| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|--|--|---------------------------|--|----------------|-------------------------|
| | | | A. BUILDING: | | | |
| | | HAL096049 | B. WING | | | C 24/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| COUNTR | YSIDE VILLAGE | | 117 NORTH LE, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE |
| D 000 | Initial Comments | | D 000 | | | |
| | complaint investiga Infection Control su 08/13/20 and 08/19 on 08/13/20 - 08/14 | ensure Section conducted a tion and a COVID-19 focused irvey with an onsite visit on 1/20 and a desk review survey 1/20, 08/17/20 - 08/21/20, and phone exit on 08/24/20. | | | | |
| D 273 | 10A NCAC 13F .09 | 02(b) Health Care | D 273 | | | |
| | | 02 Health Care Il assure referral and follow-up and acute health care needs | | | | |
| | This Rule is not me TYPE A2 VIOLATIO | | | | | |
| | facility failed to ensume the healthcare residents (#3 and # residents' primary or reported sexual about the | s and record reviews the ure referral and follow up to e needs of 2 of 4 sampled 4) by failing to notify the care provider (PCP) of use by a staff member (#3 and behaviors after reported sexual | | | | |
| | The findings are: | | | | | |
| | revealed: -Diagnoses include disturbances, latent syphilis but may be alcohol abuse. -The resident was of ambulatory, and co | ent #3's FL-2 dated 08/17/20 d dementia with behavior t syphilis (no clinical signs of sexually transmitted), and constantly disoriented, ntinent of bowel and bladder. rent level of care was "locked | | | | |

| | of Health Service Re | | | | |
|---------------|---|---|----------------|---|--------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ECONSTRUCTION | E SURVEY PLETED |
| | | | A. DUILDING. | | _ |
| | | HAL096049 | B. WING | | C 24/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | TATE, ZIP CODE | |
| | | | 17 NORTH | | |
| COUNTR | YSIDE VILLAGE | | E, NC 27863 | | |
| (X4) ID | | | ID | PROVIDER'S PLAN OF CO | (X5) |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | COMPLETE DATE |
| D 273 | Continued From pa | ge 1 | D 273 | | |
| | Review of Resident | #3's care plan dated 12/16/19 | | | |
| | revealed: | | | | |
| | -The resident was r services. | not receiving mental health | | | |
| | | history of wandering and | | | |
| | wandered througho | | | | |
| | | nostly cooperative but was ; redirecting was effective. | | | |
| | | lated with no problems. | | | |
| | | el and bladder functions were | | | |
| | normal. | hwave discriminated and had | | | |
| | | always disoriented and had loss and must be directed. | | | |
| | Confidential staff in revealed: | terview on 08/17/20 at 4:11pm | | | |
| | | th, 2020 the staff was working | | | |
| | first shift and a resid | dent (roommate of Resident | | | |
| | | e of his personal items to the | | | |
| | nurse's station. -The staff took the r | resident's items back to his | | | |
| | room, at the end of | the hall. | | | |
| | | ened the resident's bedroom | | | |
| | | rved Staff B in the room. wake and lying on his back in | | | |
| | | ers partially pulled off | | | |
| | | e parts", including his penis. | | | |
| | | knees next to the resident's over the resident's exposed | | | |
| | body. | | | | |
| | -Staff B's head was | close to the resident's | | | |
| | exposed penis. | akad" and immediately celled | | | |
| | - The staff was "sho Staff B "what are yo | cked" and immediately asked | | | |
| | | and he appeared "scared" and | | | |
| | | ot say anything but left the | | | |
| | room. | | | | |
| | I he staff observed any gloves. | that Staff B did not have on | | | |
| ision of He | ealth Service Regulation | | | | |

E STATE FORM

PLPW11

If continuation sheet 2 of 60

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVEY COMPLETED HAL096049 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COUNTRYSIDE VILLAGE 5383 US 117 NORTH PIKEVILLE, NC 27863 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) | Division | of Health Service Re | aulation | | | FORM | APPROVED |
|--|----------|---|---|----------------|--|------|----------|
| HAL096049 E. WING 08/24/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5383 US 117 MORTH 5383 US 117 MORTH COUNTRYSIDE VILLAGE CONTROLLAGE | STATEMEN | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | | |
| 5383 US 117 NORTH PREVILE, NC 2783 COUNTRYSIDE VILLAGE COUNTRYSIDE VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (PREPAR TAG SUMMARY STATEMENT OF DEFICIENCIES (PREPAR REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREPAR TAG PROVIDER'S PLAN OF CORRECTION (EACH OBRECTWE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OP COMPLET TAG D 273 Continued From page 2 D 273 D 273 D PRESIX D | | | HAL096049 | B. WING | | | |
| CONTRESIDE VILLAGE PIKEVILLE, NC 27863 (X4) ID PREFIX TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE REPECTED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY ONE TO CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY </td <td>NAME OF</td> <td>PROVIDER OR SUPPLIER</td> <td>STREET ADI</td> <td>DRESS, CITY, S</td> <td>STATE, ZIP CODE</td> <td></td> <td></td> | NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| CMUD SUMMARY STATEMENT OF DEFICIENCIES Deficiency (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Deficiency (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Deficiency (EACH OFFICIENCY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET TAG D 273 Continued From page 2 D 273 D 273 D 273 - Resident #3's bed was next to the door and Staff B was on the staff returned to the nurse's station, Staff B stated he was helping Resident #3 "clean up". D 273 D 273 - 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 resident 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 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. - The former staff did not know if the incident | COUNTE | | 5383 US 1 | 17 NORTH | | | |
| PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG CEACH ODERRECTIVE ACTION SHOULD BE CROSS-REFERENCEDED TO THE APPROPRIATE DEFICIENCY) CoMMENT DEFICIENCY D 273 Continued From page 2 D 273 D 273 - 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". D 273 - 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 began to have behavior changes after that incident. - The resident began to have shelling to get out. - The former staff did not know if the incident was reported to the resident's PCP. - Be did not know who was responsible for | | | PIKEVILL | E, NC 2786 | 3 | | |
| 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 became irritable and was restless. 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 | PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | D BE | COMPLETE |
| 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 #3s 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 with was responsible for | D 273 | Continued From pa | ge 2 | D 273 | | | |
| 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. | | -Resident #3's bed B was on the side of -When the staff retu Staff B stated he way up". -The staff reported a aide (MA) because not look right. -The MA reported th Registered Nurse way and Wellness Director -The area Health ar asked questions ab 19th) and the staff r -She did not know if the resident's Prima Telephone interview 08/19/20 at 4:33pm -The staff worked a June 2020. -Staff B had been c Resident #3's room situation" last month -The resident began after that incident. -The resident began after that incident. -The resident becar -The resident wanter would shake the ex get out. -The former staff di- reported to the resider -She did not know v reporting resident c Review of Resident on 08/03/20 at 2:32 administered a" printice of the staff of the resident of the test of the resident of the resident of the residen | was next to the door and Staff of the bed next to the door. Arred to the nurse's station, as helping Resident #3 "clean the incident to the medication what she had observed did the incident to the facility's who was also the area Health tor. The Wellness Director (HWD) out the incident (July 18th or repeated what she observed. If the incident was reported to ary Care Provider (PCP). With a former staff on revealed: t the facility from 2019 until aught by another staff in in an "inappropriate sexual in (July 2020). In to have behavior changes me irritable and was restless. ed to leave the facility; he it doors while attempting to d not know if the incident was dent's PCP. who was responsible for hanges to the PCP. #3's progress notes revealed pm, Resident #3 was ", he was very agitated and | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | E SURVEY PLETED |
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| | | | A. BUILDING. | | | С |
| | | HAL096049 | B. WING | | | 24/2020 |
| IAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| | YSIDE VILLAGE | | 117 NORTH LE, NC 27863 | | | |
| | | | · · · · · · | PROVIDER'S PLAN OF | | (YE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLE ⁻ DATE |
| D 273 | Continued From pa | nge 3 | D 273 | | | |
| | 04/17/20 revealed a 0.5mg, one tablet to anxiety (originally of Review of Residem administration reco 12:08pm, Clonazen disorders and anxie administered for an resident was still try Telephone interview Director (AED) on 0 - To her knowledge, involving Resident the resident's PCP - She could not say not contacted regal abuse by Staff B. - She was aware the with latent Syphilis transmitted disease - She was aware the through any sexual - She became awar allegations on 07/2 Specialist informed | t #3's medication rds revealed on 08/03/20 at bam 0.5mg (used to treat panic ety) was documented as ety) was documented as ety) was documented as exiety; with no relief, the ying to get out. w with the Assistant Executive 08/20/20 at 3:20pm revealed: the report of sexual abuse #3 had not been reported to why Resident #3's PCP was rding the allegation of sexual at Resident #3 was diagnosed which was a sexually e. e STD could be spread contact. e of the sexual abuse 1/20 when the Adult Home her, but she did not know the | | | | |
| | on 08/18/20 at 12:1 | w with the current area HWD 8pm revealed staff had not #3's alleged sexual abuse by | | | | |
| | 08/20/20 at 3:45pm -He had first attem | utive Director (ED) on | | | | |

| | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | | E SURVEY PLETED |
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| | | HAL096049 | B. WING | | | C 24/2020 |
| | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | ATE, ZIP CODE | | |
| | | 5383 US | 117 NORTH | | | |
| JUUNIF | RYSIDE VILLAGE | PIKEVILI | E, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| D 273 | Continued From pa | ge 4 | D 273 | | | |
| | however, a voice m leave a message at the resident's PCP busy doing staff ins Health Care Persor -The facility's proce HWD or for him to h PCP. -He thought he sho to contact the reside Telephone interview department's Direct 2:45pm revealed: -Resident #3 was d and received treatm -The resident's last 2017 and was chan after the treatment. -She did not know i sores currently beca the health departme -The facility should PCP of the alleged would have ordered an examination for disease was active Telephone interview 08/21/20 at 3:05pm -Because Resident dementia which had | ail was received, he did not nd did not attempt to contact again because he had been ervices and completing a nal Registry (HCPR) report. ss would have been for the nave contacted the resident's uld have made "every effort" ent's PCP. with the local health tor of Nursing on 08/21/20 at iagnosed with syphilis in 1990 nent. treatment for syphilis was in uged to latent syphilis one year f the resident had any open ause he had not been seen at ent since 2017. have informed Resident #3's sexual abuse and the PCP d a syphilis titer and perform sores to determine if the or latent. | | | | |
| | -If there were any s Resident #3, there y of an STD because latent syphilis. -The facility contact | exual activity involving was a possibility of the spread the resident had a history of red the PCP on 08/20/20 and \$3 was sexually abused by a | | | | |

| UVISION | of Health Service Re | egulation | | | | |
|--------------------------|---|---|---------------------------------|--|--------------------------------|--------------------------|
| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | СОМ | E SURVEY PLETED |
| | | HAL096049 | B. WING | | | C 24/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
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| 00000 | | PIKEVIL | LE, NC 27863 | | | 1 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC [\] | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| D 273 | Continued From pa | ge 5 | D 273 | | | |
| | staff member who i -The PCP had not r facility of allegations Resident #3 by a st -The PCP planned Monday (8/24/20) a STDs and a series syphilis. -Involuntary particip cause the resident behavior changes w not. -The facility had nor resident's behaviors -The PCP expected abuse or suspected behaviors. Refer to the telepho area HWD on 08/18 Refer to the review procedure for Abus Refer to the telepho area for Abus Refer to the telepho area HWD on 08/18 Refer to review of S signed 07/20/20. Refer to the telepho | ntentionally hid it. received notification from the s of sexual abuse involving aff before 08/20/20. to check the resident on and order testing for other of testing related to the latent bation in sexual activity would emotional distress and whether he had dementia or t reported any changes in the s. d the facility to report sexual d sexual abuse and change in one interview with the AED on a. one interview with the current 8/20 at 12:18pm of the facility's policy and | | | | |
| | 02/03/20 revealed: -Diagnoses include exertion, hypertens dyslipidemia. | ent #4's current FL-2 dated d dementia, dyspnea on ion, diabetes type 2 and constantly disoriented and | | | | |

| STATEMEN | of Health Service Re NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
|---------------|--|--|---------------------------|--|-----------------|--------------------|
| | | | A. BUILDING: | ····· | | С |
| | | HAL096049 | B. WING | | | 24/2020 |
| AME OF | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| COUNTR | RYSIDE VILLAGE | | 117 NORTH LE, NC 27863 | | | |
| (X4) ID | | | ID | PROVIDER'S PLAN OF | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | THE APPROPRIATE | COMPLET DATE |
| D 273 | Continued From pa | age 6 | D 273 | | | |
| | -The resident was a -The resident's rec special care unit (S | ommended level of care was a | | | | |
| | revealed: -The resident was in wandered through aggressive at times verbally abusive an -The resident was a significant memory -The resident requi with grooming, bath -The resident requi with eating. -The resident requi transfers and ambu Review of Resident | t #4's electronic progress 20 at 9:19am revealed the | | | | |
| | Confidential intervie revealed: -Staff B had been of Resident #4's in Re "inappropriate sexu time frame of the in 2020. -The staff was told "management" but | ew with a former staff caught by another staff in esident #4's room in an ual situation" estimating the incident was around February the incident was reported to was not sure if Resident #4's der (PCP) was notified of the | | | | |
| | -The incident occur weekend, prior to th part of the year (20 | red on 1st shift, during the he "pandemic", around the first | | | | |

| | of Health Service Re IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
|---------------|--|--|----------------|---|-----------------|--------------------|
| | | | A. BUILDING: | | | |
| | | HAL096049 | B. WING | | | C 24/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, S | TATE, ZIP CODE | | |
| | | 5383 US | 117 NORTH | | | |
| | | PIKEVILI | E, NC 27863 | | | |
| (X4) ID | | | ID | PROVIDER'S PLAN OF | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | THE APPROPRIATE | COMPLE DATE |
| D 273 | Continued From pa | age 7 | D 273 | | | |
| | was at the facility to the incident occurre | o monitor during the weekend | | | | |
| | -The staff was doin | g "rounds" with the resident /here another staff, Staff B | | | | |
| | was. | 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 Reside position in the roon | ent #4 were in a standing n. | | | | |
| | | ot have any clothes covering | | | | |
| | | e any gloves on and was | | | | |
| | | th Resident #4's "private area". hand on Resident #4's right | | | | |
| | shoulder and Staff | B's right hand was underneath | | | | |
| | the resident's testic -Staff B was movin | g his fingers, massaging | | | | |
| | | and around his "private area". ontinent wipes in Staff B's | | | | |
| | hands. | | | | | |
| | -The staff could rer was yesterday". | nember the incident "just like it | | | | |
| | -Staff B immediate | y ran to the resident's room | | | | |
| | position and stated | push the door back to a closed , "I got it" and he did not need | | | | |
| | any help. -The staff thought \$ | Staff B would have pushed | | | | |
| | "me" out with the d placement on the c | oor if it was not for hand | | | | |
| | • | not asked what was going on | | | | |
| | | nt would not have been able to what had happened, and the | | | | |
| | staff did not want to | o upset the resident. | | | | |
| | | eported immediately to a A), (could not recall the MA's | | | | |
| | name) at the time of | of the incident. | | | | |
| | -The incident was t of the incident to th | hen reported on the same day e previous HWD | | | | |

