STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345292	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grantsbrook Nursing and Rehabilitation Center	290 Keel Road Grantsboro, NC 28529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to provide personal privacy during activities of daily living (ADL) care when Geriatric Care Aide (GCA) #1 video recorded Resident #81 with her cellphone while in the room during care without resident representative consent. This deficient practice affected 1 of 1 resident reviewed for privacy (Resident # 81).The findings included: Resident #81 was originally admitted on [DATE] and readmitted to the facility on [DATE]. Resident #81 expired at the facility on [DATE]. Her diagnoses included diffuse traumatic brain injury without loss of consciousness (a widespread disruption of brain function often caused by the brain shifting inside the skull during an impact, that results in neurological symptoms but does not cause a blackout), and vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain) with mood disturbance (the brain damage also impacts the areas controlling emotions, resulting in symptoms like depression, severe mood swings, apathy, or sudden crying/laughing).The admission Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #81 was cognitively impaired. Resident #81 demonstrated physical and verbal behavioral symptoms directed toward others, as well as rejected care. Resident #81 was dependent on others for activities of daily living (ADLs).Review of the facility's investigative summary report dated [DATE] indicated staff reported Resident #81 was resistant to care and combative at times. On [DATE] NA #1 asked GCA #1 to witness care with Resident #81due to known behaviors. GCA #1 entered Resident #81's room and sat in a chair located behind NA #1 providing care. NA #1 provided ADL care with no concerns identified by GCA #1. Following the care, GCA #1 began video recording while NA #1 was dressing Resident #81 into a gown.The facility's revised Electronic Device Policy dated [DATE] was reviewed. The policy stated, in part, the use of personal electronic communications devices, including but not limited to, cell phones, smart phones, camera phones, texting devices, PDAs (Personal Digital Assistant: a small, handheld electronic device used as a personal organizer to store contacts, manage calendars, and take notes), and the like are prohibited during the interaction with and/or during the delivery of resident care services in non-designated areas of the company. The audio and/or video recording of any individual (employee, resident, visitor, vendor) is strictly prohibited unless approved by management. This applies to the entire company, working and non-working areas. Violation of this prohibition will result in the employee's termination.An interview with Nurse Aide (NA) #1 was conducted on [DATE] at 1:03 PM. She stated on [DATE] she needed to provide care to Resident #81 which included changing her clothes and incontinence care. NA #1 stated she was told by other staff members that Resident #81 was stiff and hard to move at times and she might need assistance to help hold her over. NA #1 stated because she hadn't worked with Resident #81 before, she asked another staff member to come into Resident #81's room with her. NA #1 stated she recalled GCA #1 was in training to be a NA. NA#1 stated GCA #1 sat in the chair in Resident #81's room in case additional assistance was needed to provide care for Resident #81. She stated Resident #81 was moving her arms around and it was initially difficult getting her gown on. NA #1 denied being rough with Resident #81 or forcing her in any way while dressing. NA #1 stated she did not know that GCA #1 video taped her performing care, nor (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did GCA #1 inform NA #1 that she video recorded. NA #1 further stated she did not ask GCA #1 to record care for Resident #81 and was unsure why she did it. NA #1 stated that prior to this incident, she knew video recording and/or taking pictures was not allowed and if she saw GCA #1 video recording, she would have told her it wasn't allowed and report it immediately. NA #1 stated she was suspended pending an investigation and when she returned to work, the entire facility received in-services on cell phone use and resident abuse.An attempt to reach GCA #1 was made, however she was no longer employed at the facility and the contact number available no longer belonged to her (wrong number) and the facility did not have an alternate contact number for her.Review of GCA #1's written statement dated [DATE] indicated she had been asked by NA #1 to witness care for Resident #81. She indicated she entered the room around 1:30 PM and sat on the chair across the room behind NA #1 to watch. GCA #1's statement indicated NA #1 was standing to Resident #81's right side and the resident's head, right arm, and lower legs; she recorded the care provided. During GCA #1's statement she indicated she recorded the care provided stating How can I be a witness if I didn't have proof? I thought that is what (NA #1) wanted me to do so I would have actual proof that she gave care. GCA #1's written statement further indicated she had not assisted NA #1 in providing care, she did not tell NA #1 she recorded the care, and she deleted the video as she awaited the arrival of management because she thought she was in trouble.An interview was conducted with the Director of Nursing (DON) on [DATE] at 2:10 PM. The DON stated she received a call on [DATE] from the facility Scheduler who initially informed her a staff member was being rough with a resident. Since the DON was not immediately available to complete the call, she instructed the Scheduler to pull both staff members off the floor and await a call back. The DON stated she called the facility back within a few minutes and was told a staff member