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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit on 08/13/20 and 08/19/20 and a desk review survey on 08/13/20 - 08/14/20, 08/17/20 - 08/21/20, and 08/24/20 and a telephone exit on 08/24/20.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews the facility failed to ensure referral and follow up to meet the healthcare needs of 2 of 4 sampled residents (#3 and #4) by failing to notify the residents' primary care provider (PCP) of reported sexual abuse by a staff member (#3 and 4) and changes in behaviors after reported sexual abuse (#3). The findings are: 1. Review of Resident #3's FL-2 dated 08/17/20 revealed: -Diagnoses included dementia with behavior disturbances, latent syphilis (no clinical signs of syphilis but may be sexually transmitted), and alcohol abuse. -The resident was constantly disoriented, ambulatory, and continent of bowel and bladder. -The resident's current level of care was "locked unit."	D 273		

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D 273	Continued From page 1 Review of Resident #3's care plan dated 12/16/19 revealed: -The resident was not receiving mental health services. -The resident had a history of wandering and wandered throughout the facility. -The resident was mostly cooperative but was aggressive at times; redirecting was effective. -The resident ambulated with no problems. -The resident's bowel and bladder functions were normal. -The resident was always disoriented and had significant memory loss and must be directed. Confidential staff interview on 08/17/20 at 4:11pm revealed: -On July 18th or 19th, 2020 the staff was working first shift and a resident (roommate of Resident #3) had taken some of his personal items to the nurse's station. -The staff took the resident's items back to his room, at the end of the hall. -When the staff opened the resident's bedroom door, the staff observed Staff B in the room. -Resident #3 was awake and lying on his back in his bed with his covers partially pulled off exposing his "private parts", including his penis. -Staff B was on his knees next to the resident's bed, with his head over the resident's exposed body. -Staff B's head was close to the resident's exposed penis. -The staff was "shocked" and immediately asked Staff B "what are you doing". -Staff B jumped up and he appeared "scared" and trembling. He did not say anything but left the room. -The staff observed that Staff B did not have on any gloves.	D 273		

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-Resident #3's bed was next to the door and Staff B was on the side of the bed next to the door.
-When the staff returned to the nurse's station, Staff B stated he was helping Resident #3 "clean up".
-The staff reported the incident to the medication aide (MA) because what she had observed did not look right.
-The MA reported the incident to the facility's Registered Nurse who was also the area Health and Wellness Director.
-The area Health and Wellness Director (HWD) asked questions about the incident (July 18th or 19th) and the staff repeated what she observed.
-She did not know if the incident was reported to the resident's Primary Care Provider (PCP).

Telephone interview with a former staff on 08/19/20 at 4:33pm revealed:
-The staff worked at the facility from 2019 until June 2020.
-Staff B had been caught by another staff in Resident #3's room in an "inappropriate sexual situation" last month (July 2020).
-The resident began to have behavior changes after that incident.
-The resident became irritable and was restless.
-The resident wanted to leave the facility; he would shake the exit doors while attempting to get out.
-The former staff did not know if the incident was reported to the resident's PCP.
-She did not know who was responsible for reporting resident changes to the PCP.

Review of Resident #3's progress notes revealed on 08/03/20 at 2:32pm, Resident #3 was administered a" prn", he was very agitated and was trying to break down the doors to get out.

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Review of a "Physician Order Sheet" dated 04/17/20 revealed an order for Clonazepam 0.5mg, one tablet twice a day as needed for anxiety (originally order on 07/25/17).

Review of Resident #3's medication administration records revealed on 08/03/20 at 12:08pm, Clonazepam 0.5mg (used to treat panic disorders and anxiety) was documented as administered for anxiety; with no relief, the resident was still trying to get out.

Telephone interview with the Assistant Executive Director (AED) on 08/20/20 at 3:20pm revealed:
-To her knowledge, the report of sexual abuse involving Resident #3 had not been reported to the resident's PCP.
-She could not say why Resident #3's PCP was not contacted regarding the allegation of sexual abuse by Staff B.
-She was aware that Resident #3 was diagnosed with latent Syphilis which was a sexually transmitted disease.
-She was aware the STD could be spread through any sexual contact.
-She became aware of the sexual abuse allegations on 07/21/20 when the Adult Home Specialist informed her, but she did not know the name of the resident.

Telephone interview with the current area HWD on 08/18/20 at 12:18pm revealed staff had not reported Resident #3's alleged sexual abuse by Staff B.

Telephone interview with the Administrator/Executive Director (ED) on 08/20/20 at 3:45pm revealed:
-He had first attempted to contact Resident #3's PCP this week to report the sexual abuse,

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however, a voice mail was received, he did not leave a message and did not attempt to contact the resident's PCP again because he had been busy doing staff inservices and completing a Health Care Personal Registry (HCPR) report.
-The facility's process would have been for the HWD or for him to have contacted the resident's PCP.
-He thought he should have made "every effort" to contact the resident's PCP.

Telephone interview with the local health department's Director of Nursing on 08/21/20 at 2:45pm revealed:
-Resident #3 was diagnosed with syphilis in 1990 and received treatment.
-The resident's last treatment for syphilis was in 2017 and was changed to latent syphilis one year after the treatment.
-She did not know if the resident had any open sores currently because he had not been seen at the health department since 2017.
-The facility should have informed Resident #3's PCP of the alleged sexual abuse and the PCP would have ordered a syphilis titer and perform an examination for sores to determine if the disease was active or latent.

Telephone interview with Resident #3's PCP on 08/21/20 at 3:05pm revealed:
-Because Resident #3 had a diagnosis of dementia which had advanced, he was not able to make any decisions, including consent for sexual activity.
-If there were any sexual activity involving Resident #3, there was a possibility of the spread of an STD because the resident had a history of latent syphilis.
-The facility contacted the PCP on 08/20/20 and reported Resident #3 was sexually abused by a

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staff member who intentionally hid it.
-The PCP had not received notification from the facility of allegations of sexual abuse involving Resident #3 by a staff before 08/20/20.
-The PCP planned to check the resident on Monday (8/24/20) and order testing for other STDs and a series of testing related to the latent syphilis.
-Involuntary participation in sexual activity would cause the resident emotional distress and behavior changes whether he had dementia or not.
-The facility had not reported any changes in the resident's behaviors.
-The PCP expected the facility to report sexual abuse or suspected sexual abuse and change in behaviors.

Refer to the telephone interview with the AED on 08/14/20 at 2:25pm.

Refer to the telephone interview with the current area HWD on 08/18/20 at 12:18pm

Refer to the review of the facility's policy and procedure for Abuse dated 06/01/16.

Refer to review of Staff B's resignation letter signed 07/20/20.

Refer to the telephone interview with the Administrator/ED on 08/18/20 at 8:59am.

2. Review of Resident #4's current FL-2 dated 02/03/20 revealed:
-Diagnoses included dementia, dyspnea on exertion, hypertension, diabetes type 2 and dyslipidemia.
-The resident was constantly disoriented and wandered.

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-The resident was ambulatory.
-The resident's recommended level of care was a special care unit (SCU).

Review of Resident #4's care plan dated 01/27/20 revealed:
-The resident was receiving hospice services, wandered throughout the facility and became aggressive at times, could be both physically and verbally abusive and redirection was effective.
-The resident was always disoriented and had significant memory loss requiring direction.
-The resident required extensive staff assistance with grooming, bathing, dressing and toileting.
-The resident required limited staff assistance with eating.
-The resident required staff supervision with transfers and ambulation.

Review of Resident #4's electronic progress notes dated 04/27/20 at 9:19am revealed the resident had expired.

Confidential interview with a former staff revealed:
-Staff B had been caught by another staff in Resident #4's in Resident #4's room in an "inappropriate sexual situation" estimating the time frame of the incident was around February 2020.
-The staff was told the incident was reported to "management" but was not sure if Resident #4's Primary Care Provider (PCP) was notified of the incident.

Confidential staff interview revealed:
-The incident occurred on 1st shift, during the weekend, prior to the "pandemic", around the first part of the year (2020).
-The previous Health Wellness Director (HWD)

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was at the facility to monitor during the weekend the incident occurred.
-The staff was doing "rounds" with the resident and did not know where another staff, Staff B was.
-The staff observed Staff B with Resident #4 with the door closed in the resident's room.
-The windows and blind in the room were in an opened position.
-Staff B and Resident #4 were in a standing position in the room.
-Resident #4 did not have any clothes covering the bottom portion of his body.
-Staff B did not have any gloves on and was "fooling around" with Resident #4's "private area".
-Staff B had his left hand on Resident #4's right shoulder and Staff B's right hand was underneath the resident's testicles.
-Staff B was moving his fingers, massaging Resident #4 behind and around his "private area".
-There were no incontinent wipes in Staff B's hands.
-The staff could remember the incident "just like it was yesterday".
-Staff B immediately ran to the resident's room door attempting to push the door back to a closed position and stated, "I got it" and he did not need any help.
-The staff thought Staff B would have pushed "me" out with the door if it was not for hand placement on the door and strength.
-Resident #4 was not asked what was going on because the resident would not have been able to recall or tell anyone what had happened, and the staff did not want to upset the resident.
-The incident was reported immediately to a medication aide (MA), (could not recall the MA's name) at the time of the incident.
-The incident was then reported on the same day of the incident to the previous HWD.

