Retaliation for Advocating

The nursing home failed to protect a resident's right to be free from mistreatment after notifying the Ombudsman of not getting showers. The nursing home also failed to: a. immediately report the allegation of abuse to the Administrator; b. report the allegation of abuse to the state survey agency within two hours of the Director of Nursing (DON) being notified; and c. failed to conduct a thorough investigation.

The resident was "cognitively aware" (based on MDS assessment) and required total dependence with two staff physical assistance with bed mobility, transfers, and bathing.

The Assistant DON arranged with the Ombudsman to make sure the resident received a weekly shower on Mondays, but with only one aide available that Monday, the resident would receive a shower on Tuesday.

During an interview, the resident reported on a Tuesday at 1:30 PM three aides came into her bedroom yelling and were mad because it was near the end of their shift, and they had to give her a shower. One of them reportedly stated, "We have to give you a shower because you went and called the Ombudsman!"

The resident added that the aides transferred her from her bed to the shower bed with a mechanical lift in a rushed and rough manner. The resident asked them to get her body wash, shampoo, and cream rinse but was told, "You won't need that!" When she requested the cream rinse, she was told, "You're getting a shower, that's all you're entitled to. Be grateful." During the shower, the resident told them that the water temperature was scalding, and was told, "You're getting a shower. Be quiet." One of the aides turned the water temperature down. The resident felt the nurse aides were being mean to her because she had called the Ombudsman about not getting showers and they were retaliating against her.

The resident added that after the shower, she was placed in the dining room to eat lunch and was left in the shower chair with wet hair. The resident usually eats in her bedroom. She stated she felt the aides brought her to the dining room instead of back to her room because they were punishing her for calling the Ombudsman. Eventually, around 3:00 PM the Wound Treatment Nurse (WTN) came and put her to bed. The resident stated that she had a horrible day, and she was very upset about the aides' behavior. The WTN stated the resident, who was genuinely upset when she saw her, told her she asked to be taken back to her bedroom on several occasions, but no one answered her. She requested her glasses so she could see what she was eating but was told "Shut up." Eventually, an aide brought her glasses.

The three aides denied the resident's complaints. The Administrator and the DON did not feel the resident was abused. The Administrator shared that the Ombudsman told her there should be criminal charges against the nursing home for what had happened to the resident.

Name of Nursing Home	Brunswick Cove Nursing Center / Provider ID: 345318
Address	1478 River Road, Winnabow, North Carolina
Date investigation completed	May 12, 2021
Type of deficiency issued	*F600 – Free from Abuse and Neglect **F607 – Develop/Implement Abuse/Neglect, etc. Policies
Severity level	*Actual Harm **Minimal harm or potential for actual harm
Overall Quality Star Rating: 3; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/345318/health/complaint?date=2021-05-12