STATE FORM

PLPW11

If continuation sheet 8 of 60

| STATEMEN | of Health Service Re | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | | E SURVEY |
|--------------------------|--|---|---------------------|---|-------------|-------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | СОМ | PLETED |
| | | HAL096049 | B. WING | | | C 24/2020 |
| NAME OF F | ROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | TATE, ZIP CODE | | |
| | YSIDE VILLAGE | 5383 US | 117 NORTH | | | |
| 500111 | | PIKEVILI | E, NC 27863 | | | 1 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLET DATE |
| D 273 | Continued From pa | ge 8 | D 273 | | | |
| | -The previous HWE look into the incider | D told the staff that she would nt. | | | | |
| | revealed: -Staff B had been c Resident #4's room situation" estimating incident was around -The staff was told "management" but, | the incident was reported to was not sure if Resident #4's der (PCP) was notified of the | | | | |
| | Administrator/Exec 08/18/20 at 8:59am any allegations of s | utive Director (ED) on revealed he was not aware of exual abuse for Resident #4 g the first part of the year | | | | |
| | | ne interview with the previous at 9:23am was unsuccessful. | | | | |
| | 08/20/20 at 3:45pm -He had attempted this week, however he did not leave a r to contact the resid had been busy doir completing a Health (HCPR) report. -The facility's proce HWD or for him to I PCP. | to contact Resident #4's PCP , a voice mail was received, message and did not attempt ent's PCP again because he ng staff inservices and in Care Personal Registry ass would have been for the have contacted the resident's uld have made "every effort" | | | | |
| | Telephone interview | v with Resident #4's PCP on | | | | |
| sion of He | ealth Service Regulation | | <u>µ</u> | | | 1 |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|---|--|---------------------|--|-----------------------------------|------------------------|
| | | HAL096049 | B. WING | | | C 24/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| | | 5383 US | 117 NORTH | | | |
| | | PIKEVIL | LE, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLE DATE |
| D 273 | Continued From pa | ige 9 | D 273 | | | |
| | consent because o -He had not receive of allegations of set a staff prior to 08/2 -There were no rep Resident #4 before -The residents at the checked for sexual (STD's). -In January 2020, F increased aggressi and it was possible threatened and fee -He could not conc in behavior was relation inappropriate sexual not have been surp was related to the a | I not be able to give sexual f his dementia. ed notification from the facility xual abuse for Resident #4 by 0/20. orts of sexual abuse involving 08/20/20. he facility were not being ly transmitted diseases Resident #4 was seen for on and combative behavior it was in a response to being ling vulnerable. lude Resident #4's increases ated to the alleged al incident, however, he would prised the resident's agitation | | | | |
| | Executive Director | (AED) on 08/14/20 at 2:25pm. | | | | |
| | Refer to the review procedure for Abus | of the facility's policy and e dated 06/01/16. | | | | |
| | Refer to review of S signed 07/20/20. | Staff B's resignation letter | | | | |
| | | one interview with the n 08/18/20 at 8:59am. | | | | |
| | Refer to Tag D 338 Resident Rights | 10A NCAC 13F .0909 | | | | |
| | Telephone interview | | | | | |

| Division | of Health Service Re | equlation | | | | APPROVED |
|--------------------------|--|--|-------------------------------|---|--------------------------------|--------------------------|
| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | E SURVEY PLETED |
| | | HAL096049 | B. WING | | | C 24/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | TATE, ZIP CODE | | |
| COUNTE | RYSIDE VILLAGE | | 117 NORTH | | | |
| | | PIKEVILL | E, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| D 273 | Continued From pa | ge 10 | D 273 | | | |
| | -Staff B no longer w | 08/14/20 at 2:25pm revealed: vorked at the facility. ue to personal family issues month ago. | | | | |
| | and Wellness Direc 12:18pm revealed: -She was not aware abuse of any reside | ted any type of alleged | | | | |
| | Abuse dated 06/01/ -The residents wou including verbal, se abuse in accordance -When reporting includent: The Execu- must notify the physic corporate representing includents in the following includent includents in the includent includents in the includent includent in the includent includent includent in the includent includent includent in the includent i | ld be protected from abuse xual, physical, and mental | | | | |
| | 07/20/20 revealed e | resignation letter signed effective 07/20/20, Staff B was on as a personal care aide / reasons. | | | | |
| | 08/18/20 at 8:59am -He was not sure if notifying the PCP for resident, however, to be notified becau resident's care. -On 07/21/20, the A | utive Director (ED) on | | | | |

Division of Health Service Regulation STATE FORM

If continuation sheet 11 of 60

| | of Health Service Re | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUI TIPI F | CONSTRUCTION | (X3) DATE | E SURVEY |
|---------------|---|---|---------------------------|---|----------------|------------------|
| | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | | PLETED |
| | | | B. WING | | | С |
| | | HAL096049 | B. WING | | 08/ | 24/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| COUNTR | RYSIDE VILLAGE | | 117 NORTH LE, NC 27863 | | | |
| (X4) ID | | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL | ID | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) | | (X5) COMPLETI |
| PREFIX TAG | | SC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | DATE |
| D 273 | Continued From pa | ge 11 | D 273 | | | |
| | were provided. -On 08/13/20, the A had contacted the A and reported another received involving t of a resident. The facility's failurer sexual abuse of 2 co #4) by Staff B after staff resulted in Resident's PCP involuntary participation facility's failure results facility's failurer results and co serious physical and the resident's and co | to notify the PCP of alleged of 4 sampled residents (#3 and reported to the management sident #3 displaying emotional anxiety) and behavioral g to leave the facility) a few sexual abuse as identified by as an expected behavioral if ant in sexual activity. The ulted in increased risk for d mental harm and neglect of onstitutes a Type A2 violation. | | | | |
| | | S. 131D-34 on 08/21/20 with | | | | |
| | | TE FOR THE TYPE A2 NOT EXCEED SEPTEMBER | ł | | | |
| D 338 | 10A NCAC 13F .09 | 09 Resident Rights | D 338 | | | |
| | all residents guarar Declaration of Resi | 09 Resident Rights shall assure that the rights of nteed under G.S. 131D-21, dents' Rights, are maintained sed without hindrance. | | | | |
| | This Rule is not me TYPE A1 VIOLATIO | | | | | |

Division of Health Service Regulation STATE FORM

If continuation sheet 12 of 60

| | Health Service Re | | | CONSTRUCTION | (X3) DATE SURVEY | |
|---------------|---|---|-----------------|---|------------------|------------------|
| | CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | |
| | | | | | | С |
| | | HAL096049 | B. WING | | | 24/2020 |
| NAME OF PRC | VIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| COUNTRYS | | 5383 US | 117 NORTH | | | |
| COUNTRYS | | PIKEVIL | LE, NC 27863 | | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI | | (X5) COMPLETE |
| PREFIX TAG | ` | SC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO T | HE APPROPRIATE | DATE |
| | | | | DEFICIENC | Y) | |
| D 338 C | ontinued From pa | ge 12 | D 338 | | | |
| | | | | | | |
| B | ased on interview | s, observations, and record | | | | |
| re | eviews, the facility | failed to ensure 2 of 2 | | | | |
| | | were free from sexual abuse | | | | |
| | | ember (Staff B) who allegedly | | | | |
| | | o residents diagnosed with | | | | |
| | dementia in a special care unit (#3, #4); and were free of neglect by not following the | | | | | |
| | | and guidance issued by the | | | | |
| | Centers for Disease Control (CDC), North | | | | | |
| | Carolina Division of Health and Human Services | | | | | |
| | | to communal dining, | | | | |
| | reminding and assisting residents in a special | | | | | |
| Ca | are unit to social d | listance and wear facial | | | | |
| | | e global pandemic of | | | | |
| C | OVID-19. | | | | | |
| Т | he findings are: | | | | | |
| 1. | . Review of the fac | cility's policy and procedure for | | | | |
| | buse dated 06/01/ | | | | | |
| -T | The residents wou | ld be protected from abuse | | | | |
| | | xual, physical, and mental | | | | |
| | buse in accordanc | | | | | |
| | | as the willful infliction of | | | | |
| | | e confinement, intimidation, or sulting physical harm, pain or | | | | |
| | iental anguish. | sutting physical flatfit, pair of | | | | |
| | | defined but not limited to | | | | |
| | | , sexual coercion and sexual | | | | |
| | ssault. | | | | | |
| | | d all personnel to immediately | | | | |
| | | esident abuse or suspected | | | | |
| | | glect or misappropriation of | | | | |
| | | y filling out an incident report | | | | |
| | | the nurse coordinator. | | | | |
| | | cidents of abuse or suspected g must be notified of the | | | | |
| | | utive Director (ED), and he/she | | | | |
| | | sician, power of attorney, | | | | |
| | th Service Regulation | | I | | | |

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
|---------------|--|---|-------------------------|--|----------------|--------------------|
| | | | A. BUILDING: B. WING | | | |
| | | HAL096049 | | | | C 08/24/2020 |
| IAME OF PI | ROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | TATE, ZIP CODE | | |
| | SIDE VILLAGE | | 117 NORTH | | | |
| | | PIKEVILI | E, NC 27863 | | | |
| (X4) ID | | | ID | PROVIDER'S PLAN OF | | (X5) COMPLET |
| PREFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | DATE |
| D 338 | Continued From pa | ge 13 | D 338 | | | |
| | corporate represen | tative and another named | | | | |
| | | iate within 24 hours. | | | | |
| | | gation would be performed. | | | | |
| | | in the allegation process would | | | | |
| | | pended without pay from work | | | | |
| | 0 | on process was completed and | | | | |
| | a decision was made. | | | | | |
| | -Authorities on the matter may be called in to help with such investigations. | | | | | |
| | | | | | | |
| | | nd to have abused or | | | | |
| | neglected a resident or misappropriated a residents' funds or property would be terminated | | | | | |
| | with no eligibility for | | | | | |
| | | also be reported to all | | | | |
| | | es in accordance with the law, | | | | |
| | | sary the Department of Health | | | | |
| | and any appropriate | | | | | |
| | -This information w | ould also be related to any | | | | |
| | | ng references in the future. | | | | |
| | | of Health Abuse Registry" | | | | |
| | | nytime the ED "concludes" or | | | | |
| | | such suspicion was never | | | | |
| | | or substantiated) that a | | | | |
| | | physically harmed as a result | | | | |
| | of an employee's al | ouse or neglect. | | | | |
| | Telenhone interview | v with the Adult Home | | | | |
| | • | th the local department of | | | | |
| | |)8/13/20 at 4:34pm revealed: | | | | |
| | | made a visit to the facility and | | | | |
| | | ant Executive Director (AED). | | | | |
| | | e AED on $07/21/20$, if she had | | | | |
| | | s or concerns of a staff and a | | | | |
| | | esident abuse, being "sexually | / | | | |
| | inappropriate" or ar | ny issues of that nature. | | | | |
| | | ny knowledge or of being | | | | |
| | notified of any incid | ences or allegations of sexual | | | | |
| | abuse. | | | | | |
| | | rovide her with any follow-up | | | | |
| | information of hour | or what she would do after | | | | 1 |

| Division of Health Service Re | egulation | | | FORM | APPROVED |
|---|--|---------------------|--|-----------------|--------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
| | HAL096049 | B. WING | | C 08/24/2020 | |
| NAME OF PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
| | 5383 US ⁻ | 117 NORTH | | | |
| COUNTRYSIDE VILLAGE | PIKEVILL | E, NC 27863 | | | |
| PRÉFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| D 338 Continued From pa | ge 14 | D 338 | | | |
| The next contact s telephone on 08/13 complaint she had the She asked the AEI resident (only the fill complaint allegation 08/12/20). The AED told her the residing at the facility AED had worked at name. She asked the AEI allegations of Staff with residents. The AED denied a notified of any incid facility and had resident on 08/13/20 at 4:08. Staff were response of resident abuse to staff receiving any should complete an Telephone interview 2:25pm revealed: She had not been allegations involving. The AHS made a vand on that date, the a complaint made resident. She informed the AHS question resident. | D if the facility had a named rst name was provided in a in received by the county on here had not been a resident ty, past nor present since the the facility with that first D if she had received any B being sexually inappropriate ny knowledge or of being ent, allegations or reports. Staff B was no longer with the gned due to personal reasons | | | | |

