STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056001	A. BUILDING: _____ B. WING _____	R-C 02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW MANOR CARE CENTER	150 CRISP STREET FRANKLIN, NC 28734

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Macon County Department of Social Services conducted a follow up survey and complaint investigation on 02/27/24 - 02/28/24.	D 000		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: FOLLOW UP TO TYPE A1 VIOLATION The Type A1 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on interviews and record reviews, the facility failed to treat all residents with dignity and respect and to ensure 1 of 5 sampled residents was free of physical and mental abuse (Resident #5) related to a personal care aide (PCA) who residents said would yell at them and handled them roughly during bathing and who caused 1 of 5 sampled residents (Resident #5) to feel embarrassed when she yelled at her in front of other residents in the dining room during the lunch meal service. The findings are: Review of Resident #5's current FL2 dated 03/23/23 revealed: -Diagnoses included anxiety and polydipsia	D 338		

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D 338	Continued From page 1 (excessive thirst). -She was documented as incontinent of urine. Interview with Resident #5 on 02/27/24 at 10:43am revealed: -On 02/25/24 she needed to change her soiled brief when she returned from church. -Since she arrived just in time to go to the dining room for lunch, and she did not want to be late, she went to her bedroom, changed her dress, and removed the soiled brief but was unable to get a new brief on quickly so she went to the dining room without a brief on under her dress. -A named personal care aide (PCA) approached her and felt the back of her dress, grabbed her bottom and told her loudly that she did not have any underwear on and needed to go back to her room and change clothes. -The named PCA led her by the hair and the back of her dress out of the dining room to her bedroom, helped her change clothes and put on a brief and then led her back to the dining room the same way. -She was embarrassed because the named PCA spoke to her inappropriately, rudely and too loudly in front of everyone in the dining room. -Two residents came to her after lunch and asked her if she was okay and said she must have been embarrassed by the way she was treated. -The named PCA treats "us like the scum of the earth when we have accidents". -The named PCA was rough in general and especially when she helped her with showers. -The named PCA scrubbed too hard, and it hurt her skin, and she had to tell her "enough". -She tried to "slip around" so the named PCA did not see her and when she used her call bell she would "pray someone else comes to help". -She reported the rough handling to other staff but never to the Administrator.	D 338		

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-She reported the incident in the dining room to the medication aide (MA) that was working on 02/25/24 and she said she would take care of it and notify the appropriate staff.

Interview with the MA supervisor on 02/27/24 at 11:30am revealed:
-She heard from staff that residents complained that the named PCA yelled at them routinely.
-Residents never reported to her that they were yelled at.
-She knew that residents reported the named PCA to the Administrator.

Interview with the PCA supervisor on 02/27/24 at 1:40pm revealed:
-No one reported to her about the incident that happened in the dining room on 02/25/24 with Resident #5.
-The other PCA that was in the dining room should have reported it to her and was just as guilty if he did not report it.
-The named PCA that Resident #5 said embarrassed her was known to talk loudly and could be intimidating.

Interview with the named PCA on 02/27/24 at 2:26pm revealed:
-She was working on 02/25/24 when Resident #5 entered the dining room.
-She went up to Resident #5 because she noticed her hair was stuck in her dress and she was helping her pull it out when she noticed she did not have on any underwear because her dress was short.
-She "touched" the back of her bottom to confirm that she was not wearing underwear and then "whispered" to her that she needed to go back to her room and put on underwear.
-She helped Resident #5 to her room, helped her

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put on underwear and then she and Resident #5 returned to the dining room.

Interview with another PCA on 02/27/24 at 2:34pm revealed:
-The named PCA that Resident #5 said embarrassed her was known to be loud, mean and insulting to the residents.
-The named PCA had a reputation of being rough with residents while helping with showers.
-She reported it to the Administrator when she first started 3 years earlier, because she was "freaked out when I heard residents screaming in the shower".

Interview with a resident on 02/27/24 at 2:00pm revealed:
-He heard the named PCA yelling at other residents.
-The named PCA was rough with him when assisting him with showers.

Interview with a second resident on 02/27/24 at 2:03pm revealed:
-The named PCA yelled at him in the past and he heard her yell at other residents.
-He was in the dining room during lunch on 02/25/24 and heard the named PCA yell at Resident #5 for not wearing any underwear.

Interview with a third resident on 02/27/24 at 3:00pm revealed:
-She was in the dining room during lunch on 02/25/24, half way across the dining room from where Resident #5 was sitting.
-She heard the named PCA tell Resident #5, loudly and rudely, that she was not wearing any underwear and to go put on underwear, pants, and a shirt.
-The named PCA told Resident #5 she could not

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wear a dress anymore.
-The named PCA was rough when assisting her with showers because she "scrubbed too hard".

Interview with a fourth resident on 02/27/24 at 3:30pm revealed:
-He was in the dining room during lunch on 02/25/24 when he heard the named PCA yell at Resident #5 for not having on any underwear.
-The named PCA told Resident #5 to go put on underwear.
-The dining room was full of residents eating lunch.
-The named PCA yelled at him and other residents in the past to "go do stuff".
-The named PCA had an attitude like she was always mad.
-He reported the named PCA to the Administrator on 02/23/24 for being rude and loud.

Interview with a MA on 02/27/24 at 3:07pm revealed:
-She worked on 02/25/24 during lunch.
-The named PCA and a second PCA were in the dining room during lunch.
-She did not receive any reports from staff that the named PCA yelled at Resident #5 during lunch.
-Resident #5 told her on 02/25/24 that the named PCA yelled at her during lunch, but she did not report it to management.
-She heard other staff talking in the halls that the named PCA was rough with residents but she did not like to get involved in the "gossip and drama".

Interview with the Administrator on 02/27/24 at 3:38pm revealed:
-She was not aware of the dining room incident until "a few minutes ago" when Resident #5 came and gave her extensive details about it.

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D 338	Continued From page 5 -The named PCA Resident #5 was referring to was known to be very loud, but she did not mistreat residents. -Staff and residents reported that she yelled at them. -She was going to terminate the named PCA in the past but decided against it. Attempted telephone interview with the second PCA in the dining room on 02/27/24 at 1:32pm was unsuccessful. _____ The facility failed to ensure residents were free from mental and physical abuse when a named personal care aide (PCA), whom the Administrator knew had a history of yelling at the residents and who had a reputation among residents and staff for handling residents roughly while providing assistance with showers, yelled at Resident #5 in the dining room during the lunch meal service, which resulted in the resident feeling embarrassed. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/27/24 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 13, 2024.	D 338		