had video recorded care being provided for a resident. When the DON inquired why the care was recorded, the accused employee (GCA #1) stated another staff member asked her to witness the care she provided. The DON insisted on seeing the video and Facetimed with the Scheduler and GCA #1 to show her the video. The video was played back during Facetime and not sent to any other device for review. The DON stated the video was of poor quality, but she saw an NA's back and the right side of Resident #81's face and right arm. The DON stated there was nothing in the content of the video that was concerning; the concern she had was that there was a video recording of Resident #81 during care. The DON stated she notified the Administrator and called in administrative on call nurses to help with corrective actions that were needed to be implemented for the incident. The DON stated when she arrived at the facility she spoke to GCA #1 who stated she deleted video. The DON and Scheduler obtained verbal permission from GCA #1 to look at her cell phone and confirmed the video was deleted and was not found in any file of her cell phone. When asked again why GCA #1 video recorded in the first place, she indicated she believed she needed proof of something that was witnessed. GCA #1 further informed the DON that NA #1 did not ask her to video record and she did not inform NA #1 she was recording. GCA #1 told the DON that NA #1 could have been gentler and kinder when she was putting on Resident #81's gown.The DON stated after she talked to GCA #1, she then interviewed NA #1, who informed her she asked GCA #1 to witness care since Resident #81 had been not allowing people into her room at times and had been demonstrating physical and verbal behaviors towards others. NA #1 informed the DON that she had not asked GCA #1 to record and she didn't know she was recording her during care. The DON had NA #1 perform a return demonstration with witnesses present, as to how Resident #81 was moving her arm while putting on her gown; no concerns were noted.The DON stated she then interviewed GCA #1 who also performed a return demonstration of how she thought NA #1 was not gentle; she stated she thought NA #1 was rough pulling the gown over her elbow; however, she denied NA #1 used force while performing care, again stated NA #1 could have been gentler and kinder when she was putting on Resident #81's gown. The DON stated both NA #1 and GCA #1 were suspended as the facility conducted their investigation. The facility did not find any concerns regarding abuse during their investigation, however the DON stated video recording or picture taking of any residents was not (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allowed within the facility and GCA #1 was terminated. The DON stated that all employees upon hire review and acknowledge facility policies which included the prohibition of video recording within the facility.An interview was conducted on [DATE] at 9:40 AM with the Scheduler. She stated she was working as a Medication Aide on [DATE] and was the only administrative staff in the building that day. The Scheduler stated a nurse brought GCA #1 to her and told her there was an issue. GCA #1 began to tell the Scheduler she was asked to assist with Resident #81 and stated while I was recording; and the Scheduler asked her why she was recording. GCA #1 informed the Scheduler that she thought that's what she was supposed to do as a witness. The Schedular stated she told GCA #1 that recording was not allowed and explained she was asked to be a witness because there had been allegations made by Resident #81 against staff. The Scheduler stated she immediately called the DON, Facetimed her showing her the video. The Scheduler stated while reviewing the video recording, she could see there was no evidence of abuse or NA #1 being rough with Resident #81, and in fact NA #1 did a lot of talking and coaching with Resident #81. The Scheduler indicated that GCA #1 didn't say anything about NA #1 being rough with Resident #81 but stated that was how she approached the nurse and the nurse immediately brought GCA #1 to her. That day the facility began re-inservicing on video recording.GCA #1 was employed at the facility beginning on [DATE]. Review of orientation records indicated she received training regarding protecting patient privacy and Health Insurance Portability and Accountability Act (HIPPA: a federal law designed to protect sensitive patient health information from being disclosed without the patient's consent or knowledge, and it provides individuals with control over their own medical records).On [DATE] at 12:07 PM an interview was conducted with Nurse #1 who stated on [DATE] GCA #1 came to her and said she may have witnessed a possible resident abuse situation and videoed it. Nurse #1 stated she didn't want to see the video and took GCA #1 to the administrative staff member working that day. Nurse #1 stated she then got NA #1 and put her in the break room, thereby separating the staff from the resident and from each other. The DON was notified. Nurse #1 further stated it was prohibited to take pictures or videos of residents without consent, and it would be a HIIPPA violation.An Administrator interview was conducted on [DATE] at 1:34 PM. Resident #81 was more challenging with care and NA #1 asked GCA #1 to be her witness while providing care. GCA #1 was behind her and proceeded to record the care on her phone because she believed she needed proof, and that was her way of witnessing something. Once administration staff were notified of the incident both staff members were suspended pending the investigation. Upon completion of the investigation, GCA #1 was terminated. The Administrator further stated the facility had a very clear policy which prohibited use of video or picture taking in any care area, and it was his expectation that all staff followed that policy.