| IVISION OF HEALTH SERVICE F TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | E SURVEY PLETED | |
|--|--|-------------------------------|--|-----------------------------------|-------------------------|--|
| | HAL096049 | B. WING | | | C 08/24/2020 | |
| AME OF PROVIDER OR SUPPLIEF | R STREET A | DDRESS, CITY, ST | ATE, ZIP CODE | | | |
| | 5383 US | 117 NORTH | | | | |
| | PIKEVIL | LE, NC 27863 | | | | |
| PREFIX (EACH DEFICIENC | ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| D 338 Continued From p | age 15 | D 338 | | | | |
| -She immediately Administrator/Exe 07/21/20 and prov given to her by the abuse allegation w -The Administrato any directives con allegation with a s -She had spoken (08/13/20) and wa been received wh thing" in resident r allegations). -The AHS questio named (first name -She informed the resident with that -The AHS questio staff employed at she had one male -The AHS asked h (first name given w Staff B). -She informed the worked at the faci B had resigned du AHS asked her wh the facility. -She notified the A (08/13/20) and pro given to her by the -She had only spo yesterday (08/13/2) staff if there had b abuse. | cutive Director (ED) on rided him with the information a AHS involving the sexual with a staff and a resident. r/ED did not provide her with cerning the sexual abuse taff and a resident. to the AHS yesterday morning is told another complaint had ich was "basically the same ights (sexual abuse med her if she had a resident e given). AHS she had never had a first name. ned her if she had any male the facility and she told the AHS staff. her if she had a staff member which was same first name as AHS that Staff B no longer lity and informed her that Staff the to family reasons after the hy Staff B no longer worked at administrator/ED yesterday povided him with the information a AHS. ken with staff working 20) and had questioned those een any reports of resident | | | | | |

| Division | of Health Service Re | gulation | | | | |
|---------------|---|---|---------------------------------|--|-----------------|--------------------|
| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | | E SURVEY PLETED |
| | | HAL096049 | B. WING | | C 08/24/2020 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, S | TATE, ZIP CODE | | |
| | | 5383 US | 117 NORTH | | | |
| COUNTR | | PIKEVILI | LE, NC 27863 | | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | THE APPROPRIATE | COMPLETE DATE |
| D 338 | Continued From pa | ge 16 | D 338 | | | |
| | neglect of the resid | ents. | | | | |
| | | any issues or concerns of | | | | |
| | abuse or neglect to | the area Health and Wellness | ; | | | |
| | Director (HWD), A | ED or the Administrator/ED. | | | | |
| | Telephone interviev | v 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. | the area HWD. | | | | |
| | -She was at the fac | ility as needed but was there | | | | |
| | least 2-3 times per | | | | | |
| | | MA were the point of contact | | | | |
| | for staff related to r | | | | | |
| | -She had not received any reports of any types of | | | | | |
| | | n staff in July 2020 from | | | | |
| | anyone. | aived any reports of any types | | | | |
| | | eived any reports of any types Staff B from family, staff or | | | | |
| | | as employed at the facility. | | | | |
| | Telephone interviev 08/18/20 at 8:59am | v with the Administrator/ED on | | | | |
| | | notified of any resident right | | | | |
| | | was in the building or not. | | | | |
| | | ssues with resident rights | | | | |
| | | the named staff would be | | | | |
| | removed from the o | community while the incident | | | | |
| | was being investiga | | | | | |
| | | to immediately report any | | | | |
| | | e issues to the supervisor | | | | |
| | | ho would report to the | | | | |
| | | HWD), then the department | | | | |
| | him and an investig | report it to the AED and to | | | | |
| | | ED reported to him the AHS | | | | |
| | | plaint of possible sexual | | | | |
| | | on 07/21/20 and no names | | | | |
| | were provided. | | | | | |
| | | ED reported to him the AHS | | | | |
| | | AED by telephone on 08/13/20 | | | | |

| Division | of Health Service Re | aulation | | | FORM | APPROVED |
|--------------------------|---|--|---------------------|---|--------------------------------|--------------------------|
| STATEMEN | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
| | | HAL096049 | B. WING | B. WING | | C 24/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, S | TATE, ZIP CODE | | |
| COUNT | | 5383 US | 117 NORTH | | | |
| COUNT | RYSIDE VILLAGE | PIKEVILL | E, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| D 338 | Continued From pa | ge 17 | D 338 | | | |
| | | er complaint had been he same possible sexual | | | | |
| | 08/17/20 revealed: -Diagnoses include disturbances, latent -The resident was of ambulatory, and co | ent #3's current FL-2 dated d dementia with behavior t syphilis, and alcohol abuse. constantly disoriented, ntinent of bowel and bladder. rent level of care was "locked | | | | |
| | revealed: -The resident ambu -The resident's bow normal. -The resident was a | #3's care plan dated 12/16/19 Ilated with no problems. vel and bladder functions were always disoriented and had loss and must be directed. | | | | |
| | revealed: -On July 18th or 19 first shift and took a room, at the end of -When the staff ope door, the staff obse -Resident #3 was a | terview on 08/17/20 at 4:11pm th, 2020 the staff was working a resident's items back to his the hall. ened the resident's bedroom rved Staff B in the room. wake and lying on his back in rers partially pulled off | | | | |
| | exposing his "privat -Staff B was on his bed, with his head of body. -Staff B's head was exposed penis. -The staff was "sho Staff B "what are yo -Staff B jumped up | te parts", including his penis. knees next to the resident's over the resident's exposed close to the resident's cked" and immediately asked | | | | |

Division of Health Service Regulation STATE FORM

| | of Health Service Re T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO | | | E SURVEY PLETED |
|--------------------------|--|---|---------------------|--|--------------------------------|-------------------------|
| IND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | | |
| | | HAL096049 | B. WING | | C 08/24/2020 | |
| AME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STAT | E, ZIP CODE | | |
| | YSIDE VILLAGE | | 117 NORTH | | | |
| | | PIKEVIL | LE, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLET DATE |
| D 338 | Continued From pa | ige 18 | D 338 | | | |
| | room. -The staff observed | I that Staff B did not have on | | | | |
| | | was next to the door and Staff | - | | | |
| | | of the bed next to the door. urned to the nurse's station, | | | | |
| | Staff B stated he was helping Resident #3 "clean up. | | | | | |
| | | ontinent of bladder and ver required staff to assist with | | | | |
| | incontinent care. He | e used the bathroom | | | | |
| | independently and bathed independently and only required prompting to remind him to | | | | | |
| | shower/bathe. -The staff did not si | mell urine or feces when she | | | | |
| | entered Resident # | 3's room. the incident to the medication | | | | |
| | | what she had observed did | | | | |
| | -She had worked w | ith Staff B and she had never | | | | |
| | observed him or an care in that position | iy other staff providing resident n. | t | | | |
| | | he incident to the facility's no was the area Health and | | | | |
| | Wellness Director (| HWD). | | | | |
| | incident and the sta | ked questions about the iff repeated what she | | | | |
| | | caught doing something" to | | | | |
| | | this year (2020) by another who reported to this staff and | | | | |
| | management. | | | | | |
| | became upset and | cribed what she saw and teary. | | | | |
| | Telephone interviev 08/19/20 at 4:33pm | v with a former staff on revealed: | | | | |
| | -Staff B had been c | aught by another staff in | | | | |
| | situation" last mont | i in an "inappropriate sexual h (July 2020). | | | | |

| | of Health Service Re NT OF DEFICIENCIES | | | | | |
|---------------|--|---|----------------|--|----------------|--------------------|
| | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING: | | | E SURVEY PLETED |
| | | HAL096049 | B. WING | | | C 24/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
| COUNT | | 5383 US | 117 NORTH | | | |
| COUNTR | | PIKEVILL | E, NC 27863 | | | |
| (X4) ID | | | ID | PROVIDER'S PLAN OF | | (X5) |
| PREFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | COMPLETE DATE |
| D 338 | Continued From pa | ge 19 | D 338 | | | |
| | -The resident bega | n to have behavior changes | | | | |
| | after the alleged inc | | | | | |
| | | me irritable and was restless. | | | | |
| | | d to leave the facility; he would | | | | |
| | shake the exit door | s while attempting to get out. | | | | |
| | Telephone interview with Resident #3's family on | | | | | |
| | 08/20/20 at 1:50pm | | | | | |
| | | lved in Resident #3's care, | | | | |
| | 0 | e) and expected the facility to | | | | |
| | | inform her of any problems or changes involving | | | | |
| | the resident. | 10 mandancia, alta visitad | | | | |
| | | -19 pandemic, she visited t one time a week and she | | | | |
| | | medical appointments and | | | | |
| | | edication from an outside | | | | |
| | pharmacy. | | | | | |
| | | alk to the staff and Resident | | | | |
| | | ay via video call since the | | | | |
| | - | never been informed by the | | | | |
| | resident. | ns or incidents involving the | | | | |
| | | equired "standby" assistance | | | | |
| | | (showers and bathes) and | | | | |
| | | independently. He was | | | | |
| | continent of bowel a | | | | | |
| | | asy to get along with but had | | | | |
| | | ented. He flirted with the | | | | |
| | female staff at time | 5. | | | | |
| | Telephone interview | v with Resident #3's Primary | | | | |
| | | P) on 08/21/20 at 3:05pm | | | | |
| | revealed: | · · | | | | |
| | | #3 had a diagnosis of | | | | |
| | | d advanced, he was not able | | | | |
| | | ons, including consent for | | | | |
| | sexual activity. | exual activity involving | | | | |
| | | was a possibility of the spread | | | | |
| | | nitted disease (STD) because | | | | |
| vision of H | lealth Service Regulation | | μ | | | |

| STATEME | of Health Service Re | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | | |
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| and plan | N OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COM | PLETED |
| | | HAL096049 | B. WING | | | C 24/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | TATE, ZIP CODE | | |
| COUNT | RYSIDE VILLAGE | | 17 NORTH | | | |
| | 1 | | E, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC) | ON SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| D 338 | Continued From pa | ge 20 | D 338 | | | |
| | -The facility contact reported Resident # staff member last m intentionally hid it. -The PCP planned Monday (8/24/20) a STDs and a series syphilis. -Involuntary particip cause the resident | history of latent syphilis. red the PCP on 08/20/20 and 43 was sexually abused by a honth (July 2020) who to check the resident on nd order testing for other of testing related to the latent pation in sexual activity would emotional distress and whether he had dementia or | | | | |
| | 02/03/20 revealed: -Diagnoses include exertion, hypertens dyslipidemia. -The resident was of wandered -The resident was a | ommended level of care was a | | | | |
| | revealed: -The resident was r wandered througho aggressive at times verbally abusive an -The resident was a significant memory -The resident require with grooming, bath -The resident require with eating. | #4's care plan dated 01/27/20 eceiving hospice services, ut the facility and became , could be both physically and d redirection was effective. always disoriented and had loss requiring direction. red extensive staff assistance ing, dressing and toileting. red limited staff assistance red staff supervision with lation. | | | | |

| Division | of Health Service Re | aulation | | | FORM | APPROVED |
|--------------------------|---|--|------------------------------|--|-----------|--------------------------|
| STATEME | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | LETED |
| | | HAL096049 | B. WING | | (08/2 | , 4/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| COUNT | RYSIDE VILLAGE | | 17 NORTH | | | |
| | | | E, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| D 338 | Continued From pa | ge 21 | D 338 | | | |
| | Confidential staff im -The incident occur weekend, prior to th part of the year (202 -The previous Healt (HWD) was at the f weekend the incide -The staff was doing and did not know w was. -The staff observed the door closed in tt -The windows and R opened position. -Staff B and Reside position in the room -Resident #4 did not the bottom portion of -Staff B did not hav "fooling around" wit -Staff B had his left shoulder and Staff I the resident's "priva -Staff B was moving Resident #4 behind -There were no inco hands. -The staff could ren was yesterday". -Staff B immediatel door attempting to p position and stated, any help. -The staff thought S "me" out with the do placement on the d -Resident #4 was n because the resident | terview revealed: red on 1st shift, during the ne "pandemic", around the first 20). th and Wellness Director acility to monitor during the nt occurred. g "rounds" with the residents here another staff, Staff B Staff B with Resident #4 with he resident's room. olind in the room were in an ant #4 were in a standing thave any clothes covering of his body. e any gloves on and was h Resident #4's "private area". hand on Resident #4's right B's right hand was underneath the area." g his fingers, massaging and around his "private area". ontinent wipes in Staff B's nember the incident "just like it y ran to the resident's room oush the door back to a closed "I got it" and he did not need Staff B would have pushed oor if it was not for hand oor and strength. ot asked what was going on nt would not have been able to what had happened, and the | | | | |