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D 273	Continued From page 8 -The previous HWD told the staff that she would look into the incident. Confidential interview with a former staff revealed: -Staff B had been caught by another staff in Resident #4's room in an "inappropriate sexual situation" estimating the time frame of the incident was around February 2020. -The staff was told the incident was reported to "management" but, was not sure if Resident #4's Primary Care Provider (PCP) was notified of the incident. Telephone interview with the Administrator/Executive Director (ED) on 08/18/20 at 8:59am revealed he was not aware of any allegations of sexual abuse for Resident #4 by Staff B occurring the first part of the year (2020). Attempted telephone interview with the previous HWD on 08/20/20 at 9:23am was unsuccessful. Telephone interview with the Administrator/ED on 08/20/20 at 3:45pm revealed: -He had attempted to contact Resident #4's PCP this week, however, a voice mail was received, he did not leave a message and did not attempt to contact the resident's PCP again because he had been busy doing staff inservices and completing a Health Care Personal Registry (HCPR) report. -The facility's process would have been for the HWD or for him to have contacted the resident's PCP. -He thought he should have made "every effort" to contact the resident's PCP. Telephone interview with Resident #4's PCP on	D 273		

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D 273	Continued From page 9 08/21/20 at 3:20pm revealed: -Resident #4 would not be able to give sexual consent because of his dementia. -He had not received notification from the facility of allegations of sexual abuse for Resident #4 by a staff prior to 08/20/20. -There were no reports of sexual abuse involving Resident #4 before 08/20/20. -The residents at the facility were not being checked for sexually transmitted diseases (STD's). -In January 2020, Resident #4 was seen for increased aggression and combative behavior and it was possible it was in a response to being threatened and feeling vulnerable. -He could not conclude Resident #4's increases in behavior was related to the alleged inappropriate sexual incident, however, he would not have been surprised the resident's agitation was related to the alleged abuse. Refer to the telephone interview with the Assistant Executive Director (AED) on 08/14/20 at 2:25pm. Refer to the telephone interview with the current area HWD on 08/18/20 at 12:18pm Refer to the review of the facility's policy and procedure for Abuse dated 06/01/16. Refer to review of Staff B's resignation letter signed 07/20/20. Refer to the telephone interview with the Administrator/ED on 08/18/20 at 8:59am. Refer to Tag D 338 10A NCAC 13F .0909 Resident Rights _____ Telephone interview with the Assistant Executive	D 273		

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Director (AED) on 08/14/20 at 2:25pm revealed:
-Staff B no longer worked at the facility.
-Staff B resigned due to personal family issues approximately one month ago.

Telephone interview with the current area Health and Wellness Director (HWD) on 08/18/20 at 12:18pm revealed:
-She was not aware of any reports of sexual abuse of any residents.
-Staff had not reported any type of alleged resident sexual abuse by Staff B.

Review of the facility's policy and procedure for Abuse dated 06/01/16 revealed:
-The residents would be protected from abuse including verbal, sexual, physical, and mental abuse in accordance with the law.
-When reporting incidents of abuse or suspected abuse, the following must be notified of the incident: The Executive Director (ED), and he/she must notify the physician, power of attorney, corporate representative and another named state when appropriate within 24 hours.

Review of Staff B's resignation letter signed 07/20/20 revealed effective 07/20/20, Staff B was resigning his position as a personal care aide (PCA) due to family reasons.

Telephone interview with the Administrator/Executive Director (ED) on 08/18/20 at 8:59am revealed:
-He was not sure if the facility's policy covered notifying the PCP for alleged sexual abuse of a resident, however, the residents' PCP would need to be notified because the PCP was over the resident's care.
-On 07/21/20, the AED reported to him the AHS had received a complaint of possible sexual

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D 273	Continued From page 11 abuse of a resident on 07/21/20 and no names were provided. -On 08/13/20, the AED reported to him the AHS had contacted the AED by telephone on 08/13/20 and reported another complaint had been received involving the same type of sexual abuse of a resident. The facility's failure to notify the PCP of alleged sexual abuse of 2 of 4 sampled residents (#3 and #4) by Staff B after reported to the management staff resulted in Resident #3 displaying emotional distress (increased anxiety) and behavioral changes (attempting to leave the facility) a few days after reported sexual abuse as identified by the resident's PCP as an expected behavioral if involuntary participant in sexual activity. The facility's failure resulted in increased risk for serious physical and mental harm and neglect of the residents and constitutes a Type A2 violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/21/20 with addendum. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 23, 2020.	D 273		
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: TYPE A1 VIOLATION	D 338		

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Based on interviews, observations, and record reviews, the facility failed to ensure 2 of 2 sampled residents were free from sexual abuse by a former staff member (Staff B) who allegedly sexually abused two residents diagnosed with dementia in a special care unit (#3, #4); and were free of neglect by not following the recommendations and guidance issued by the Centers for Disease Control (CDC), North Carolina Division of Health and Human Services (NC DHHS) related to communal dining, reminding and assisting residents in a special care unit to social distance and wear facial coverings during the global pandemic of COVID-19.

The findings are:

1. Review of the facility's policy and procedure for Abuse dated 06/01/16 revealed:
-The residents would be protected from abuse including verbal, sexual, physical, and mental abuse in accordance with the law.
-Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.
-Sexual abuse was defined but not limited to sexual harassment, sexual coercion and sexual assault.
-The facility required all personnel to immediately report incidents of resident abuse or suspected abuse, resident neglect or misappropriation of resident property by filling out an incident report and submitting it to the nurse coordinator.
-When reporting incidents of abuse or suspected abuse, the following must be notified of the incident: The Executive Director (ED), and he/she must notify the physician, power of attorney,

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corporate representative and another named state when appropriate within 24 hours.
-A thorough investigation would be performed.
-Any staff involved in the allegation process would be immediately suspended without pay from work until the investigation process was completed and a decision was made.
-Authorities on the matter may be called in to help with such investigations.
-Any employee found to have abused or neglected a resident or misappropriated a residents' funds or property would be terminated with no eligibility for rehire.
-This finding would also be reported to all appropriate agencies in accordance with the law, including, as necessary the Department of Health and any appropriate licensing agency.
-This information would also be related to any care provider seeking references in the future.
-The "Department of Health Abuse Registry" should be notified anytime the ED "concludes" or "suspects" (even if such suspicion was never conclusively proven or substantiated) that a resident had been physically harmed as a result of an employee's abuse or neglect.

Telephone interview with the Adult Home Specialist (AHS) with the local department of social services on 08/13/20 at 4:34pm revealed:
-On 07/21/20, she made a visit to the facility and met with the Assistant Executive Director (AED).
-The AHS asked the AED on 07/21/20, if she had received any reports or concerns of a staff and a resident related to resident abuse, being "sexually inappropriate" or any issues of that nature.
-The AED denied any knowledge or of being notified of any incidences or allegations of sexual abuse.
-The AED did not provide her with any follow-up information of how or what she would do after

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being told about the allegation of sexual abuse.
-The next contact she had with the AED was by telephone on 08/13/20 to inform her of another complaint she had received.
-She asked the AED if the facility had a named resident (only the first name was provided in a complaint allegation received by the county on 08/12/20).
-The AED told her there had not been a resident residing at the facility, past nor present since the AED had worked at the facility with that first name.
-She asked the AED if she had received any allegations of Staff B being sexually inappropriate with residents.
-The AED denied any knowledge or of being notified of any incident, allegations or reports.
-The AHS was told Staff B was no longer with the facility and had resigned due to personal reasons on 07/20/20.

Telephone interview with a medication aide (MA) on 08/13/20 at 4:08pm revealed:
-Staff were responsible to report any allegations of resident abuse to the Lead MA or the AED.
-Staff receiving any allegations of resident abuse should complete an Incident/Accident report.

