine culture and sensitivity. The order was entered into the computer that day. Review of the laboratory analysis for Resident #5's urine sample revealed the specimen was received by the laboratory on 11/07/18 and the	F 690	Preparation and submission of this Plan of Correction does not constitute an admission of or an agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously implore the quality of care to comply with State and Federal requirements. Based on physician interview, resident interview, and record review the facility failed to timely follow up on a urine culture which caused a delay in treatment for 1 of 1 sampled residents reviewed for urinary tract infection. 1. Resident #5 was treated for a UTI beginning 11/14/18. She currently has no signs or symptoms of a UTI. 2. An audit will be performed for all labs that have been ordered January, 2019 to ensure they were drawn, the physician reviewed timely and any issues identified were addressed. 3. Licensed nursing staff will be re-educated by the DON/Designee on the facility lab process including retrieving results and physician notification.	

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F 690	Continued From page 38 results were available to the facility on 11/09/18. Resident #5's urine culture revealed there were greater than 100,000 CFU/mL (Colony Forming Units per milliliter) of Escherichia coli indicating a positive UTI. The organism Escherichia coli was shown to be sensitive to Ampicillin among other antibiotics. Review of Resident #5's medical record revealed no physician orders were written from 11/09/18 to 11/14/18 to treat the resident's UTI. Review of the Care Plan updated 11/14/18 revealed Resident #5 was at risk for infections due to a history of UTIs. Cultures were to be performed as ordered and the physician was to be informed of abnormal results. Review of the Medication Administration Record (MAR) dated 11/15/18 revealed an order for Ampicillin 500MG (milligrams) give 1 capsule by mouth four times a day for UTI at 6:00 AM, 12:00 PM, 4:00 PM, and 10:00 PM. The medication was started on 11/15/18 at the 10:00 PM dose. In an interview on 01/09/19 at 1:45 PM the Director of Nursing (DON) indicated that getting results from the laboratory was a problem. She indicated it was the responsibility of the Unit Manager to get the results from the laboratory, review the results, and to report the results to the physicians. She indicated that the delay in treatment for Resident #5's UTI was a problem because staff did not follow-up with the laboratory to get the results of the culture which caused the delay in treatment. In a telephone interview on 01/09/19 at 4:54 PM former Unit Manager (UM) #1 stated it was part of	F 690	4. Physician ordered labs will be reviewed by the DON/and or designee 5 days a week for 4 weeks, 3x a week for 2 weeks, and weekly for 2 weeks to validate compliance with the lab process. The DON and/or designee will present audit results in QAPI each month for review and any recommendations.	

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F 690	Continued From page 39	F 690		

the UM's duties to follow-up on laboratory results. She indicated there were issues with the laboratory not sending the results to the facility which necessitated the need for the UM's to call and get the results.

In an interview on 01/09/19 at 5:00 PM the Assistant DON, (who was a UM at the time of the incident), stated it was the responsibility of the UM to follow-up on laboratory results. She indicated Resident #5's laboratory results from 11/09/18 had been faxed to the Urologist but was unsure of the date they had been faxed. She confirmed that antibiotics were not begun until 11/15/18. She indicated that she did not follow-up on the laboratory results for Resident #5 in providing them to the doctor.

In a telephone interview on 01/10/19 at 2:28 PM Resident #5's Urologist stated he did not know about Resident #5's positive urine culture until the day he treated it (11/15/18). The Urologist stated he expected the facility to call him with positive culture results so he could have the option to treat or not based on the presenting symptoms, the organism and the history of the resident. He indicated that although there was a delay in treatment, he did not feel the delay caused any harm to Resident #5.

In an interview with the DON on 01/10/19 at 3:46 PM she stated she expected laboratory tests to be followed up on and provided to the physician when the result was received. She indicated if there was a positive result, the result should be called to the physician. The DON confirmed the physician should have been notified of Resident #5's positive culture on 11/09/18 when the laboratory result was available.

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F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to provide safe and secure storage of medications for 1 of 4 medication carts observed (700 hall medication cart). Findings included: In an observation on 01/09/19 beginning at 1:34 PM Nurse #3 was observed entering room 703 and closed the room's door. The medication cart was outside and to the left of the door to room	F 761	Preparation and submission of this Plan of Correction does not constitute an admission of or an agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously implore the quality of care to comply with State and Federal requirements.	2/4/19

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F 761	Continued From page 41 703 with the drawers and the lock facing into the hallway. The lock on the medication cart did not appear to be engaged. There were no medications noted on the top of the medication cart. A continuous observation of the medication cart was conducted until 1:42 PM. During the eight minutes of the continuous observation a staff member walked past the medication cart pushing a resident in a wheelchair. Another staff member approached the door of room 703 and knocked on the door. After not receiving a response the staff member left the area. A resident walked past the medication cart using a rolling walker. At 1:42 PM Nurse #3 exited room 703 and pushed the resident in a wheelchair down the hallway and around the corner before returning to the medication cart. In an interview and observation on 01/09/19 at 1:42 PM Nurse #3 demonstrated by pulling on and opening a drawer that the medication cart had not been locked. She stated it was not her usual practice to leave the medication cart unlocked and that it was a problem that she did so. She indicated staff, residents, or visitors could have opened a drawer in the medication cart and removed medications without her knowledge. In an interview on 01/10/19 at 3:46 PM the Director of Nursing (DON) stated it was unacceptable for medication carts to be left unlocked.	F 761	Based on physician interview, resident interview, and record review the facility failed to provide safe and secure storage of medications for 1 of 4 medication carts observed on the 700 hall medication cart. 1. Medication cart was immediately locked when observed by licensed nurse. All other medication carts were check and no other cart were observed unlocked in the facility. The assigned nurse received 1:1 education and there were no negative outcome to any resident. 2. Current residents are all at risk for this issue. 3. Education provided to all licensed nurses regarding expectation for securing the medication cart when unattended. 1:1 education given to the specific nurse that left the medication cart open and unattended. 4. Audit medication carts 5 days a week x2 weeks, 3 days a week x4 weeks, and then weekly x4 weeks. The DON and/or designee will present audit results in QAPI each month for review and any recommendations.	