| | of Health Service Re TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | E SURVEY PLETED |
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| | 0. 00 | | A. BUILDING: | | | |
| | | HAL096049 | 049 B. WING | | C 08/24/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| | NYSIDE VILLAGE | | 117 NORTH | | | |
| | | | LE, NC 27863 | | 0000000000 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLE DATE |
| D 338 | Continued From pa | ige 22 | D 338 | | | |
| | -The incident was r medication aide (M name) at the time of -The staff reported (of the incident) to t -The previous HWE look into the incident Confidential intervie Staff B had been ca Resident #4's room situation" estimation incident was around Review of Resident notes dated 04/27/2 resident had expire Telephone interview (PCA) on 08/14/20 #4 needed staff sup admitted to the faci dementia progress staff assistance the Telephone interview 1:55pm revealed: -Resident #4 liked to lot. -Resident #4 was a his needs changed staff "earlier in year remember exactly of | eported immediately to a A), (could not recall the MA's of the incident. the incident on the same day the previous HWD. D told the staff that she would nt. ew with a former staff revealed aught by another staff in a in an "inappropriate sexual g the time frame of the d February 2020. t #4's electronic progress 20 at 9:19am revealed the | | | | |
| | Telephone interview 08/18/20 at 8:59am | of any allegation of sexual | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING: _ | CONSTRUCTION | | E SURVEY PLETED C |
|---|--|---|---------------------------|--|--------------------------------|-------------------------|
| | | HAL096049 | B. WING | | 08/24/2020 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | ATE, ZIP CODE | | |
| COUNTR | SYSIDE VILLAGE | | 117 NORTH _E, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ON SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| D 338 | reported for Reside resident his manag handled it by invest -He expected to be issues whether he w -When there were i physical or sexual, removed from the of was being investiga -He expected staff resident right abuse (Supervisor in charg report to the depart department head (H Assistant Executive and an investigation -On 07/21/20, the A had received a com abuse of a resident were provided. -On 08/13/20, the A had contacted the A and reported another received involving t abuse of a resident Telephone interview 2:25pm revealed sh | allegations of sexual abuse nt #4 and another named ement team would have igating the allegations. notified of any resident right was in the building or not. ssues with resident rights the named staff would be community while the incident ated. to immediately report any e issues to the supervisor ge (SIC)/MA), who would ment head (HWD), then the HWD) would report it to the e Director (AED) and to him n initiated. ED reported to him the AHS aplaint of possible sexual on 07/21/20 and no names AED reported to him the AHS AED by telephone on 08/13/20 er complaint had been he same possible sexual | D 338 | | | |
| | Wellness Director (12:18pm revealed s reports of any types | with the area Health and HWD) on 08/18/20 at she had not received any s of abuse related to Staff B anything when he was sility. | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | E SURVEY PLETED |
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| | | HAL096049 | B. WING | | C 08/24/2020 | |
| | PROVIDER OR SUPPLIER | | DDRESS, CITY, S | | 00/ | 24/2020 |
| | | | 117 NORTH | TATE, ZIF CODE | | |
| COUNTR | | | LE, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLE ⁻ DATE |
| D 338 | Continued From pa | ige 24 | D 338 | | | |
| | 08/21/20 at 3:20pm -Resident #4 would consent because of -He had not receive of allegations of se a staff prior to 08/2 -There were no rep involving Resident Attempted telephor on 08/20/20 at 9:25 Attempted telephor HWD on 08/20/20 at 9:25 Attempted telephor HWD on 08/20/20 at 9:25 2. Review of the C Memory Care Units revealed: -Routines are very dementia. Try to ke routines as consist reminding and assi hygiene, social dist coverings (if tolerat -Cloth face coverin anyone who has tro unconscious, incap to remove the mas -Limit the number of at least 6 feet apart a common area, ar who are ambulator other residents or p | a revealed: a not be able to give sexual f his dementia. ad notification from the facility xual abuse for Resident #4 by 0/20. borts of sexually abuse #4 before 08/20/20. be interview with with Staff B form was unsuccessful. be interview with the previous at 9:23am was unsuccessful. DC Considerations for a in Long-term Care Facilities important for residents with the pheir environment and ent as possible while still sting with frequent hand ancing, and use of cloth face ed). gs should not be used for puble breathing, or is racitated, or otherwise unable k without assistance. of residents or space residents at as much as feasible when in and gently redirect residents y and are in close proximity to personnel. ty's undated Active Screening D-19 policy revealed: | | | | |
| | activities. -Communal activity | participate in communal programs had been tified or advised by the Center | | | | |

| STATEMEN | of Health Service Re IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | 0. 001 | | A. BUILDING: | | | |
| | | HAL096049 | B. WING | | C 08/24/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, S | TATE, ZIP CODE | | |
| | | 5383 US | 117 NORTH | | | |
| JOUNTR | | PIKEVILI | LE, NC 27863 | | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF | | (X5) |
| PREFIX TAG | | ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | COMPLETI DATE |
| D 338 | Continued From pa | ge 25 | D 338 | | | |
| | Health and Human Department of Heal -Residents received rooms. -Residents received notified or advised I Department of Heal a. Observations ma of the facility on 08/ 10:55am revealed: -At 9:47am, there w | d enrichment activities in their d meals in their rooms until by the CDC, DHHS or the NC lth. de intermittently in the hallway 13/20 between 9:47am - vas one female resident sitting | , | | | |
| | sitting in a wheelcha facility. -The two female res covering. -There was one sta the two female resid from the common li -Staff were not obso female residents to | eside another female resident air in the front hallway of the sidents did not have a face ff observed in direct view of dents, walking back and forth ving room and nurse's station. erved redirecting the two social distance or to wear | | | | |
| | female residents set residents sat directl -The three residents coverings. -Residents were ob up and down the ha -Staff were not obset | ront hall there were three eated in this area, the ly beside each other. s were not wearing facial served intermittently walking allway with no facial coverings. erved redirecting any of the distance or to wear a facial | | | | |
| | living room of the fa 10:13am-10:56am | e intermittently of the common acility on 08/13/20 between revealed: e cushioned couches in the | | | | |

| STATE DEVENOP CORRECTION (M) PROVIDERS UPPLIERCAL P2 MALTIFLE CONSTRUCTION (P2 | Division | of Health Service Re | egulation | | | FORM | APPROVED |
|--|--------------|---|---|----------------|---|-------|----------|
| HAL096049 B. WING | STATEMEN | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | COMP | LETED |
| B383 US 117 DORTH PRECIS. V(I) D PRECIS. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG D PRECIS. D PRECIS. PROVIDER'S PLAN OF CORRECTION ACTION AND/LD BE CONSERFERENCE ACTION WITH NO FACE ACTION AND/LD BE CONSERFERENCE ACTION ACTION AND/LD BE CONSERFERENCE ACTION ACTION ACTION AND/LD BE CONSERFERENCE ACTION ACTION ACTION AND/LD BE ACTIONAL ACTION AND/LD BE ACTIONAL ACTIONAL ACTIONAL ACTIONAL ACTIONAL ACTIONAL ACTIONAL ACTIONAL ACTIONAL ACTIONAL ACTIONAL ACTIONAL ACTIONAL ACTIONAL ACTIONAL ACTIO | | | HAL096049 | B. WING | | | |
| COUNTRYSIDE VILLAGE PIKEVILLE, NC 27863 (xq) D PREFIX TXG SUMMARY STATEMENT OF DEFICIENCIES (EXC) DEFICIENCY ON USE DEPRECEEDED BY FULL RESOLUTIONY ON USE DEPRIFITIYING INFORMATION) D PREFIX TXG D ROVIDERS PLAN OF CORRECTION (EXC) DEFICIENCY) Construction (EXC) DEFICIENCY) D 338 Continued From page 26 D 338 D -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 10:26am, 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 sat directly beside another female resident walked toward a resident and sat directly beside another female resident walked toward a resident and sat directly beside another female resident walked toward a resident and sat directly beside a resident sitting in a wheelchair. -At 10:56am, a female resident walked toward a resident, pating the resident sitting in the wheelchair. -At 10:56am, a personal care aide (PCA) walked down the halway, glanced in the common living room and did not redirect the resident that continued pating the resident's leg while leaning forward near the resident sitting in the wheelchair. -At 10:55am, a personal care aide (PCA) walked dinto the doorwary of the common living room and walked back out with a resident. -At 10:55am, a personal care aide (PCA) walked dinto the doorwary of the common living room and did not redirect the resident that had positioned herself close to the resident that had positioned herself close to the resident the wheelchair. Interview with a PCA on 08/13/20 at 10:18am revea | NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
| PIREVILLE, NO PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) COMPLET DEFICIENCY D 338 Continued From page 26 D 338 D 338 D 338 - 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. D 338 D 338 - At 10:42am, 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 seated in the common living room. D 338 At 10:40am, a female resident seated in the common living room. - At 10:40am, a female resident seated in the common living room. - At 10:40am, a female resident seated in the common living room. - At 10:50am, a female resident seated in the common living room. - At 10:50am, a female resident seated in the common living room. - At 10:50am, a female resident seated in the common living room. - At 10:50am, a personal care ade (MA) walked down the hallway, glanced in the common living room and did not redirect the resident that continued pating the resident's leg while leaning forward near the resident setting in the wheelchair. - At 10:59am, a personal care ade (PCA) walked into the doorway of the common living room and walked back out with a resident to the wheelchair. - There were facial coverings available for staff to - There were facial covering because the residents to wear a facial covering because the residents were in a sp | COUNTE | RYSIDE VILLAGE | | | | | |
| Preferix TAG (EACH DEPRICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 26 D 338 D 338 Continued From page 26 D 338 D 338 D 34 - There were 8 residents stiting in the living room with no face coverings. - At 10:13am, there were two residents stiting on a 3 cushioned couch approximately 2 ft from each other. D 338 D 34 - Staff were not observed redirecting any of the residents to social distance or to wear facial coverings. - At 10:40am, a female resident sat directly beside another female resident at directly beside another female resident at directly beside another female resident stiting face coverings. - At 10:40am, a female resident stiting in a wheelchair. - A female 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 pating the resident's leg while leaning forward near the resident stiting 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 were in a special care unit (SCU). There were facial covering savailable for staff to | 00000 | | PIKEVILL | E, NC 27863 | | | |
| There were 8 residents sitting in the living room with no face coverings. At 10:13am, there were two residents sitting on a 3 c ushioned 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 residents to sected not the three cushioned couch. At 10:40am, there mine residents seated in the common living room. The residents were not seated six feet apart. 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 and sat directly beside a resident sitting in a wheelchair. A female resident leaned over toward the other resident pating the resident on the leg. At 10:55am, a medication aide (MA) walked down the hallway, glanced in the common living room and did not redirect the resident. At forsign a personal care aide (PCA) walked into the dorward opating the resident. The PCA did not redirect the female resident that had positioned herself close to the resident in the wheelchair. The PCA did not redirect the resident time wheelchair. The PCA did not redirect the resident time wheelchair. There were facial coverings available for staff to | PRÉFIX | (EACH DEFICIENC) | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC | LD BE | COMPLETE |
| 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 stat directly beside couch. At 10:48am, there nine residents setted in the common living room. The residents were not seated six feet apart. The residents were not seated six feet apart. The residents were not wearing face coverings. At 10:58am, a female resident walked toward a resident and at directly beside a resident and set directly beside a resident and set directly beside a resident sitting in a wheelchair. At 10:58am, a medication aide (MA) walked doward a resident, patting the resident in the common living room and did not redirect the resident that continued patting the resident in the common living room and did not redirect the resident that continued patting the resident. At 10:58am, 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 in the wheelchair. The PCA did not redirect the 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 were in a special care unit (SCU). There were facial coverings available for staff to | D 338 | Continued From pa | ge 26 | D 338 | | | |
| Division of Health Service Regulation | ivision of H | with no face coverin -At 10:13am, there 3 cushioned couch other. -Staff were not obso residents to social of coverings. -At 10:28am, there by side on the three -At 10:40am, a fem another female resi couch. -At 10:48am, there common living roor -The residents were -At 10:56am, a fem resident and sat dir in a wheelchair. -A female resident I resident, patting the -At 10:58am, a mee down the hallway, g room and did not re continued patting th forward near the re -At 10:59am, a pers into the doorway of walked back out wir -The PCA did not re had positioned hers wheelchair. | ngs. were two residents sitting on a approximately 2 ft from each erved redirecting any of the distance or to wear facial were 3 residents sitting side e cushioned couch. ale resident sat directly beside dent on the three cushioned nine residents seated in the n. e not seated six feet apart. e not seated six feet apart. e not seated six feet apart. e not wearing face coverings. ale resident walked toward a ectly beside a resident sitting eaned over toward the other e resident on the leg. dication aide (MA) walked planced in the common living edirect the resident that ne resident's leg while leaning sident sitting in the wheelchair. sonal care aide (PCA) walked the common living room and th a resident. edirect the female resident that self close to the resident in the A on 08/13/20 at 10:18am ct the residents to wear a ause the residents were in a CU). | | | | |

| TATEMENT OF I | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | CONSTRUCTION | | E SURVEY PLETED |
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| | | | A. BUILDING: | | | |
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| AME OF PROVI | DER OR SUPPLIER | STREET AI | DDRESS, CITY, S | TATE, ZIP CODE | | |
| OUNTRYSID | E VILLAGE | | 117 NORTH | | | |
| | | | LE, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLE ⁻ DATE |
| D 338 Con | tinued From pa | ige 27 | D 338 | | | |
| -Not the -She wate Exe the ence main wea not Inte reve -Res cove -Res plac -Res plac -Res spac -Res -Res spac -Res -Res -Res spac -Res -Res spac -Res -Res -Res spac -Res -Res -Res -Res -Res -Res -Res -Res | pandemic. e had received ched videos pro- cutive Director pandemic bega ouraging and re- ntain 6ft distand in their room. rview with a MA ealed: sidents were no erings because sidents were no erings because sidents became sidents became en transported to facility. sidents who sha ced on them. sidents wore re- en transported to facility. sidents who sha ced six feet apa ly one resident ch at a time and e common living ff tried to redire rt. e had complete 0 and August 20 rview with a sec 21am and 10:37 vas hard to soci n each other. off would redirected. | ents had left the facility since infection control training and ovided by the Assistant (AED) a few months ago after in which included assisting, edirecting the residents to sing from one another and to gs when the residents were A on 08/13/20 at 10:29am of required to wear face of their diagnosis of dementia e combative when masks were their face coverings. quired to wear face coverings of the hospital or when they left ared a room had their beds art. was allowed to sit on the d staff monitored the bench. g area seated eight residents. ect residents to remain six feet d a COVID-19 training in July 020. cond PCA on 08/13/20 at | | | | |