Telephone interview with the AED on 08/14/20 at 2:25pm revealed:
-She had not been notified of any sexual abuse allegations involving any residents from staff.
-The AHS made a visit to the facility on 07/21/20 and on that date, the AHS told her there had been a complaint made regarding sexual abuse allegations.
-The AHS questioned her if a staff had sex with a resident.
-She informed the AHS that she had not received any reports; she had been out of the facility since

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07/15/20 and had just returned from vacation.
-She immediately contacted the Administrator/Executive Director (ED) on 07/21/20 and provided him with the information given to her by the AHS involving the sexual abuse allegation with a staff and a resident.
-The Administrator/ED did not provide her with any directives concerning the sexual abuse allegation with a staff and a resident.
-She had spoken to the AHS yesterday morning (08/13/20) and was told another complaint had been received which was "basically the same thing" in resident rights (sexual abuse allegations).
-The AHS questioned her if she had a resident named (first name given).
-She informed the AHS she had never had a resident with that first name.
-The AHS questioned her if she had any male staff employed at the facility and she told the AHS she had one male staff.
-The AHS asked her if she had a staff member (first name given which was same first name as Staff B).
-She informed the AHS that Staff B no longer worked at the facility and informed her that Staff B had resigned due to family reasons after the AHS asked her why Staff B no longer worked at the facility.
-She notified the Administrator/ED yesterday (08/13/20) and provided him with the information given to her by the AHS.
-She had only spoken with staff working yesterday (08/13/20) and had questioned those staff if there had been any reports of resident abuse.

Interview with Lead Medication Aide on 08/13/20 at 10:57am revealed:
-She was not aware of any issues with abuse or

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neglect of the residents.
-She would report any issues or concerns of abuse or neglect to the area Health and Wellness Director (HWD), AED or the Administrator/ED.

Telephone interview with the area HWD on 08/18/20 at 12:18pm revealed:
-She had worked for the facility for one year as the area HWD.
-She was at the facility as needed but was there least 2-3 times per week.
-She and the Lead MA were the point of contact for staff related to resident care.
-She had not received any reports of any types of resident abuse from staff in July 2020 from anyone.
-She had never received any reports of any types of abuse related to Staff B from family, staff or anyone when he was employed at the facility.

Telephone interview with the Administrator/ED on 08/18/20 at 8:59am revealed:
-He expected to be notified of any resident right issues whether he was in the building or not.
-When there were issues with resident rights physical or sexual, the named staff would be removed from the community while the incident was being investigated.
-He expected staff to immediately report any resident right abuse issues to the supervisor (Supervisor/MA), who would report to the department head (HWD), then the department head (HWD) would report it to the AED and to him and an investigation initiated.
-On 07/21/20, the AED reported to him the AHS had received a complaint of possible sexual abuse of a resident on 07/21/20 and no names were provided.
-On 08/13/20, the AED reported to him the AHS had contacted the AED by telephone on 08/13/20

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and reported another complaint had been received involving the same possible sexual abuse of a resident.

a. Review of Resident #3's current FL-2 dated 08/17/20 revealed:
-Diagnoses included dementia with behavior disturbances, latent syphilis, and alcohol abuse.
-The resident was constantly disoriented, ambulatory, and continent of bowel and bladder.
-The resident's current level of care was "locked unit".

Review of Resident #3's care plan dated 12/16/19 revealed:
-The resident ambulated with no problems.
-The resident's bowel and bladder functions were normal.
-The resident was always disoriented and had significant memory loss and must be directed.

Confidential staff interview on 08/17/20 at 4:11pm revealed:
-On July 18th or 19th, 2020 the staff was working first shift and took a resident's items back to his room, at the end of the hall.
-When the staff opened the resident's bedroom door, the staff observed Staff B in the room.
-Resident #3 was awake and lying on his back in his bed with his covers partially pulled off exposing his "private parts", including his penis.
-Staff B was on his knees next to the resident's bed, with his head over the resident's exposed body.
-Staff B's head was close to the resident's exposed penis.
-The staff was "shocked" and immediately asked Staff B "what are you doing".
-Staff B jumped up and he appeared "scared" and trembling. He did not say anything but left the

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room.
-The staff observed that Staff B did not have on any gloves.
-Resident #3's bed was next to the door and Staff B was on the side of the bed next to the door.
-When the staff returned to the nurse's station, Staff B stated he was helping Resident #3 "clean up.
-Resident #3 was continent of bladder and bowels and had never required staff to assist with incontinent care. He used the bathroom independently and bathed independently and only required prompting to remind him to shower/bathe.
-The staff did not smell urine or feces when she entered Resident #3's room.
-The staff reported the incident to the medication aide (MA) because what she had observed did not look right.
-She had worked with Staff B and she had never observed him or any other staff providing resident care in that position.
-The MA reported the incident to the facility's registered nurse who was the area Health and Wellness Director (HWD).
-The area HWD asked questions about the incident and the staff repeated what she observed.
-Staff B had been "caught doing something" to Resident #4 earlier this year (2020) by another staff (former staff) who reported to this staff and management.
-the other staff described what she saw and became upset and teary.

Telephone interview with a former staff on 08/19/20 at 4:33pm revealed:
-Staff B had been caught by another staff in Resident #3's room in an "inappropriate sexual situation" last month (July 2020).

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-The resident began to have behavior changes after the alleged incident.
-The resident became irritable and was restless. The resident wanted to leave the facility; he would shake the exit doors while attempting to get out.

Telephone interview with Resident #3's family on 08/20/20 at 1:50pm revealed:
-She was very involved in Resident #3's care, including health care) and expected the facility to inform her of any problems or changes involving the resident.
-Before the COVID-19 pandemic, she visited Resident #3 at least one time a week and she transported him to medical appointments and ordered all of his medication from an outside pharmacy.
-She continued to talk to the staff and Resident #3 every Wednesday via video call since the pandemic and has never been informed by the staff of any problems or incidents involving the resident.
-Resident #3 only required "standby" assistance with personal care (showers and bathes) and used the bathroom independently. He was continent of bowel and bladder.
-Resident #3 was easy to get along with but had memory loss/disoriented. He flirted with the female staff at times.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 08/21/20 at 3:05pm revealed:
-Because Resident #3 had a diagnosis of dementia which had advanced, he was not able to make any decisions, including consent for sexual activity.
-If there were any sexual activity involving Resident #3, there was a possibility of the spread of a sexually transmitted disease (STD) because

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the resident had a history of latent syphilis.
-The facility contacted the PCP on 08/20/20 and reported Resident #3 was sexually abused by a staff member last month (July 2020) who intentionally hid it.
-The PCP planned to check the resident on Monday (8/24/20) and order testing for other STDs and a series of testing related to the latent syphilis.
-Involuntary participation in sexual activity would cause the resident emotional distress and behavior changes whether he had dementia or not.

b. Review of Resident #4's current FL-2 dated 02/03/20 revealed:
-Diagnoses included dementia, dyspnea on exertion, hypertension, diabetes type 2 and dyslipidemia.
-The resident was constantly disoriented and wandered
-The resident was ambulatory.
-The resident's recommended level of care was a special care unit (SCU).

Review of Resident #4's care plan dated 01/27/20 revealed:
-The resident was receiving hospice services, wandered throughout the facility and became aggressive at times, could be both physically and verbally abusive and redirection was effective.
-The resident was always disoriented and had significant memory loss requiring direction.
-The resident required extensive staff assistance with grooming, bathing, dressing and toileting.
-The resident required limited staff assistance with eating.
-The resident required staff supervision with transfers and ambulation.

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D 338	Continued From page 21 Confidential staff interview revealed: -The incident occurred on 1st shift, during the weekend, prior to the "pandemic", around the first part of the year (2020). -The previous Health and Wellness Director (HWD) was at the facility to monitor during the weekend the incident occurred. -The staff was doing "rounds" with the residents and did not know where another staff, Staff B was. -The staff observed Staff B with Resident #4 with the door closed in the resident's room. -The windows and blind in the room were in an opened position. -Staff B and Resident #4 were in a standing position in the room. -Resident #4 did not have any clothes covering the bottom portion of his body. -Staff B did not have any gloves on and was "fooling around" with Resident #4's "private area". -Staff B had his left hand on Resident #4's right shoulder and Staff B's right hand was underneath the resident's "private area." -Staff B was moving his fingers, massaging Resident #4 behind and around his "private area". -There were no incontinent wipes in Staff B's hands. -The staff could remember the incident "just like it was yesterday". -Staff B immediately ran to the resident's room door attempting to push the door back to a closed position and stated, "I got it" and he did not need any help. -The staff thought Staff B would have pushed "me" out with the door if it was not for hand placement on the door and strength. -Resident #4 was not asked what was going on because the resident would not have been able to recall or tell anyone what had happened, and the staff did not want to upset the resident.	D 338		

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-The incident was reported immediately to a medication aide (MA), (could not recall the MA's name) at the time of the incident.
-The staff reported the incident on the same day (of the incident) to the previous HWD.
-The previous HWD told the staff that she would look into the incident.

Confidential interview with a former staff revealed Staff B had been caught by another staff in Resident #4's room in an "inappropriate sexual situation" estimating the time frame of the incident was around February 2020.

Review of Resident #4's electronic progress notes dated 04/27/20 at 9:19am revealed the resident had expired.

Telephone interview with a personal care aide (PCA) on 08/14/20 at 1:05pm revealed Resident #4 needed staff supervision when he was first admitted to the facility, but the resident's dementia progressed and started requiring more staff assistance the first part of 2020.

Telephone interview with a MA on 08/14/20 at 1:55pm revealed:
-Resident #4 liked to walk in the facility hallways a lot.
-Resident #4 was able to do more for himself until his needs changed and required assistance from staff "earlier in year (2020)" but she could not remember exactly when this change occurred.
-Resident #4 "occasionally would have a little bit of anxiety".

Telephone interview with the Administrator/ED on 08/18/20 at 8:59am revealed:
-He was not aware of any allegation of sexual abuse for Resident #4 by Staff B.

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-If there were any allegations of sexual abuse reported for Resident #4 and another named resident his management team would have handled it by investigating the allegations.
-He expected to be notified of any resident right issues whether he was in the building or not.
-When there were issues with resident rights physical or sexual, the named staff would be removed from the community while the incident was being investigated.
-He expected staff to immediately report any resident right abuse issues to the supervisor (Supervisor in charge (SIC)/MA), who would report to the department head (HWD), then the department head (HWD) would report it to the Assistant Executive Director (AED) and to him and an investigation initiated.
-On 07/21/20, the AED reported to him the AHS had received a complaint of possible sexual abuse of a resident on 07/21/20 and no names were provided.
-On 08/13/20, the AED reported to him the AHS had contacted the AED by telephone on 08/13/20 and reported another complaint had been received involving the same possible sexual abuse of a resident.

Telephone interview with the AED on 08/14/20 at 2:25pm revealed she had not been notified of any sexual abuse allegations involving any residents from staff.

Telephone interview with the area Health and Wellness Director (HWD) on 08/18/20 at 12:18pm revealed she had not received any reports of any types of abuse related to Staff B from family, staff or anything when he was employed at the facility.

Telephone interview with Resident #4's PCP on

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D 338	Continued From page 24 08/21/20 at 3:20pm revealed: -Resident #4 would not be able to give sexual consent because of his dementia. -He had not received notification from the facility of allegations of sexual abuse for Resident #4 by a staff prior to 08/20/20. -There were no reports of sexually abuse involving Resident #4 before 08/20/20. Attempted telephone interview with with Staff B on 08/20/20 at 9:25am was unsuccessful. Attempted telephone interview with the previous HWD on 08/20/20 at 9:23am was unsuccessful. 2. Review of the CDC Considerations for Memory Care Units in Long-term Care Facilities revealed: -Routines are very important for residents with dementia. Try to keep their environment and routines as consistent as possible while still reminding and assisting with frequent hand hygiene, social distancing, and use of cloth face coverings (if tolerated). -Cloth face coverings should not be used for anyone who has trouble breathing, or is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. -Limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory and are in close proximity to other residents or personnel. Review of the facility's undated Active Screening of Residents COVID-19 policy revealed: -Residents did not participate in communal activities. -Communal activity programs had been suspended until notified or advised by the Center	D 338		

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for Disease Control (CDC), NC Department of Health and Human Services (DHHS) or NC Department of Health.
-Residents received enrichment activities in their rooms.
-Residents received meals in their rooms until notified or advised by the CDC, DHHS or the NC Department of Health.

a. Observations made intermittently in the hallway of the facility on 08/13/20 between 9:47am - 10:55am revealed:
-At 9:47am, there was one female resident sitting in a chair directly beside another female resident sitting in a wheelchair in the front hallway of the facility.
-The two female residents did not have a face covering.
-There was one staff observed in direct view of the two female residents, walking back and forth from the common living room and nurse's station.
-Staff were not observed redirecting the two female residents to social distance or to wear face coverings.
-At 9:56am, in the front hall there were three female residents seated in this area, the residents sat directly beside each other.
-The three residents were not wearing facial coverings.
-Residents were observed intermittently walking up and down the hallway with no facial coverings.
-Staff were not observed redirecting any of the residents to social distance or to wear a facial coverings.

Observations made intermittently of the common living room of the facility on 08/13/20 between 10:13am-10:56am revealed:
-There were 2 three cushioned couches in the living room.

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D 338	Continued From page 26 -There were 8 residents sitting in the living room with no face coverings. -At 10:13am, there were two residents sitting on a 3 cushioned couch approximately 2 ft from each other. -Staff were not observed redirecting any of the residents to social distance or to wear facial coverings. -At 10:28am, there were 3 residents sitting side by side on the three cushioned couch. -At 10:40am, a female resident sat directly beside another female resident on the three cushioned couch. -At 10:48am, there nine residents seated in the common living room. -The residents were not seated six feet apart. -The residents were not wearing face coverings. -At 10:56am, a female resident walked toward a resident and sat directly beside a resident sitting in a wheelchair. -A female resident leaned over toward the other resident, patting the resident on the leg. -At 10:58am, a medication aide (MA) walked down the hallway, glanced in the common living room and did not redirect the resident that continued patting the resident's leg while leaning forward near the resident sitting in the wheelchair. -At 10:59am, a personal care aide (PCA) walked into the doorway of the common living room and walked back out with a resident. -The PCA did not redirect the female resident that had positioned herself close to the resident in the wheelchair. Interview with a PCA on 08/13/20 at 10:18am revealed: -Staff did not redirect the residents to wear a facial covering because the residents were in a special care unit (SCU). -There were facial coverings available for staff to	D 338		

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assist the residents to wear.
-None of the residents had left the facility since the pandemic.
-She had received infection control training and watched videos provided by the Assistant Executive Director (AED) a few months ago after the pandemic began which included assisting, encouraging and redirecting the residents to maintain 6ft distancing from one another and to wear facial coverings when the residents were not in their room.

Interview with a MA on 08/13/20 at 10:29am revealed:
-Residents were not required to wear face coverings because of their diagnosis of dementia.
-Residents became combative when masks were placed on them.
-Residents took off their face coverings.
-Residents were required to wear face coverings when transported to the hospital or when they left the facility.
-Residents who shared a room had their beds spaced six feet apart.
-Only one resident was allowed to sit on the bench at a time and staff monitored the bench.
-The common living area seated eight residents.
-Staff tried to redirect residents to remain six feet apart.
-She had completed a COVID-19 training in July 2020 and August 2020.

Interview with a second PCA on 08/13/20 at 10:21am and 10:37am revealed:
-It was hard to socially distance the residents from each other.
-Staff would redirect residents as much as they could.
-The two ladies sitting in the hallway should not have been sitting side by side.

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-Prior to the female residents sitting together in the hallway, she had spaced the furniture in the hallway to keep the two female residents apart, however, one of the ladies moved the furniture and sat next to the other female resident.

Interview with the Lead Medication Aide on 08/13/20 at 10:57am revealed:
-The staff provided facial coverings to the residents.
-She did not know if the residents were required to wear facial coverings.
-Residents wore facial coverings when they had an elevated temperature of 99.4 or higher.
-She tried to keep the residents six feet apart, but it was hard because residents became agitated.
-She had completed some training on COVID-19 infection control.

Telephone interview with a third PCA on 08/13/20 at 3:39pm revealed:
-Residents would not keep their facial coverings on.
-The residents at the facility did not like to wear facial coverings, however, staff were responsible to encourage the residents to wear them.
-She encouraged residents to wear their facial coverings.
-She last encouraged residents to wear their facial coverings on 08/11/20.
-She had completed training on COVID-19 infection control and was told to keep the residents 6ft apart and encourage residents to wear facial coverings.

Telephone interview with a second MA on 08/13/20 at 4:08pm revealed:
-She encouraged residents to wear facial coverings, but they took their facial coverings off.
-Staff encouraged residents to wear facial

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coverings but it was hard for some of the residents to keep the facial coverings on.
-Some of the residents would wear facial coverings and some would not.
-Staff wore facial coverings to make it safer for the residents and tried to keep the residents socially distant.
-When staff explained the purpose of the facial coverings, some of the residents at the facility would wear them.
-She was instructed by management to encourage residents to wear a facial coverings each time staff observed a resident in the common areas of the facility without wearing a facial covering.
-She documented in the 72-hour Log and Temperature Book of the residents that had not worn a facial covering.
-Staff were responsible to monitor and redirect residents to ensure only two residents sat on the couch at a time, with one resident on each end of the couch.