STATE FORM

PLPW11

If continuation sheet 28 of 60

| T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | | | | |
|--|---|---|--|---|---|
| AND PLAN OF CORRECTION | | | | | E SURVEY PLETED |
| | HAL096049 | B. WING | | C 08/24/2020 | |
| ROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | TATE, ZIP CODE | | |
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| TSIDE VILLAGE | PIKEVILI | E, NC 27863 | | | |
| (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| Continued From page | ge 28 | D 338 | | | |
| the hallway, she had hallway to keep the however, one of the and sat next to the of Interview with the Le 08/13/20 at 10:57ar -The staff provided residents. -She did not know if to wear facial cover -Residents wore fac an elevated tempera -She tried to keep th it was hard because | d spaced the furniture in the two female residents apart, e ladies moved the furniture other female resident. ead Medication Aide on n revealed: facial coverings to the f the residents were required ings. cial coverings when they had ature of 99.4 or higher. he residents six feet apart, but e residents became agitated. | | | | |
| at 3:39pm revealed -Residents would no on. -The residents at th facial coverings, how to encourage the re -She encouraged re coverings. -She last encourage facial coverings on -She had completed infection control and residents 6ft apart a wear facial covering Telephone interview 08/13/20 at 4:08pm -She encouraged re coverings, but they | : ot keep their facial coverings e facility did not like to wear wever, staff were responsible sidents to wear them. esidents to wear their facial ed residents to wear their 08/11/20. d training on COVID-19 d was told to keep the and encourage residents to gs. / with a second MA on revealed: esidents to wear facial took their facial coverings off. | | | | |
| | YSIDE VILLAGE SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa -Prior to the female the hallway, she hav hallway to keep the however, one of the and sat next to the of Interview with the Lu 08/13/20 at 10:57ar -The staff provided residents. -She did not know if to wear facial cover -Residents wore fac an elevated temper -She tried to keep the it was hard because -She had completed infection control. Telephone interview at 3:39pm revealed -Residents would no on. -The residents at the facial coverings, ho to encourage the re -She last encourage facial coverings on -She had completed infection control and residents 6ft apart a wear facial covering Telephone interview 08/13/20 at 4:08pm -She encouraged re coverings, but they | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 -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 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 their facial coverings on 08/11/20. -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 off apart and encourage residents to wear facial coverings. -She last encouraged residents to wear their facial coverings. -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. | SUBE VILLAGE Summary statement of DEFICENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 28 D 338 -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. D 338 Interview with the Lead Medication Aide on 08/13/20 at 10:57 am revealed: -The staff provided facial coverings to the residents. -She did not know if the residents were required to wear facial coverings when they had an elevated temperature of 99.4 or higher. -She tried to keep the residents became agitated. -She tried to keep the residents became agitated. -She had completed some training on COVID-19 infection control. -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 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 of ta part and encourage residents to wear facial coverings. -She had completed training on COVID-19 infection control and was told to keep the residents off apart and encourage residents to wear facial coverings. -She had completed training on COVID-19 infection control and was told to keep the residents off apart | SUBE VILLAGE Status Status North PICKULLE, NC 27863 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) Image: Deficiency MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) D 338 Continued From page 28 D 338 -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 residents apart, however, one of the ladies moved the furniture and sat next to the other female residents. D 338 Interview with the Lead Medication Aide on 08/13/20 at 10:57 am revealed: -The staff provided facial coverings to the residents. -The staff provided facial coverings to the residents. -She did not know if the residents were required to wear facial coverings. -She did not know if the residents were required to wear facial coverings. -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 to wear their facial coverings. -She had completed some training on COVID-19 infection control and was told to keep the residents to wear their facial coverings. -She had completed training on COVID-19 infection control and was told to keep the residents fit apart and encourage residents to wear facial coverings. -She had coverings. -She had completed training on COVID-19 infection control and was | SUBJE VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EQC) DEFICIENCY MUST BE PRECEDED BY FULL PRECULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE A OTO SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 28 D 338 D 338 -Prior to the female residents sitting together in the hallway to keep the two female resident sapart, however, one of the ladies moved the furniture and sat next to the other female resident. D 338 Interview with the Lead Medication Aide on 08/13/20 at 10:57am revealed: -The staff provided facial coverings to the residents. D 338 -She did not know if the residents were required to wear facial coverings. Not high the second staff the apart, but it was hard because residents were required to wear facial coverings. -She trid to keep the resident six feet apart, but it was hard because residents some training on COVID-19 infection control. Staff were responsible to encourage the residents to wear their facial coverings, however, staff were responsible to encourage the residents to wear their facial coverings. She had completed training on COVID-19 infection control and was told to keep the residents to wear their facial coverings. She had completed training on COVID-19 infection control and was told to keep the residents to wear their facial coverings. She had completed training on COVID-19 infection control and was told to keep the residents fot apart and encourage residents to wear facial coverings. She had completed training on COVID-19 infection control and was told to keep the residents fit apart and enco |

Division of Health Service Regulation STATE FORM

| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | | | E SURVEY PLETED |
|--|---|---|--|----------------------------------|-------------------------|
| | | | | С | |
| | HAL096049 | | | | 24/2020 |
| AME OF PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | ATE, ZIP CODE | | |
| OUNTRYSIDE VILLAGE | | 117 NORTH | | | |
| | | E, NC 27863 | | 0000000000 | |
| PREFIX (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| D 338 Continued From pa | age 29 | D 338 | | | |
| residents to keep t -Some of the resid coverings and som -Staff wore facial c the residents and t socially distant. -When staff explain coverings, some of would wear them. -She was instructe encourage residen each time staff obs common areas of t facial covering. -She documented Temperature Book worn a facial cover -Staff were respon- residents to ensure | overings to make it safer for ried to keep the residents ned the purpose of the facial f the residents at the facility d by management to ts to wear a facial coverings served a resident in the the facility without wearing a in the 72-hour Log and of the residents that had not | | | | |
| 08/14/20 at 1:11pm -Residents would r -Staff did not prom face coverings bec would not keep the -Management had get residents to we redirect the resider as possible. -She had complete infection control. Telephone interview 2:44pm revealed: | not keep facial coverings on. pt or redirect residents to wear ause staff knew residents | | | | |

Division of Health Service Re STATE FORM

PLPW11

If continuation sheet 30 of 60

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | E SURVEY PLETED |
|---------------|-------------------------------------|--|------------------------------|---|-----------------|--------------------|
| | | | A. BUILDING: | | | |
| | | HAL096049 | B. WING | | | C 24/2020 |
| IAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S ⁻ | TATE, ZIP CODE | | |
| | | 5383 US | 117 NORTH | | | |
| JUUNIR | | PIKEVIL | LE, NC 27863 | | | |
| (X4) ID | | | ID | PROVIDER'S PLAN OF (EACH CORRECTIVE AC | | (X5) COMPLET |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO DEFICIENC | THE APPROPRIATE | DATE |
| D 338 | Continued From pa | ge 30 | D 338 | | | |
| | -Residents were m | onitored for signs and | | | | |
| | | n or respiratory symptoms, | | | | |
| | | checked every shift and pulse | | | | |
| | | ere done daily. (A pulse | | | | |
| | | vasive test to measure oxygen | | | | |
| | levels in the blood | | | | | |
| | | f each shift, staff temperatures | 5 | | | |
| | | questionnaire was completed. shift, staff temperatures were | | | | |
| | | ented on the questionnaire. | | | | |
| | | it developed any signs or | | | | |
| | | atory illness, then COVID-19 | | | | |
| | test would be done | | | | | |
| | -It was hard to get i | residents to wear facial | | | | |
| | | d to redirect residents to wear | | | | |
| | 5 | , it was difficult because | | | | |
| | residents would not | | | | | |
| | | right to remove the facial | | | | |
| | | expected staff to encourage | | | | |
| | the residents to we | | | | | |
| | socially distancing. | sible to ensure residents were | | | | |
| | -Staff were doing th | e "best we can" | | | | |
| | | d to monitor common areas | | | | |
| | | s living room and hallways to | | | | |
| | | ere safely socially distant but | | | | |
| | | y "things" going on such as | | | | |
| | | eeds for the residents it was | | | | |
| | | continuously monitor. | | | | |
| | | nonitor common areas were | | | | |
| | | t residents to ensure residents | S | | | |
| | were not sitting side | | | | | |
| | | redirected the residents le by side and near each other | | | | |
| | on 08/13/20. | o by side and near each Uller | | | | |
| | Telephone interview | v with the AED on 08/14/20 at | | | | |
| | 2:25pm revealed sl | ne was aware of the guidelines | 6 | | | |
| | | ons from CDC, however, did | | | | |
| | not understand why | the residents needed to wear | - 1 | | | |

| | of Health Service Re | | 1 | | | |
|--------------------------|---|---|-------------------------------|---|---------------------------------|--------------------------|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | | | E SURVEY PLETED |
| | | HAL096049 | B. WING | | | C 24/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| | | 5383 US | 117 NORTH | | | |
| COUNTR | | PIKEVIL | LE, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETI DATE |
| D 338 | Continued From pa | ge 31 | D 338 | | | |
| | facial coverings wh keep the residents | en staff were attempting to socially distanced and even if sitting side by side, the | | | | |
| | health department (revealed: -The facility had no department for any | v with a nurse with the local (LHD) on 08/14/20 at 2:15pm t contacted the health guidance regarding concerns | | | | |
| | wearing face masks -She thought it wou redirect and encour SCU because those of spacing distance | Id be important for staff to rage residents residing in a e residents would be unaware and not be able to | | | | |
| | coverings. -Residents relied or residents would not tasks themselves. | son or need to wear facial n staff in the SCU and the t be able to perform these and wearing facial coverings | | | | |
| | could help to prever COVID-19. -The LHD had not p recommendations a | nt a new outbreak of provided the facility with and guidance related the | | | | |
| | department, the dep | eached out to the health partment could offer guidance lestions or concerns. | | | | |
| | 08/21/20 at 3:20pm facility to follow thei COVID-19, howeve | r, would have preferred the | | | | |
| | encourage the residue the second | ial distancing guidelines and dents to wear facial coverings e practices known to flatten ndemic and would reduce the COVID-19. | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | E SURVEY PLETED |
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| | | | | A. BUILDING. | | |
| | | HAL096049 | B. WING | | C 08/24/2020 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| COUNTR | | | 117 NORTH LE, NC 27863 | | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF | CORRECTION | (X5) |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | THE APPROPRIATE | COMPLE DATE |
| D 338 | Continued From pa | age 32 | D 338 | | | |
| | 08/13/20 at 10:02a -There were 10 din dining room. -There were three there there there were seven | ne dining room of the facility or m and 10:25am revealed: ing tables and 34 chairs in the tables with four chairs. tables with three chairs. rge walkways leading the | | | | |
| | 08/13/20 at 10:18a | rsonal care aide (PCA) on m revealed there were o 27 residents in the dining uring meals. | | | | |
| | 08/13/20 at 3:39pm -She started workin 07/21/20. -All residents were dining room at the working at the facili -Staff were respons were 6 ft apart duri room was not that I -She tried to keep t -The residents had apart when in the d -There were two to table during meals. -There were eight t served their meals | ng 2nd shift at the facility on served their meals in the same time since she started ity. sible to ensure the residents ng meals, however, the dining big. the residents six feet apart. been seated three to four feet lining room. three residents seated at each | 1 | | | |
| | revealed there were | A on 08/13/20 at 10:29am e eight to ten residents who neals in the dining hall at one | | | | |

| Division of Health Service R | egulation | | | FORM | APPROVED |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | СОМ | E SURVEY PLETED |
| | HAL096049 | B. WING | | | C 24/2020 |
| NAME OF PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| COUNTRYSIDE VILLAGE | | 117 NORTH | | | |
| | PIKEVIL | LE, NC 27863 | | | 1 |
| PREFIX (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE | (X5) COMPLETE DATE |
| D 338 Continued From pa | age 33 | D 338 | | | |
| 10:37am revealed: -The residents wer dining room. -Communal dining stopped since the aide (MA) on 08/13 -Residents had the sat two to three res -Residents were se the dining table. -During the resider keep residents limit other to keep germ Telephone interview at 1:11pm revealed | e served their meals in the for the residents had never pandemic started. w with a second medication 8/20 at 4:08pm revealed: eir meals in the dining room and sidents per table. eated three to four feet apart at nts' meals, staff attempted to ited and distant from each as from spreading. w with a third PCA on 08/14/20 d eir meals at the same time and | | | | |
| -She tried to redire feet apart from eac | ct the residents to remain six | | | | |
| Director (AED) on -There was no CO residents at the fac -Communal dining been canceled". | 08/13/20 at 2:44pm revealed: VID-19 positive staff or cility. for residents had not "really | | | | |
| 30 residents were but typically not all the same time. | mes during the pandemic, all in the dining room at one time 30 residents ate their meals at te and left the dining room, | | | | |
| some residents too residents would lin -Staff tried to serve that were in wheel | ok longer to eat, and other ger in the dining room. e residents in the dining room chairs, Geri-chairs, and | | | | |
| residents that requ | ired feeding assistance prior to | | | | |