Telephone interview with a fourth PCA on 08/14/20 at 1:11pm revealed:
-Residents would not keep facial coverings on.
-Staff did not prompt or redirect residents to wear face coverings because staff knew residents would not keep the face masks on.
-Management had instructed staff to attempt to get residents to wear facial coverings and to redirect the residents to keep them apart as much as possible.
-She had completed training on COVID-19 infection control.

Telephone interview with the AED on 08/13/20 at 2:44pm revealed:
-There was no COVID-19 positive staff or residents at the facility.

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-Residents were monitored for signs and symptoms of cough or respiratory symptoms, temperatures were checked every shift and pulse oximetry checks were done daily. (A pulse oximetry is a noninvasive test to measure oxygen levels in the blood using a sensor)
-At the beginning of each shift, staff temperatures were taken, and a questionnaire was completed.
-At the end of each shift, staff temperatures were retaken and documented on the questionnaire.
-If a staff or resident developed any signs or symptoms of respiratory illness, then COVID-19 test would be done.
-It was hard to get residents to wear facial coverings; staff tried to redirect residents to wear facial coverings but, it was difficult because residents would not wear them.
-Residents had the right to remove the facial coverings but she expected staff to encourage the residents to wear them.
-Staff were responsible to ensure residents were socially distancing.
-Staff were doing the "best we can".
-Staff were assigned to monitor common areas such as the facility's living room and hallways to ensure residents were safely socially distant but there were so many "things" going on such as showers, toileting needs for the residents it was difficult for staff to continuously monitor.
-Staff assigned to monitor common areas were expected to redirect residents to ensure residents were not sitting side by side.
-Staff should have redirected the residents observed sitting side by side and near each other on 08/13/20.

Telephone interview with the AED on 08/14/20 at 2:25pm revealed she was aware of the guidelines and recommendations from CDC, however, did not understand why the residents needed to wear

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facial coverings when staff were attempting to keep the residents socially distanced and even if the residents were sitting side by side, the residents did not leave the facility.

Telephone interview with a nurse with the local health department (LHD) on 08/14/20 at 2:15pm revealed:
-The facility had not contacted the health department for any guidance regarding concerns or issues with social distancing or residents not wearing face masks.
-She thought it would be important for staff to redirect and encourage residents residing in a SCU because those residents would be unaware of spacing distance and not be able to understand the reason or need to wear facial coverings.
-Residents relied on staff in the SCU and the residents would not be able to perform these tasks themselves.
-Social distancing and wearing facial coverings could help to prevent a new outbreak of COVID-19.
-The LHD had not provided the facility with recommendations and guidance related the global pandemic of COVID-19.
-If the facility had reached out to the health department, the department could offer guidance and address any questions or concerns.

Telephone interview with a resident's PCP on 08/21/20 at 3:20pm revealed he expected the facility to follow their policies related to COVID-19, however, would have preferred the facility to follow social distancing guidelines and encourage the residents to wear facial coverings because these were practices known to flatten the curve of the pandemic and would reduce the risk of contracting COVID-19.

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D 338	Continued From page 32 b. Observation of the dining room of the facility on 08/13/20 at 10:02am and 10:25am revealed: -There were 10 dining tables and 34 chairs in the dining room. -There were three tables with four chairs. -There were seven tables with three chairs. -There were two large walkways leading the dining room. Interview with a personal care aide (PCA) on 08/13/20 at 10:18am revealed there were approximately 26 to 27 residents in the dining room at one time during meals. Telephone interview with a second PCA on 08/13/20 at 3:39pm revealed: -She started working 2nd shift at the facility on 07/21/20. -All residents were served their meals in the dining room at the same time since she started working at the facility. -Staff were responsible to ensure the residents were 6 ft apart during meals, however, the dining room was not that big. -She tried to keep the residents six feet apart. -The residents had been seated three to four feet apart when in the dining room. -There were two to three residents seated at each table during meals. -There were eight to nine residents who were served their meals in the dining hall at one time. -Residents were seated two at a table at least six feet apart. Interview with a MA on 08/13/20 at 10:29am revealed there were eight to ten residents who were served their meals in the dining hall at one time.	D 338		

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D 338	Continued From page 33 Interview with a second PCA on 08/13/20 at 10:37am revealed: -The residents were served their meals in the dining room. -Communal dining for the residents had never stopped since the pandemic started. Telephone interview with a second medication aide (MA) on 08/13/20 at 4:08pm revealed: -Residents had their meals in the dining room and sat two to three residents per table. -Residents were seated three to four feet apart at the dining table. -During the residents' meals, staff attempted to keep residents limited and distant from each other to keep germs from spreading. Telephone interview with a third PCA on 08/14/20 at 1:11pm revealed -Residents had their meals at the same time and dined in the dining room. -She tried to redirect the residents to remain six feet apart from each other. Telephone interview with theAssistant Executive Director (AED) on 08/13/20 at 2:44pm revealed: -There was no COVID-19 positive staff or residents at the facility. -Communal dining for residents had not "really been canceled". -There had been times during the pandemic, all 30 residents were in the dining room at one time but typically not all 30 residents ate their meals at the same time. -Some residents ate and left the dining room, some residents took longer to eat, and other residents would linger in the dining room. -Staff tried to serve residents in the dining room that were in wheelchairs, Geri-chairs, and residents that required feeding assistance prior to	D 338		

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the other residents eating in the dining room.
-The facility took small groups of residents into the dining room to allow more social distancing, however, other residents saw other residents eating.
-Staff could "redirect, redirect" however, the other residents would be insistent they were coming in the dining room and eating at the same time also and other residents would start trickling in.
-Staff attempted to socially distance the residents' during meals, however, it was very difficult to socially distance the residents because they are in a special care unit (SCU).
-During the residents' meals, all staff walked through the dining room attempting to space residents apart.
-Three residents were seated at a dining room table distanced approximately 2-3 ft apart from each other during the residents' meals.
-Residents could not eat meals in their room because of the level of care the residents required.
-Serving residents meals in their room would have required too many staff "almost one to one".

Telephone interview with the AED on 08/14/20 at 2:25pm revealed:
-All residents residing at the facility ate their meals in the dining room and were spaced approximately 2-5 ft apart during meals.
-There was an additional facility infection control policy for the SCU that covered communal dining at the facility that must not have been in the infection control policy provided previously.
-She would provide a copy of the facility's infection control policy for SCU and communal dining.

No additional facility infection control policies for the SCU that covered communal dining was

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D 338	Continued From page 35 provided at the time of exit on 08/24/20. Telephone interview with a nurse with the local health department on 08/14/20 at 2:15pm revealed: -The facility had not contacted the health department for any guidance regarding concerns or issues with communal dining. -If the facility had reached out to the health department the department could offer guidance and address any questions or concerns. Telephone interview with a resident's primary care provider (PCP) on 08/21/20 at 3:20pm revealed: -He had observed the residents at the facility continuing to have communal dining during the pandemic of COVID-19. -He expected the facility to follow their policies related to COVID-19, however, would have preferred the facility to follow social distancing guidelines. Telephone interview with the Administrator/Executive Director on 08/19/20 at 4:40pm revealed staff were expected to ensure residents were socially distancing. _____ The facility failed to protect 2 of 2 sampled residents (Resident #3 and #4) who were diagnosed with dementia and resided in a locked facility after witnessed incidences (by other staff) of alleged sexual abuse by Staff B which was reported to management. Staff B was observed by a staff massaging the "private parts" of Resident #4 early in 2020 before the beginning of the COVID-19 pandemic. In July of 2020 Staff B was found in Resident #3's room on his knees with his face close to the residents exposed penis. Staff B continued to provide direct resident care and have direct contact with all of the	D 338		

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D 338	Continued From page 36 residents between the first incident in early 2020 and the last reported incident in July 2020. The facility's failure resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/14/20. A POP addendum was provided on 08/17/20, 08/18/20 and 08/24/20. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 23, 2020.	D 338		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to report allegations of sexual abuse by Staff B to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours, failed to investigate, and failed to complete the 5-day follow-up reporting for 2 of 2 sampled residents (#3, #4). The findings are: Telephone interview with the Assistant Executive Director (AED) on 08/13/20 at 2:44pm revealed: -She had worked at the facility for 4 years.	D 438		

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D 438	Continued From page 37 -She had not received complaints related to resident rights as far as alleged abuse that would have required an investigation. -She had not been required to complete a report to Health Care Personnel Registry (HCPR). -Staff were responsible to immediately report any resident right concerns related to abuse or neglect to the Administrator/Executive Director (ED), the Health and Wellness Director (HWD) and herself. -The Administrator/ED would be responsible for submitting any HCPR reports. a. Review of Resident #4's current FL-2 dated 02/03/20 revealed: -Diagnoses included dementia, dyspnea on exertion, hypertension, diabetes type 2 and dyslipidemia. -The resident was constantly disoriented and wandered. -The resident was ambulatory. -The resident's recommended level of care was a special care unit (SCU). Review of Resident #4's electronic progress notes dated 04/27/20 at 9:19am revealed the resident had expired. Confidential staff interviews revealed: -An incident occurred prior to the "pandemic", around the first part of the year (2020). -The staff observed another staff, Staff B, with Resident #4 in the resident's room with the door closed. -The windows and blind in the room were in an opened position. -Staff B and Resident #4 were in a standing position in the room. -Resident #4 did not have any clothes covering the bottom portion of his body.	D 438		

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-Staff B did not have any gloves on and was "fooling around" with Resident #4's "private area".
-Staff B had his left hand on Resident #4's right shoulder and Staff B's right hand was underneath the resident's "private area."
-Staff B was moving his fingers, massaging Resident #4 behind and around his "private area".
-There were no incontinent wipes in Staff B's hands.
-The staff did not ask Resident #4 what was going on because the resident would not have been able to recall or tell anyone what had happened.
-The staff reported the incident to a medication aide (MA). (The staff could not recall the MA's name that the incident had been reported to).
-The staff also reported the incident to the previous Health and Wellness Director (HWD).
-The previous HWD said she would look into the incident.

Attempted telephone interview with the previous HWD on 08/20/20 at 9:23am was unsuccessful.

Telephone interview with HCPR Administrative Specialist on 08/14/20 at 10:07am revealed there had not been any HCPR reports received for Staff B.

Telephone interview with the Assistant Executive Director (AED) on 08/14/20 at 2:25pm revealed she was aware HCPR reports should occur initially within 24 hours followed by a 5-day working report.

Review of a fax received from the AED on 08/14/20 at 4:15pm revealed:
-There was a faxed confirmation dated 08/14/20 of 4:20pm to the Complaint Unit with the Adult Licensure Section at the Division of Health

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Service Regulation (DHSR).
-There was a Complaint Intake Unit Complaint Form dated 08/14/20.
-The AED was named as the complainant.
-There was documentation on 07/21/20 at approximately 4:45pm the AHS stopped by the facility on and unannounced visit and reported she was on a complaint regarding resident rights, asked if any reports had been made for sexual abuse on 07/15/20 and/or 07/16/20.
-There was documentation on 08/13/20, the AHS called the facility and reported to the AED that she was notified of sexual abuse allegations by Staff B for another resident on 08/12/20 by phone.
-The facility notified the AHS that Staff B was no longer with the facility and had resigned due to personal reasons.

Telephone interview with the Administrator/ED on 08/18/20 at 8:59am revealed:
-When there was an allegation of resident abuse the facility was responsible to complete a "24/5" to the HCPR.
-When there was notification of resident abuse the accused staff would be removed immediately from the community while the facility conducted an investigation.
-A 24-hour report and a 5-day report would be completed and submitted to HCPR.

Telephone interview with the AED on 08/20/20 at 3:22pm revealed:
-The HCPR 5-day report had been completed and faxed.
-Resident #4's information was not included in the HCPR 5-day report.
-She was "assuming" the allegation regarding Resident #4 was not in the HCPR report because the resident was deceased, but the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 438	Continued From page 40 Administrator/Executive Director (ED) completed the investigation and would provide additional feedback regarding the information included in the 5-day HCPR report. -The previous HWD was not interviewed during the facility's internal investigation regarding the sexual abuse allegation of Resident #4 by Staff B because she was no longer employed by the facility. -The Administrator/ED did most of the interviews for the investigation. Telephone interview with the Administrator/ED on 08/20/20 at 3:45pm revealed: -The 5-day HCPR report did not include the allegation that Resident #4 was sexually abused by Staff B. -The other named resident was a current resident of the facility and because Resident #4 was deceased, he was not aware he had to include the resident's alleged sexual abuse by Staff B. -He included specific questions when he interviewed staff concerning the allegation that would have been applicable to Resident #4 and the other named resident. -He would complete an addendum and fax the allegation of sexual abuse of Resident #4 by Staff B to HCPR to include Resident #4. -He did not interview the previous HWD because she no longer worked at the facility. -He was not experienced involving allegations like this. -He did not interview Staff B regarding the allegations of sexual abuse because Staff B was no longer employed at the facility. -He was not sure if he "had a right" to interview Staff B because he was no longer working at the facility. -He would attempt to contact Staff B.	D 438		

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D 438	Continued From page 41 b. Review of Resident #3's current FL-2 dated 08/17/20 revealed: -Diagnoses included dementia with behavior disturbances, latent syphilis, and alcohol abuse. -The resident was constantly disoriented, ambulatory, and continent of bowel and bladder. -The resident's current level of care was "locked unit". Telephone interview with the Adult Home Specialist (AHS) with the local department of social services (DSS) on 08/13/20 at 4:34pm revealed: -On 07/21/20, she made a visit the facility. -She met with the AED regarding an allegation of sexual abuse. -She asked the AED if she had received any reports or concerns of a staff and abusing or "sexually inappropriate" with a resident or any issues of that nature. -The AED denied any knowledge or being notified of any incidences or allegations of sexual abuse. -The AED did not provide her with any follow-up information of how or what she would do after being told about the allegation of sexual abuse. -The next contact she had with the AED was by telephone on 08/13/20 to inform her another complaint had been received regarding sexual abuse allegations of a resident by a staff. -She asked the AED if the facility had a named resident (only the first name) that was provided in a complaint allegation received by the county on 08/12/20. -The AED told her there had not been a resident residing at the facility, past nor present with that name. -She asked the AED if she had received any allegations of Staff B being sexually inappropriate with residents and AED denied any knowledge or being notified of any incident, allegations or	D 438		

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D 438	Continued From page 42 reports regarding Staff B. Telephone interview with the AHS with the local DSS on 08/14/20 at 830am revealed she had spoken with the AED regarding the staff to resident sexual abuse allegation on 08/13/20 at 8:37am. Telephone interview with Health Care Personnel Registry (HCPR) Administrative Specialist on 08/14/20 at 10:07am revealed: -There had not been any reports made of sexual abuse from the facility as of 07/21/20. -There had not been any reports made relating to Staff B. Telephone interview with the AED on 08/14/20 at 2:25pm revealed: -She did not initiate an internal investigation because there had not been any allegations "brought" to her and at that point, there was no investigation needed. -She did not interview any residents or staff and to her knowledge, the Administrator/Executive Director (ED) did not either. -She had only spoken with staff working yesterday (08/13/20) and had questioned those staff if there had been any reports of resident abuse. -She had not reported this allegation of sexual abuse to HCPR. -She was aware HCPR reports should occur initially within 24 hours followed by a 5-day working report. -Since there had not been any reports of abuse brought to her and it was given to the AHS, she thought "it was already handled". -She would complete a 24-hour report to HCPR for the sexual abuse allegations received from the AHS on 07/21/20 and 08/12/20.	D 438		

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D 438	Continued From page 43 Review of a fax received from the AED on 08/14/20 at 4:15pm revealed: -There was a faxed confirmation with a received result as "ok" dated 08/14/20 of 4:20pm to the Complaint Unit with the Adult Licensure Section at the Division of Health Service Regulation (DHSR). -There was a Complaint Intake Unit Complaint Form dated 08/14/20. -The AED was named as the complainant. -There was an documentation that on 07/21/20 at approximately 4:45pm the AHS stopped by the facility on and unannounced visit and reported she was on a complaint regarding resident rights, asked if any reports had been made for sexual abuse on 07/15/20 and/or 07/16/20. -The AED documented there had been no complaints brought to her attention. -There was additional documentation that on 08/13/2, the AHS called the facility to notify of a complaint of sexual abuse allegations. -The AHS asked if there was a named resident (first name only) that lived at the facility. -Staff reported there were no residents by that name. -The AHS then asked if there was ever a resident by that name and staff reported there has never been a resident by that name. -The AHS asked if there were any male staff at the facility and was told there was currently one male staff. -The AHS asked if there was a named male staff (Staff B) and was told the staff was no longer with the facility. -The AHS was told Staff B was no longer with the facility and had resigned due to personal reasons. Review of Staff B's resignation letter signed	D 438		