Division of Health Service Regulation STATE FORM

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | HAL096049 | B. WING | | C 08/24/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| | | | 117 NORTH | | | |
| | | PIKEVIL | LE, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE |
| D 338 | Continued From pa | age 34 | D 338 | | | |
| | The facility took sn the dining room to a however, other residents eating. Staff could "redired residents would be the dining room and and other residents. Staff attempted to during meals, howe socially distance the in a special care un-During the resident through the dining nesidents apart. Three residents we table distanced appeach other during the resident we table distanced appeach other during the required. Serving residents in have required to no full residents residents apart. There residents could no because of the level required. Serving residents in have required to no full residents residents residents residents in the dining approximately 2-5 fier the facility that m infection control poing. | Its' meals, all staff walked room attempting to space ere seated at a dining room proximately 2-3 ft apart from he residents' meals. ot eat meals in their room el of care the residents meals in their room would nany staff "almost one to one". w with the AED on 08/14/20 at ing at the facility ate their room and were spaced ft apart during meals. itional facility infection control that covered communal dining bust not have been in the licy provided previously. e a copy of the facility's licy for SCU and communal | | | | |
| | | y infection control policies for ed communal dining was | | | | |

| Division | of Health Service Re | egulation | | | FORM | APPROVED |
|---------------|--|--|---------------------------|---|-----------------|--------------------|
| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | COM | E SURVEY PLETED |
| | | HAL096049 | B. WING | | C 08/24/2020 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, S | TATE, ZIP CODE | | |
| COUNTR | | | 117 NORTH LE, NC 27863 | | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF COF | | (X5) |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | | COMPLETE DATE |
| D 338 | Continued From pa | age 35 | D 338 | | | |
| | provided at the time | e of exit on 08/24/20. | | | | |
| | health department of revealed: -The facility had no department for any or issues with comm- -If the facility had re- department the dep and address any qu Telephone interview provider (PCP) on 0 -He had observed to continuing to have of pandemic of COVII -He expected the far related to COVID-1 | eached out to the health bartment could offer guidance uestions or concerns. w with a resident's primary care 08/21/20 at 3:20pm revealed: the residents at the facility communal dining during the | | | | |
| | | utive Director on 08/19/20 at taff were expected to ensure | | | | |
| | residents (Resident diagnosed with den facility after witness of alleged sexual al reported to manage by a staff massagin Resident #4 early in the COVID-19 pand was found in Resid with his face close penis. Staff B contin | protect 2 of 2 sampled t #3 and #4) who were nentia and resided in a locked sed incidences (by other staff) buse by Staff B which was ement. Staff B was observed ing the "private parts" of in 2020 before the beginning of demic. In July of 2020 Staff B ent #3's room on his knees to the residents exposed nued to provide direct resident ct contact with all of the | | | | |

| Division | of Health Service Re | egulation | | | FORM | APPROVED |
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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED |
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| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| COUNTR | RYSIDE VILLAGE | | 117 NORTH LE, NC 27863 | | | |
| (X4) ID PREFIX | | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO | | (X5) COMPLETE |
| TAG | | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE DEFICIENCY) | E APPROPRIATE | DATE |
| D 338 | Continued From pa | ge 36 | D 338 | | | |
| | and the last reporte | the first incident in early 2020 Ind incident in July 2020. The Ilted in serious neglect and A1 Violation. | | | | |
| | accordance with G. | d a plan of protection in S. 131D-34 on 08/14/20. A as provided on 08/17/20, /20. | | | | |
| | | TE FOR THE TYPE A1 NOT EXCEED SEPTEMBER | ł | | | |
| D 438 | 10A NCAC 13F .12 Registry | 05 Health Care Personnel | D 438 | | | |
| | Registry The facility shall co | 05 Health Care Personnel mply with G.S. 131E-256 and DA NCAC 13O .0101 and | | | | |
| | This Rule is not me TYPE A1 VIOLATIO | et as evidenced by: DN | | | | |
| | facility failed to report by Staff B to the No Personnel Registry failed to investigate | views and interviews, the ort allegations of sexual abuse orth Carolina Health Care (HCPR) within 24 hours, , and failed to complete the orting for 2 of 2 sampled | | | | |
| | The findings are: | | | | | |
| | Director (AED) on 0 | v with the Assistant Executive 08/13/20 at 2:44pm revealed: t the facility for 4 years. | | | | |

| | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ECONSTRUCTION | | E SURVEY PLETED | |
|--------------------------|---|--|---------------------|--|----------------------------------|-------------------------|--|
| | | | A. BUILDING: | | С | | |
| | | HAL096049 | B. WING | B. WING | | 08/24/2020 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, S | TATE, ZIP CODE | | | |
| COUNTR | RYSIDE VILLAGE | | 117 NORTH | | | | |
| | | | E, NC 27863 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| D 438 | Continued From pa | age 37 | D 438 | | | | |
| | resident rights as fa have required an ir -She had not been to Health Care Per- -Staff were respons resident right concer- neglect to the Adm (ED), the Health ar and herself. -The Administrator/ submitting any HCI a. Review of Resid 02/03/20 revealed: -Diagnoses include exertion, hypertens dyslipidemia. -The resident was wandered. -The resident was -The resident was -The resident srec special care unit (S Review of Residen notes dated 04/27// resident had expire Confidential staff ir -An incident occurr around the first par -The staff observed Resident #4 in the closed. -The windows and opened position. -Staff B and Reside position in the room | required to complete a report sonnel Registry (HCPR). sible to immediately report any erns related to abuse or inistrator/Executive Director ad Wellness Director (HWD) /ED would be responsible for PR reports. ent #4's current FL-2 dated ed dementia, dyspnea on sion, diabetes type 2 and constantly disoriented and ambulatory. ommended level of care was a GCU). t #4's electronic progress 20 at 9:19am revealed the ed. terviews revealed: ed prior to the "pandemic", t of the year (2020). d another staff, Staff B, with resident's room with the door blind in the room were in an ent #4 were in a standing n. | | | | | |
| ivision of H | Resident #4 in the closed. -The windows and opened position. -Staff B and Reside position in the room -Resident #4 did no the bottom portion ealth Service Regulation | resident's room with the door blind in the room were in an ent #4 were in a standing n. ot have any clothes covering of his body. | 6899 | | If continuati | | |

STATE FORM

| STATEMEN | of Health Service Re IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | E SURVEY PLETED | |
|---------------|--|--|---------------------------|---|-----------------|-----------------------------|--|
| | | | B. WING | | | C | |
| | | HAL096049 | | | 08/24/2020 | | |
| NAME OF F | PROVIDER OR SUPPLIER | | DDRESS, CITY, S | TATE, ZIP CODE | | | |
| COUNTR | YSIDE VILLAGE | | 117 NORTH LE, NC 27863 | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF | | (X5) | |
| PREFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(| THE APPROPRIATE | COMPLE ⁻ DATE | |
| D 438 | Continued From pa | ge 38 | D 438 | | | | |
| D 438 | 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. | | | | | | |
| | HWD on 08/20/20 a Telephone interview Specialist on 08/14 | ne interview with the previous at 9:23am was unsuccessful. v with HCPR Administrative /20 at 10:07am revealed there ICPR reports received for Staf | | | | | |
| | B. Telephone interview Director (AED) on 0 she was aware HC initially within 24 ho working report. Review of a fax rec 08/14/20 at 4:15pm -There was a faxed | w with the Assistant Executive 08/14/20 at 2:25pm revealed PR reports should occur urs followed by a 5-day every followed by a 5-day revealed: I confirmation dated 08/14/20 | | | | | |
| | | omplaint Unit with the Adult at the Division of Health | | | | | |

| Division | of Health Service Re | egulation | | | FORM | APPROVED |
|--------------------------|--|---|-------------------------------|---|------------------------------|--------------------------|
| STATEME | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | | E SURVEY PLETED |
| | | HAL096049 | B. WING | | | C 24/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
| COUNTE | RYSIDE VILLAGE | | 17 NORTH | | | |
| 00000 | | PIKEVILL | E, NC 27863 | | | 1 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| D 438 | Continued From pa | ge 39 | D 438 | | | |
| | Form dated 08/14/2 -The AED was nam -There was docume approximately 4:45 facility on and unan she was on a comp asked if any reports abuse on 07/15/20 -There was docume called the facility ar she was notified of Staff B for another phone. -The facility notified longer with the facil personal reasons. | blaint Intake Unit Complaint 20. The das the complainant. Entation on 07/21/20 at pm the AHS stopped by the mounced visit and reported blaint regarding resident rights, is had been made for sexual and/or 07/16/20. Entation on 08/13/20, the AHS and reported to the AED that sexual abuse allegations by resident on 08/12/20 by I the AHS that Staff B was no lity and had resigned due to | | | | |
| | 08/18/20 at 8:59am -When there was a the facility was resp to the HCPR. -When there was n the accused staff w from the community an investigation. | n allegation of resident abuse consible to complete a "24/5" otification of resident abuse yould be removed immediately y while the facility conducted nd a 5-day report would be | | | | |
| | 3:22pm revealed: -The HCPR 5-day r and faxed. -Resident #4's infor HCPR 5-day report -She was "assumin | g" the allegation regarding ot in the HCPR report because | | | | |

Division of Health Service Regulation STATE FORM

| Division of Health Service F | Regulation | | | FURIN | APPROVED |
|--|---|-------------------------------|---|-----------------|--------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLI A. BUILDING: | E CONSTRUCTION | COM | E SURVEY PLETED |
| | HAL096049 | B. WING | | C 08/24/2020 | |
| NAME OF PROVIDER OR SUPPLIER | | | TATE, ZIP CODE | | |
| COUNTRYSIDE VILLAGE | | 117 NORTH _E, NC 27863 | 3 | | |
| | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORREC | | (X5) |
| | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | | COMPLETE DATE |
| D 438 Continued From p | age 40 | D 438 | | | |
| the investigation a feedback regardin the 5-day HCPR r -The previous HW the facility's intern sexual abuse alley because she was facility. -The Administrato for the investigation for the investigation the investigation of the investigation 8/20/20 at 3:45p -The 5-day HCPR allegation that Re by Staff B. -The other named of the facility and deceased, he was the resident's alley -He included spect interviewed staff of would have been the other named r -He would complet allegation of sexu B to HCPR to incl -He did not intervi she no longer wor -He was not expet this. -He did not intervi allegations of sex no longer employe -He was not sure Staff B because h facility. | D was not interviewed during al investigation regarding the gation of Resident #4 by Staff B no longer employed by the r/ED did most of the interviews on. ww with the Administrator/ED on m revealed: report did not include the sident #4 was sexually abused resident was a current resident because Resident #4 was on taware he had to include ged sexual abuse by Staff B. ific questions when he oncerning the allegation that applicable to Resident #4 and esident. te an addendum and fax the al abuse of Resident #4 by Staff ude Resident #4. ew the previous HWD because ked at the facility. rienced involving allegations like wal abuse because Staff B was | | | | |

Division of Health Service Regulation STATE FORM

| STATEMEN | of Health Service Re T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|---|---|---------------------|--|-----------------------------------|-------------------------|
| | | | A. BUILDING: | | | |
| | | HAL096049 | B. WING | | | C 24/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, S | TATE, ZIP CODE | | |
| | RYSIDE VILLAGE | | 117 NORTH | | | |
| | | PIKEVILI | LE, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| D 438 | Continued From pa | ge 41 | D 438 | | | |
| | b. Review of Reside 08/17/20 revealed: Diagnoses include disturbances, latem The resident was of ambulatory, and co The resident's currunit". Telephone interview Specialist (AHS) wi social services (DS revealed: On 07/21/20, she net sexual abuse. She met with the A sexual abuse. She asked the AEI reports or concerns "sexually inapproprisues of that nature - The AED denied a of any incidences of - The AED did not p information of how being told about the - The next contact st telephone on 08/13 complaint had beer abuse allegations of - She asked the AEI resident (only the fi a complaint allegations of - She asked the AEI residing at the facilit name. She asked the AEI allegations of Staff | ent #3's current FL-2 dated d dementia with behavior t syphilis, and alcohol abuse. constantly disoriented, ntinent of bowel and bladder. rent level of care was "locked w with the Adult Home th the local department of S) on 08/13/20 at 4:34pm made a visit the facility. ED regarding an allegation of D if she had received any of a staff and abusing or iate" with a resident or any | | | | |

| | of Health Service Re TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | CONSTRUCTION | | E SURVEY PLETED |
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| | | | A. BUILDING: | | | |
| | | HAL096049 | B. WING | B. WING | | C 24/2020 |
| IAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| | NYSIDE VILLAGE | 5383 US | 117 NORTH | | | |
| | | PIKEVIL | LE, NC 27863 | | | |
| (X4) ID | | | ID | PROVIDER'S PLAN OF | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO | | COMPLE DATE |
| | | | | DEFICIENC | CY) | |
| D 438 | Continued From pa | ige 42 | D 438 | | | |
| | reports regarding S | staff B. | | | | |
| | | | | | | |
| | | v with the AHS with the local | | | | |
| | | t 830am revealed she had | | | | |
| | | D regarding the staff to | | | | |
| | 8:37am. | use allegation on 08/13/20 at | | | | |
| | 0.07 am. | | | | | |
| | Telephone interview | v with Health Care Personnel | | | | |
| | | dministrative Specialist on | | | | |
| | 08/14/20 at 10:07a | | | | | |
| | | n any reports made of sexual | | | | |
| | abuse from the fac | | | | | |
| | Staff B. | n any reports made relating to | | | | |
| | T . 1 | | | | | |
| | 2:25pm revealed: | v with the AED on 08/14/20 at | | | | |
| | | an internal investigation | | | | |
| | | not been any allegations | | | | |
| | | d at that point, there was no | | | | |
| | investigation neede | | | | | |
| | | ew any residents or staff and | | | | |
| | | he Administrator/Executive | | | | |
| | Director (ED) did no | en with staff working | | | | |
| | | 0) and had questioned those | | | | |
| | | en any reports of resident | | | | |
| | abuse. | | | | | |
| | | ted this allegation of sexual | | | | |
| | abuse to HCPR. | CDD reports abould accur | | | | |
| | | CPR reports should occur ours followed by a 5-day | | | | |
| | working report. | are renewed by a J-day | | | | |
| | | ot been any reports of abuse | | | | |
| | brought to her and | it was given to the AHS, she | | | | |
| | thought "it was alre | | | | | |
| | | te a 24-hour report to HCPR | | | | |
| | for the sexual abus the AHS on 07/21/2 | e allegations received from | | | | |
| | ealth Service Regulation | LU aliu U0/12/20. | | | | |