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D 438	Continued From page 44 07/20/20 revealed effective 07/20/20, Staff B was resigning his position as a personal care aide (PCA) due to family reasons. Confidential staff interview on 08/17/20 at 4:11pm revealed: -On July 18th or 19th, 2020, the staff opened the Resident #3's bedroom door, the staff observed Staff A in the room. -Resident #3 was awake and lying on his back in his bed with his covers partially pulled off exposing his "private parts", including his penis. -Staff B was on his knees next to the resident's bed, with his head over the resident's exposed body. -Staff B's head was close to the resident's exposed penis. -The staff was "shocked" and immediately asked Staff A "what are you doing". -Staff B jumped up and he appeared "scared" and trembling. He did not say anything but left the room. -The staff observed that Staff B did not have on any gloves. -Resident #3's bed was next to the door and Staff B was on the side of the bed next to the door. -When the staff returned to the nurse's station, Staff A stated he was helping Resident #3 "clean up." -The staff reported the incident to the 1st shift MA because what she had observed did not look right. -She had worked with Staff B and she had never observed him or any other staff providing resident care in that position. -The MA reported the incident to the facility's registered nurse who was the current area Health and Wellness Director (HWD). Telephone interview with the current area HWD	D 438		

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D 438	Continued From page 45 on 08/18/20 at 12:18pm revealed: -She had not received any reports of any types of abuse related to Staff B from family, staff or anyone when he was employed at the facility. -If there was any type of resident abuse, staff would be responsible to report it to her or other management at the facility and they would start an investigation. -If anything was reported to her, she would follow the appropriate channels, would start our internal investigation and file a complaint. -If a staff was named in an allegation of resident abuse, the staff would be sent home and would not work. Telephone interview with the Administrator/ED on 08/18/20 at 8:59am revealed: -He was not aware of any reports Resident #3 was allegedly sexually abused by Staff B. -He was conducting a 5-day working report and investigation on the allegations of sexual abuse. -He would ask the current area HWD today (08/18/20) if she had received any reports from staff that Resident #3 was allegedly sexually abused by Staff B. Review of the 5-day Compliant Intake and Health Care Personnel Investigation Report for Resident #3 dated 08/19/20 revealed: -The report was completed by the Administrator/ED. -In the allegation section of the form there was documentation Resident #3 was allegedly sexually abused by a staff member within the community. Reports were made to the local county DSS and NC DHHS which reported to the facility via phone and unannounced visit. -The accused individual was Staff B who was no longer employee by the facility. -Resident #3 and 4 other named residents were	D 438		

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D 438	Continued From page 46 interviewed. -The AED and 6 other employees were interviewed. -The investigation process was started on 08/14/20. -The Administrator/ED gathered resident and employee roster information to decide who would be interviewed. -The interviews were completed by the Administrator/ED with staff and residents from 08/17/20 to 08/19/20. - A copy of the resident and staffs' responses to the questions were attached to the HCPR report. -There was documentation, after thorough investigation, it was concluded the facility was unable to validate any instance of abuse occurred from interviews conducted. -The investigation HCPR report was signed by the Administrator/ED. -There was no documentation an interview was attempted with Staff B. -There was no documentation the current area HWD was interviewed. Telephone interview with the Administrator/ED on 08/20/20 at 3:45pm revealed: -The 5-day HCPR report was faxed today (08/20/20) for the allegation of sexual abuse of Resident #3 by Staff B -He did not interview the current area HWD regarding the allegation Resident #3 was sexually abused by Staff B. Refer to Tag D 338 10A NCAC 13F .0909 Resident Rights _____ The facility failed to report allegations of alleged sexual abuse by a staff (Staff B) for 2 of 2 sampled residents (#3 and #4) who were disoriented and resided in a locked facility within	D 438		

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D 438	Continued From page 47 the 24 hours and a 5 day investigation report to the HCPR. Staff B was observed by a staff massaging the "private parts" of Resident #4 early in 2020 before the beginning of the COVID-19 pandemic and he was observed by a second staff in July 2020 in Resident #3's room on his knees next to the resident's bed with his head over the resident's exposed penis. Both allegations were reported to a supervisor (MA) and the HWDs at the time of the incidents. The facility's failure to report incidents of sexual abuse resulted in Staff B being allowed to continue to work in the facility with direct contact to all of the residents in the locked facility and at least one allegation of sexual abuse to one other resident several months later until he resigned on 07/20/20. This failure resulted in serious harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/14/20. A POP addendum was provided on 08/17/20, 08/18/20, 08/20/20 and 08/24/20. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 23, 2020.	D 438		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a	D 453		

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D 453	Continued From page 48 resident. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to immediately notify the local law enforcement for 2 of 2 sampled residents (#3, #4) after staff reported an allegation of sexual abuse from Staff B. The findings are: Telephone interview with the Adult Home Specialist (AHS) with the local department of social services on 08/13/20 at 4:34pm revealed: -On 07/21/20, she met with the Assistant Executive Director (AED). -The AED Assistant denied she had received any reports or concerns of a staff and a resident related to resident abuse, being "sexually inappropriate" or any issues of that nature. -The AED denied any knowledge or of being notified of any incident, allegations or reports. -The AED did not provide her with any information of how or what she would do after being told about the allegation regarding following up on the sexual abuse allegation. -On 8/13/20, the AED denied the facility had a named resident (only the first name) past nor present with that name since she had worked at the facility. -The AED denied she had received any allegations of Staff B being sexually inappropriate with a resident and denied any knowledge of being notified of any incidents, allegations or reports.	D 453		

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1. Review of Resident #4's current FL-2 dated 02/03/20 revealed:
-Diagnoses included dementia, dyspnea on exertion, hypertension, diabetes type 2 and dyslipidemia.
-The resident was constantly disoriented and wandered.
-The resident was ambulatory.
-The resident's recommended level of care was a special care unit (SCU).

Confidential staff interviews revealed:
-Staff B was with Resident #4 with the door closed in the resident's room.
-Staff B and Resident #4 were in a standing position in the room.
-Resident #4 did not have any clothes on the bottom portion of his body.
-Staff B did not have any gloves on and was "fooling around" with Resident #4's "private area".
-Staff B had his left hand on Resident #4 right shoulder and Staff B's right hand was underneath the resident's "private area."
-Staff B was moving his fingers, massaging Resident #4 behind and around his "private area".
-There were no incontinent wipes in Staff B's hands.
-Staff B immediately ran to the resident's room door attempting to push the door back closed and stated, "I got it" and Staff B did not need any help.
-The confidential interview did not ask Resident #4 what was going on because the resident would not have been able to recall or tell anyone what had happened, and the confidential interview did not want to upset the resident.
-The incident was reported to a MA (could not recall the MA's name) and the MA was upset after being told about the incident then the incident was reported to the previous HWD.
-The previous HWD told the confidential interview

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D 453	Continued From page 50 that she would investigate the incident. Review of Incident and Accident Reports for Resident #4 from January 2020 - April 2020 revealed there was no Incident and Accident reports completed for the alleged sexual assault of Resident #4. Refer to the telephone interview with a local law enforcement officer on 08/19/20 at 2:10pm. Refer to the telephone interview with the Administrator/Executive Director (ED) on 08/18/20 at 8:59am. Refer to the telephone interview with the Assistant Executive Director (AED) on 08/20/20 at 3:22pm Refer to the telephone interview with the Administrator/ED on 08/20/20 at 3:45pm. 2. Review of Resident #3's FL-2 dated 08/17/20 revealed: -Diagnoses included dementia with behavior disturbances, latent syphilis, and alcohol abuse. -The resident was constantly disoriented, ambulatory, and continent of bowel and bladder. -The resident's current level of care was "locked unit". Confidential staff interview on 08/17/20 at 4:11pm revealed: -On July 18th or 19th, 2020, the staff opened the Resident #3's bedroom door, the staff observed Staff A in the room. -Resident #3 was awake and lying on his back in his bed with his covers partially pulled off exposing his "private parts", including his penis. -Staff B was on his knees next to the resident's bed, with his head over the resident's exposed	D 453		

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D 453	Continued From page 51	D 453		

body.
-Staff B's head was close to the resident's exposed penis.
-The staff was "shocked" and immediately asked Staff A "what are you doing".
-Staff B jumped up and he appeared "scared" and trembling. He did not say anything but left the room.
-The staff observed that Staff B did not have on any gloves.
-Resident #3's bed was next to the door and Staff B was on the side of the bed next to the door.
-When the staff returned to the nurse's station, Staff A stated he was helping Resident #3 "clean up."
-The staff reported the incident to the medication aide (MA) because what she had observed did not look right.
-She had worked with Staff B and she had never observed him or any other staff providing resident care in that position.
-The MA reported the incident to the facility's registered nurse who was the Health and Wellness Director (HWD).