STATE FORM

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | | | | | <u>_</u> |
| | | HAL096049 | B. WING | B. WING | | C 24/2020 |
| IAME OF P | ROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| | YSIDE VILLAGE | 5383 US | 117 NORTH | | | |
| | | PIKEVIL | LE, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| D 438 | Continued From pa | ge 43 | D 438 | | | |
| | 08/14/20 at 4:15pm -There was a faxed result as "ok" dated Complaint Unit with the Division of Heal (DHSR). -There was a Comp Form dated 08/14/2 -The AED was nam -There was an docu approximately 4:45 facility on and unan she was on a comp asked if any reports abuse on 07/15/20 -The AED documer complaints brought -There was addition 08/13/2, the AHS ca complaint of sexual abuse alle -The AHS asked if the (first name only) that -Staff reported there name. -The AHS then asked by that name and states been a resident by -The AHS asked if the the facility and was to the facility. -The AHS was told facility and had resi | confirmation with a received d 08/14/20 of 4:20pm to the the Adult Licensure Section a the Service Regulation colaint Intake Unit Complaint 20. ced as the complainant. cumentation that on 07/21/20 at pm the AHS stopped by the nounced visit and reported blaint regarding resident rights, is had been made for sexual and/or 07/16/20. ced there had been no to her attention. chal documentation that on alled the facility to notify of a egations. ce were no residents by that e were no residents by that ed if there was ever a resident taff reported there has never that name. there was a named male staff at told there was no longer with the gned due to personal reasons | | | | |
| | Review of Staff B's | resignation letter signed | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096049 | (X2) MULTIPLE A. BUILDING: <u></u> B. WING | CONSTRUCTION | Сом | E SURVEY PLETED C 24/2020 |
|---------------|--|---|--|--|----------------|------------------------------------|
| | | | | | 08/ | 24/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST 117 NORTH | TATE, ZIP CODE | | |
| COUNTR | | | E, NC 27863 | | | |
| (X4) ID | | | ID | PROVIDER'S PLAN OF C | | (X5) |
| PREFIX TAG | | YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | HE APPROPRIATE | COMPLET DATE |
| D 438 | Continued From pa | ge 44 | D 438 | | | |
| | resigning his position | 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 back with his acycles particily pulled off | | | | | |
| | 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 "sho Staff A "what are yo | cked" and immediately asked u doing". | | | | |
| | | and he appeared "scared" and ot say anything but left the | | | | |
| | any gloves. | I that Staff B did not have on was next to the door and Staff | | | | |
| | B was on the side of -When the staff retu Staff A stated he wa | of the bed next to the door and stan urned to the nurse's station, as helping Resident #3 "clean | | | | |
| | • | the incident to the 1st shift MA nad observed did not look | | | | |
| | -She had worked w | ith Staff B and she had never y other staff providing resident | | | | |
| | -The MA reported th | ne incident to the facility's no was the current area Health | | | | |
| | Telephone interview ealth Service Regulation | v with the current area HWD | | | | |

| | of Health Service Re IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | E SURVEY PLETED |
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| | | | A. BUILDING: | | с | |
| | | HAL096049 | B. WING | | | C 24/2020 |
| IAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S ⁻ | TATE, ZIP CODE | | |
| | | | 117 NORTH | | | |
| | | PIKEVIL | LE, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLE DATE |
| D 438 | Continued From pa | ige 45 | D 438 | | | |
| | abuse related to St anyone when he wa -If there was any ty would be responsib management at the an investigation. -If anything was rep the appropriate cha investigation and fil -If a staff was name | ved any reports of any types of aff B from family, staff or as employed at the facility. pe of resident abuse, staff ole to report it to her or other e facility and they would start ported to her, she would follow annels, would start our internal | | | | |
| | 08/18/20 at 8:59am -He was not aware was allegedly sexu -He was conducting investigation on the -He would ask the (08/18/20) if she ha | w with the Administrator/ED on a revealed: of any reports Resident #3 ally abused by Staff B. g a 5-day working report and a allegations of sexual abuse. current area HWD today ad received any reports from #3 was allegedly sexually | | | | |
| | Care Personnel Inv #3 dated 08/19/20 -The report was co Administrator/ED. -In the allegation se documentation Res sexually abused by community. Report county DSS and No facility via phone ar | mpleted by the ection of the form there was sident #3 was allegedly a staff member within the s were made to the local C DHHS which reported to the nd unannounced visit. idual was Staff B who was no y the facility. | | | | |

| Division | of Health Service Re | egulation | | | FORM | APPROVED |
|--------------------------|--|--|---------------------|---|--------------------------------|--------------------------|
| STATEMEN | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
| | | HAL096049 | B. WING | | | C 24/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, S | TATE, ZIP CODE | | |
| COUNTE | RYSIDE VILLAGE | | 117 NORTH | | | |
| | 1 | | E, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| D 438 | Continued From pa | ge 46 | D 438 | | | |
| | interviewed. -The investigation p 08/14/20. -The Administrator/ employee roster inf be interviewed. -The interviews were Administrator/ED w 08/17/20 to 08/19/2 - A copy of the resid the questions were -There was docume investigation, it was unable to validate a from interviews corr -The investigation H the Administrator/E -There was no docu attempted with Staf | dent and staffs' responses to attached to the HCPR report. entation, after thorough concluded the facility was iny instance of abuse occurred iducted. HCPR report was signed by D. umentation an interview was f B. umentation the current area | | | | |
| | 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 | | | | | |
|)ivision of L | sexual abuse by a sampled residents | report allegations of alleged staff (Staff B) for 2 of 2 (#3 and #4) who were ided in a locked facility within | | | | |

If continuation sheet 47 of 60

| Division | of Health Service Re | equlation | | | FORM | APPROVED |
|---------------|--|---|--------------------------|--|-------------------|------------------|
| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | HAL096049 | B. WING | | C 08/24/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| COUNTR | | | 117 NORTH E, NC 27863 | 3 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | , ID | PROVIDER'S PLAN OF CORREC | TION | (X5) |
| PREFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | | COMPLETE DATE |
| D 438 | Continued From pa | ge 47 | D 438 | | | |
| | 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. | | | | | |
| | accordance with G. POP addendum wa 08/18/20, 08/20/20 | d a plan of protection in S. 131D-34 on 08/14/20. A Is provided on 08/17/20, and 08/24/20. TE FOR THE TYPE A1 . NOT EXCEED SEPTEMBER | | | | |
| D 453 | 10A NCAC 13F .12 and Incidents | 12(d) Reporting of Accidents | D 453 | | | |
| | Incidents (d) The facility shal department of socia G.S. 108A-102 and authority as require | 12 Reporting of Accidents and Il immediately notify the county al services in accordance with the local law enforcement d by law of any mental or glect or exploitation of a | | | | |

| | NT OF DEFICIENCIES I OF CORRECTION | Agulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096049 | (X2) MULTIPLE A. BUILDING: _ B. WING | CONSTRUCTION | Сом | E SURVEY PLETED C 24/2020 |
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| | | | | | 00/ | 24/2020 |
| NAME OF | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| COUNTR | RYSIDE VILLAGE | | 117 NORTH LE, NC 27863 | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF | CORRECTION | (X5) |
| PRÉFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | COMPLETE DATE |
| D 453 | Continued From pa | ge 48 | D 453 | | | |
| | resident. | | | | | |
| | | | | | | |
| | | | | | | |
| | This Rule is not me | | | | | |
| | TYPE A2 VIOLATIC | JN | | | | |
| | | s and record reviews, the | | | | |
| | | nediately notify the local law of 2 sampled residents (#3, #4) | | | | |
| | | an allegation of sexual abuse |) | | | |
| | from Staff B. | an anogation of coxual abace | | | | |
| | The findings are: | | | | | |
| | Specialist (AHS) wi social services on 0 -On 07/21/20, she r Executive Director of -The AED Assistant reports or concerns related to resident a inappropriate" or ar -The AED denied a notified of any incid -The AED did not p of how or what she about the allegation sexual abuse allega -On 8/13/20, the AE named resident (on present with that na the facility. -The AED denied sl allegations of Staff with a resident and | t denied she had received any of a staff and a resident abuse, being "sexually ny issues of that nature. ny knowledge or of being ent, allegations or reports. rovide her with any information would do after being told n regarding following up on the | n | | | |

| Division | of Health Service Re | egulation | | | FORM | APPROVE |
|---------------|--|--|-------------------------------|--|----------------|--------------------|
| STATEMEI | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | | E SURVEY PLETED |
| | | HAL096049 | B. WING | B. WING | | C 24/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, S | TATE, ZIP CODE | | |
| | | 5383 US | 117 NORTH | | | |
| COUNT | RYSIDE VILLAGE | PIKEVIL | LE, NC 27863 | i de la construcción de la constru | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF (| | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | COMPLETE DATE |
| D 453 | Continued From pa | ige 49 | D 453 | | | |
| | 1. Review of Reside | ent #4's current FL-2 dated | | | | |
| | 02/03/20 revealed: | | | | | |
| | | d dementia, dyspnea on | | | | |
| | | ion, diabetes type 2 and | | | | |
| | dyslipidemia. | | | | | |
| | - The resident was of wandered. | constantly disoriented and | | | | |
| | -The resident was a | ambulatory | | | | |
| | | ommended level of care was a | | | | |
| | special care unit (S | | | | | |
| | Confidential staff in | terviews revealed: | | | | |
| | -Staff B was with Resident #4 with the door | | | | | |
| | closed in the reside | | | | | |
| | | ent #4 were in a standing | | | | |
| | position in the room | | | | | |
| | bottom portion of hi | ot have any clothes on the | | | | |
| | | e any gloves on and was | | | | |
| | | h Resident #4's "private area". | | | | |
| | | hand on Resident #4 right | | | | |
| | shoulder and Staff | B's right hand was underneath | | | | |
| | the resident's "priva | | | | | |
| | | g his fingers, massaging | | | | |
| | | I and around his "private area" ontinent wipes in Staff B's | - | | | |
| | hands. | onument wipes in Stan D's | | | | |
| | | y ran to the resident's room | | | | |
| | | push the door back closed and | 1 | | | |
| | | Staff B did not need any help | | | | |
| | | terview did not ask Resident | | | | |
| | 0 0 | on because the resident would | 1 | | | |
| | | to recall or tell anyone what | | | | |
| | not want to upset th | I the confidential interview did | | | | |
| | | eported to a MA (could not | | | | |
| | | ne) and the MA was upset after | r I | | | |
| | | e incident then the incident | | | | |
| | was reported to the | previous HWD. | | | | |
| | -The previous HWE lealth Service Regulation | D told the confidential interview | · | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|------------------------------|--|-----------------------------------|-------------------------|
| | | HAL096049 | B. WING | | | C 24/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S ⁻ | TATE, ZIP CODE | | |
| COUNTR | YSIDE VILLAGE | | 117 NORTH LE, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| D 453 | Continued From pa | age 50 | D 453 | | | |
| | that she would inve | stigate the incident. | | | | |
| | Resident #4 from J revealed there was | and Accident Reports for anuary 2020 - April 2020 no Incident and Accident for the alleged sexual assault | | | | |
| | | one interview with a local law r on 08/19/20 at 2:10pm. | | | | |
| | | one interview with the utive Director (ED) on 1. | | | | |
| | | one interview with the Assistan (AED) on 08/20/20 at 3:22pm | t | | | |
| | | one interview with the n 08/20/20 at 3:45pm. | | | | |
| | revealed: -Diagnoses include disturbances, laten -The resident was ambulatory, and co | ent #3's FL-2 dated 08/17/20 ed dementia with behavior t syphilis, and alcohol abuse. constantly disoriented, ontinent of bowel and bladder. rent level of care was "locked | | | | |
| | revealed: -On July 18th or 19 Resident #3's bedry Staff A in the room. -Resident #3 was a his bed with his cov exposing his "priva -Staff B was on his | terview on 08/17/20 at 4:11pm th, 2020, the staff opened the oom door, the staff observed wake and lying on his back in vers partially pulled off te parts", including his penis. knees next to the resident's over the resident's exposed | | | | |