Review of Incident and Accident Reports for Resident #3 from January 2020 - current revealed there was no Incident and Accident reports completed for the alleged sexual assault of Resident #3.

Refer to the telephone interview with a local law enforcement officer on 08/19/20 at 2:10pm.

Refer to the telephone interview with the Assistant Executive Director (AED) on 08/18/20 at 8:59am

Refer to the telephone interview with the AED on 08/20/20 at 3:22pm

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D 453	Continued From page 52 Refer to the telephone interview with the Administrator/ED on 08/20/20 at 3:45pm. Telephone interview with a local law enforcement officer on 08/19/20 at 2:10pm revealed there had not been any police reports taken from the facility since January 2020. Telephone interview with the Administrator/Executive Director (ED) on 08/18/20 at 8:59am revealed he was not aware and had not been notified of any sexual abuse allegations involving Resident #3 and Resident #4 by Staff B. Telephone interview with the AED on 08/20/20 at 3:22pm revealed local law enforcement was not involved in the facility's investigation regarding the sexual abuse allegations against Staff B. Telephone interview with the Administrator/ED on 08/20/20 at 3:45pm revealed: -Local law enforcement was not notified of the allegations of sexual abuse of Resident #4 and Resident #3.. -He was not aware there was a rule that local law enforcement should have been notified regarding the allegations of sexual abuse against residents by Staff B. Refer to Tag D 338 10A NCAC 13F .0909 Resident Rights The facility failed to immediately notify local law enforcement authorities for 2 of 2 sampled residents (#3, #4) after staff reported allegations of sexual assault by Staff B, the first allegation was observed around February 2020 (#4) and the second allegation was observed around July 18 or 19, 2020 (#3) . The facility's previous HWD	D 453		

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D 453	Continued From page 53 and MA were informed of the February 2020 allegation in February 2020 and the current area HWD and MA were informed of the July 2020 allegation in July 2020, and again in August 2020. The Administrator/ED was also informed of the allegations of sexual abuse to Resident #3 and Resident #4 on 08/18/20, however, failed to immediately notify local law enforcement of the sexual abuse allegations after being prompted multiple times to report the allegations to law enforcement. This failure resulted in substantial risk for harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/21/20. A POP addendum was provided on 08/24/20. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 23, 2020.	D 453		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were in an environment free of abuse and neglect as related to resident rights, health care, reporting of incidents and accidents, health care personnel registry, and implementation. The findings are:	D914		

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	HAL096049	A. BUILDING: _____ B. WING _____	C 08/24/2020

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D914	Continued From page 54 1. Based on interviews and record reviews the facility failed to ensure referral and follow up to meet the healthcare needs of 2 of 4 sampled residents (#3 and #4) by failing to notify the residents' primary care provider (PCP) of reported sexual abuse by a staff member (#3 and 4) and changes in behaviors after reported sexual abuse (#3). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 2. Based on record reviews and interviews, the facility failed to report allegations of sexual abuse by Staff B to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours, failed to investigate, and failed to complete the 5-day follow-up reporting for 2 of 2 sampled residents (#3, #4). [Refer to Tag D438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the Administrator/Executive Director (ED) failed to assure the total operation of the facility to meet and maintain rules related to health care, residents' rights, health care personnel registry and reporting of incident and accidents. [Refer to Tag D980, G.S. 131D-25 Implementation (Type A1 Violation)]. 4. Based on interviews and record reviews, the facility failed to immediately notify the local law enforcement for 2 of 2 sampled residents (#3, #4) after staff reported an allegation of sexual abuse from Staff B. [Refer to Tag D453, 10A NCAC 13F .1212(d) Reporting of Accidents and Incidents (Type A2 Violation)]. 5. Based on interviews, observations, and record reviews, the facility failed to ensure 2 of 2	D914		

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D914	Continued From page 55 sampled residents were free from sexual abuse by a former staff member (Staff B) who allegedly sexually abused two residents diagnosed with dementia in a special care unit (#3, #4); and were free of neglect by not following the recommendations and guidance issued by the Centers for Disease Control (CDC), North Carolina Division of Health and Human Services (NC DHHS) related to communal dining, reminding and assisting residents in a special care unit to social distance and wear facial coverings during the global pandemic of COVID-19. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the Administrator/Executive Director (ED) failed to assure the total operation of the facility to meet and maintain rules related to health care, residents' rights, health care personnel registry and reporting of incident and accidents. The findings are: Telephone interview with the Assistant Executive Director (AED) on 08/14/20 at 3:35pm revealed: -She was a licensed Administrator however, her	D980		

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D980	Continued From page 56 current job title was AED. -She was responsible for the day to day oversight and daily function of the facility when the Administrator/Executive Director (ED) was not at the facility. -She was at the facility Monday- Friday. -The Administrator/ED came to the facility 2-3 days per week and covered the Administrator/ED role at a sister facility. -The days or frequency the Administrator/ED was in the facility varied because he went based on the needs of the facility for that week. Telephone interview with the Administrator/ED on 08/18/20 at 8:59am revealed: -The AED handled the day to day operations of the facility and reported to him. -He was the Administrator/ED and "Area Manager". -The days he was at the facility was dependent on the needs of the community how often he was at the facility, it could be 3 days one week or 2 days. -He expected to be notified of any resident right issues whether he was in the building or not. -When there were issues with resident rights physical or sexual, the named staff would be removed from the community while the incident was being investigated. Telephone interview with the AED on 08/21/20 at 8:23am revealed: -She had worked at the facility since 2016 as the Business Office Manager. -The Administrator/ED started working at the facility around November 2018 as the Corporate Administrator for the facility and a sister facility. Non-compliance was identified in the following rule areas at violation level:	D980		

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D980	Continued From page 57 1. Based on interviews and record reviews the facility failed to ensure referral and follow up to meet the healthcare needs of 2 of 4 sampled residents (#3 and #4) by failing to notify the residents' primary care provider (PCP) of reported sexual abuse by a staff member (#3 and 4) and changes in behaviors after reported sexual abuse (#3). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 2. Based on record reviews and interviews, the facility failed to report allegations of sexual abuse by Staff B to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours, failed to investigate, and failed to complete the 5-day follow-up reporting for 2 of 2 sampled residents (#3, #4). [Refer to Tag D438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the Administrator/Executive Director (ED) failed to assure the total operation of the facility to meet and maintain rules related to health care, residents' rights, health care personnel registry and reporting of incident and accidents. [Refer to Tag D980, G.S. 131D-25 Implementation (Type A1 Violation)]. 4. Based on interviews and record reviews, the facility failed to immediately notify the local law enforcement for 2 of 2 sampled residents (#3, #4) after staff reported an allegation of sexual abuse from Staff B. [Refer to Tag D453, 10A NCAC 13F .1212(d) Reporting of Accidents and Incidents (Type A2 Violation)]. 5. Based on interviews, observations, and record reviews, the facility failed to ensure 2 of 2	D980		

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D980	Continued From page 58 sampled residents were free from sexual abuse by a former staff member (Staff B) who allegedly sexually abused two residents diagnosed with dementia in a special care unit (#3, #4); and were free of neglect by not following the recommendations and guidance issued by the Centers for Disease Control (CDC), North Carolina Division of Health and Human Services (NC DHHS) related to communal dining, reminding and assisting residents in a special care unit to social distance and wear facial coverings during the global pandemic of COVID-19. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]. _____ The facility failed to ensure responsibility for the overall management, administration and operation of the facility which resulted in failing to protect Resident #3 and Resident #4 after incidences were reported for alleged sexual abuse by a staff (Staff B); failing to investigate and report the allegations of sexual abuse to HCPR, local law enforcement and the residents PCP. Resident #3 displayed increased agitation/anxiety, banging on the facility's exit door while attempting to open the door to leave, and according to Resident #4's PCP the resident was experiencing an episode of increased aggression and combative behavior in January 2020 which possibly could have been a response of feeling threatened and feeling vulnerable if the residents were engaged in a involuntary sexual encounter; failure to assure guidelines and recommendations established by the Center for Disease Control (CDC), and the North Carolina Department of Health and Human Service were followed to protect the residents in a SCU from the global coronavirus (COVID-19) pandemic as evidenced by staff not ensuring residents were redirected to maintain safe social distancing and	D980		

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D980	Continued From page 59 redirecting residents to wear masks and continued to have communal dining when 6 ft spacing was not possible. This failure resulted in serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/21/20 with addendum. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 23, 2020.	D980		