STATE FORM

6899

| STATEMEN | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
|---------------|--|---|----------------------------|--|------------------|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | LETED |
| | | HAL096049 | B. WING | | C 08/24/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | TATE. ZIP CODE | · | |
| | | | 117 NORTH | , | | |
| COUNTR | | PIKEVILL | E, NC 27863 | | | |
| (X4) ID | | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL | ID | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT | | (X5) COMPLETE |
| PREFIX TAG | | SC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO T DEFICIENC | THE APPROPRIATE | DATE |
| D 453 | Continued From pa | ge 51 | D 453 | | | |
| | body. | | | | | |
| | | close to the resident's | | | | |
| | exposed penis. | cked" and immediately asked | | | | |
| | Staff A "what are yo | | | | | |
| | -Staff B jumped up | and he appeared "scared" and | | | | |
| | trembling. He did no room. | ot say anything but left the | | | | |
| | | that Staff B did not have on | | | | |
| | any gloves. | | | | | |
| | | 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 wa | as helping Resident #3 "clean | | | | |
| | up." | 4h - in -i 4 4 - 4h | | | | |
| | | the incident to the medication what she had observed did | | | | |
| | -She had worked w observed him or an | ith Staff B and she had never y other staff providing resident | | | | |
| | care in that position | n. The incident to the facility's | | | | |
| | | no was the Health and | | | | |
| | Wellness Director (| | | | | |
| | | and Accident Reports for | | | | |
| | | anuary 2020 - current revealed ent and Accident reports | | | | |
| | | lleged sexual assault of | | | | |
| | Resident #3. | C C | | | | |
| | Refer to the telepho | one interview with a local law | | | | |
| | | on 08/19/20 at 2:10pm. | | | | |
| | | one interview with the Assistant (AED) on 08/18/20 at 8:59am | | | | |
| | Refer to the telepho 08/20/20 at 3:22pm | one interview with the AED on | | | | |

| STATEMEN | of Health Service Re NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | | | E SURVEY PLETED |
|--------------------------|---|--|---------------------------------|--|----------------------------------|--------------------------|
| | | HAL096049 | B. WING | B. WING | | C 24/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, S | TATE, ZIP CODE | | |
| COUNTF | RYSIDE VILLAGE | | 117 NORTH _E, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETI DATE |
| D 453 | Continued From pa | ge 52 | D 453 | | | |
| | | one interview with the n 08/20/20 at 3:45pm. | | | | |
| | officer on 08/19/20 | v with a local law enforcement at 2:10pm revealed there had reports taken from the facility). | | | | |
| | 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. | | ŀ | | | |
| | 3:22pm revealed lo involved in the facil | v with the AED on 08/20/20 at cal law enforcement was not ity's investigation regarding the ations against Staff B. | | | | |
| | 08/20/20 at 3:45pm -Local law enforcer allegations of sexua Resident #3 -He was not aware enforcement should | v with the Administrator/ED on a revealed: nent was not notified of the al abuse of Resident #4 and there was a rule that local law d have been notified regarding exual abuse against residents | | | | |
| | Refer to Tag D 338 Resident Rights | 10A NCAC 13F .0909 | | | | |
| | enforcement author residents (#3, #4) a of sexual assault by was observed arou second allegation w | immediately notify local law rities for 2 of 2 sampled fter staff reported allegations y Staff B, the first allegation nd February 2020 (#4) and the vas observed around July 18 'he facility's previous HWD | | | | |

| STATEMEN | T OF DEFICIENCIES | egulation (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY | |
|-------------------|--|---|-----------------|--|------------------|------------------|
| | OF CORRECTION | IDENTIFICATION NUMBER: | | | | PLETED |
| | | HAL096049 | B. WING | | C 08/24/2020 | |
| | ROVIDER OR SUPPLIER | | DRESS, CITY, SI | | | |
| | | | 117 NORTH | TATE, ZIF CODE | | |
| COUNTR | YSIDE VILLAGE | | E, NC 27863 | | | |
| (X4) ID PREFIX | | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO | | (X5) COMPLETE |
| TAG | , | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO TH DEFICIENCY | HE APPROPRIATE | DATE |
| D 453 | Continued From pa | ige 53 | D 453 | | | |
| | | ned of the February 2020 | | | | |
| | | ary 2020 and the current area | | | | |
| | | informed of the July 2020 020, and again in August 2020. | | | | |
| | | ED was also informed of the | | | | |
| | allegations of sexua | al abuse to Resident #3 and | | | | |
| | | 18/20, however, failed to | | | | |
| | | ocal law enforcement of the ations after being prompted | | | | |
| | | port the allegations to law | | | | |
| | | failure resulted in substantial | | | | |
| | risk for harm and co | onstitutes a Type A2 Violation. | | | | |
| | | d a plan of protection in | | | | |
| | accordance with G. POP addendum wa 08/24/20. | S. 131D-34 on 08/21/20. A as provided on | | | | |
| | | TE FOR THE TYPE A2 NOT EXCEED SEPTEMBER | | | | |
| D914 | G.S. 131D-21(4) De | eclaration of Residents' Rights | D914 | | | |
| | G.S. 131D-21 Dec | laration of Residents' Rights | | | | |
| | | I have the following rights: | | | | |
| | 4. To be free of men neglect, and exploit | ntal and physical abuse, tation. | | | | |
| | This Rule is not me | et as evidenced bv: | | | | |
| | | ions, interviews and record | | | | |
| | | failed to ensure residents | | | | |
| | | nent free of abuse and neglect nt rights, health care, reporting | | | | |
| | | cidents, health care personnel | | | | |
| | registry, and impler | | | | | |
| | The findings are: | | | | | |

Division of Health Service Regulation STATE FORM

| STATEMEN | of Health Service Re TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | COM | E SURVEY PLETED | |
|--------------------------|---|--|---------------------------|--|----------------------------------|-------------------------|--|
| | | HAL096049 | B. WING | | | 08/24/2020 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | ATE, ZIP CODE | | | |
| COUNTR | RYSIDE VILLAGE | | 117 NORTH LE, NC 27863 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| D914 | Continued From pa | age 54 | D914 | | | | |
| | facility failed to ens meet the healthcard residents (#3 and # residents' primary of reported sexual about 4) and changes in H abuse (#3). [Refer .0902(b) Health Ca 2. Based on record facility failed to report by Staff B to the No Personnel Registry failed to investigate | iews and record reviews the ure referral and follow up to e needs of 2 of 4 sampled (4) by failing to notify the care provider (PCP) of use by a staff member (#3 and behaviors after reported sexua to Tag D273, 10A NCAC 13F re (Type A2 Violation)]. d reviews and interviews, the ort allegations of sexual abuse orth Carolina Health Care (HCPR) within 24 hours, e, and failed to complete the arting for 2 of 2 approach | I | | | | |
| | residents (#3, #4). | orting for 2 of 2 sampled [Refer to Tag D438, 10A lealth Care Personnel Registry]. | , | | | | |
| | reviews, the Admin (ED) failed to assur facility to meet and health care, resider personnel registry a | vations, interviews, and record istrator/Executive Director re the total operation of the maintain rules related to nts' rights, health care and reporting of incident and o Tag D980, G.S. 131D-25 rpe A1 Violation)]. | | | | | |
| | facility failed to imm enforcement for 2 of after staff reported from Staff B. [Refer | ews and record reviews, the nediately notify the local law of 2 sampled residents (#3, #4 an allegation of sexual abuse r to Tag D453, 10A NCAC 13F of Accidents and Incidents]. | | | | | |
| | | ews, observations, and record failed to ensure 2 of 2 | | | | | |

| | of Health Service Re | egulation (X1) PROVIDER/SUPPLIER/CLIA | (X2) MI II TIDI E | CONSTRUCTION | | SURVEY |
|--------------------------|---|---|---------------------|---|--------------------------------|--------------------------|
| | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | | PLETED |
| | | HAL096049 | B. WING | | | C 24/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, S | TATE, ZIP CODE | | |
| COUNTE | RYSIDE VILLAGE | | 117 NORTH | | | |
| | | | E, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC) | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| D914 | Continued From pa | ge 55 | D914 | | | |
| | by a former staff me sexually abused two dementia in a speci free of neglect by n recommendations a Centers for Disease Carolina Division of (NC DHHS) related reminding and assis care unit to social d coverings during the COVID-19. [Refer t | were free from sexual abuse ember (Staff B) who allegedly o residents diagnosed with al care unit (#3, #4); and were ot following the and guidance issued by the e Control (CDC), North F Health and Human Services to communal dining, sting residents in a special istance and wear facial e global pandemic of o Tag D338, 10A NCAC 13F hts (Type A1 Violation)]. | | | | |
| D980 | G.S. § 131D-25 lm G.S. 131D-25 lmple | | D980 | | | |
| | Responsibility for in this Article shall res facility. Each facilit training to staff to in | nplementing the provisions of t with the administrator of the y shall provide appropriate nplement the declaration of luded in G.S. 131D-21. | | | | |
| | reviews, the Admini (ED) failed to assur facility to meet and health care, resider | et as evidenced by: ons, interviews, and record strator/Executive Director e the total operation of the maintain rules related to nts' rights, health care and reporting of incident and | | | | |
| | The findings are: | | | | | |
| | Director (AED) on 0 | v with the Assistant Executive 08/14/20 at 3:35pm revealed: d Administrator however, her | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | СОМ | E SURVEY PLETED | |
|--------------------------|---|--|---------------------------|--|---------------------------------|-------------------------|--|
| | | HAL096049 | B. WING | | | C 08/24/2020 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | TATE, ZIP CODE | | | |
| COUNTR | | | 117 NORTH .E, NC 27863 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC' | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE | |
| D980 | • | - | D980 | | | | |
| | and daily function of Administrator/Exec the facility. -She was at the fac -The Administrator/ days per week and role at a sister facil -The days or freque in the facility varied the needs of the fac Telephone interview 08/18/20 at 8:59am -The AED handled the facility and repo -He was the Admin Manager". -The days he was a on the needs of the at the facility, it cou days. -He expected to be issues whether he -When there were i physical or sexual, removed from the of was being investiga Telephone interview 8:23am revealed: -She had worked a Business Office Ma -The Administrator/ facility around Nove Administrator for the | ble for the day to day oversight of the facility when the utive Director (ED) was not at cility Monday- Friday. (ED came to the facility 2-3 covered the Administrator/ED ity. ency the Administrator/ED was because he went based on cility for that week. with the Administrator/ED on n revealed: the day to day operations of orted to him. istrator/ED and "Area at the facility was dependent e community how often he was ld be 3 days one week or 2 notified of any resident right was in the building or not. issues with resident rights the named staff would be community while the incident ated. w with the AED on 08/21/20 at t the facility since 2016 as the anager. (ED started working at the ember 2018 as the Corporate re facility and a sister facility. | | | | | |
| | Non-compliance wa rule areas at violati ealth Service Regulation | as identified in the following on level: | | | | | |

STATE FORM

| STATEMEN | of Health Service Re IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | | | E SURVEY PLETED |
|--------------------------|---|---|-------------------------------|--|-----------------|--------------------------|
| | | HAL096049 | B. WING | | C 08/24/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| COUNTR | RYSIDE VILLAGE | | 117 NORTH LE, NC 27863 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE | (X5) COMPLETI DATE |
| D980 | Continued From pa | ge 57 | D980 | | | |
| | facility failed to ens meet the healthcard residents (#3 and # residents' primary of reported sexual abo 4) and changes in the abuse (#3). [Refer .0902(b) Health Ca 2. Based on record facility failed to report by Staff B to the No Personnel Registry failed to investigate 5-day follow-up rep residents (#3, #4). | ews and record reviews the ure referral and follow up to e needs of 2 of 4 sampled (4) by failing to notify the care provider (PCP) of use by a staff member (#3 and behaviors after reported sexual to Tag D273, 10A NCAC 13F re (Type A2 Violation)]. reviews and interviews, the orth Carolina Health Care (HCPR) within 24 hours, e, and failed to complete the orting for 2 of 2 sampled (Refer to Tag D438, 10A lealth Care Personnel Registry]. | 1 | | | |
| | reviews, the Admin (ED) failed to assur facility to meet and health care, resider personnel registry a | vations, interviews, and record istrator/Executive Director re the total operation of the maintain rules related to hts' rights, health care and reporting of incident and o Tag D980, G.S. 131D-25 rpe A1 Violation)]. | | | | |
| | facility failed to imm enforcement for 2 c after staff reported from Staff B. [Refer | ews and record reviews, the nediately notify the local law of 2 sampled residents (#3, #4 an allegation of sexual abuse to Tag D453, 10A NCAC 13F of Accidents and Incidents | | | | |
| | | ews, observations, and record failed to ensure 2 of 2 | | | | |

| Division | of Health Service Re | aulation | | | FORM | IAPPROVED |
|---------------|-------------------------------------|---|------------------------------|---|-----------------|--------------------|
| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | E SURVEY PLETED |
| | | HAL096049 | B. WING | | C 08/24/2020 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, S | STATE, ZIP CODE | | |
| 0011117 | | 5383 US | 117 NORTH | | | |
| COUNTR | | PIKEVILI | E, NC 27863 | 3 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF COR | | (X5) |
| PREFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY) | | COMPLETE DATE |
| D980 | Continued From pa | ge 58 | D980 | | | |
| | sampled residents | were free from sexual abuse | | | | |
| | | ember (Staff B) who allegedly | | | | |
| 1 | | o residents diagnosed with | | | | |
| | dementia in a spec | ial care unit (#3, #4); and were | | | | |
| | free of neglect by n | | | | | |
| | | and guidance issued by the | | | | |
| | | e Control (CDC), North | | | | |
| | | Health and Human Services | | | | |
| | | to communal dining, sting residents in a special | | | | |
| | 0 | listance and wear facial | | | | |
| | | e global pandemic of | | | | |
| | | o Tag D338, 10A NCAC 13F | | | | |
| | | hts (Type A1 Violation)]. | | | | |
| | The facility failed to | ensure responsibility for the | | | | |
| | | nt, administration and | | | | |
| | | ility which resulted in failing to | | | | |
| | • | and Resident #4 after | | | | |
| | | ported for alleged sexual | | | | |
| | | aff B); failing to investigate | | | | |
| | | ations of sexual abuse to | | | | |
| | | forcement and the residents displayed increased | | | | |
| | | anging on the facility's exit | | | | |
| | | ng to open the door to leave, | | | | |
| | | esident #4's PCP the resident | | | | |
| | | n episode of increased | | | | |
| | | nbative behavior in January | | | | |
| | | y could have been a response | | | | |
| | | d and feeling vulnerable if the | | | | |
| | | aged in a involuntary sexual | | | | |
| | | o assure guidelines and | | | | |
| | | established by the Center for DC), and the North Carolina | | | | |
| | | Ith and Human Service were | | | | |
| 1 | | the residents in a SCU from | | | | |
| | | rus (COVID-19) pandemic as | | | | |
| 1 | | not ensuring residents were | | | | |
| | | ain safe social distancing and | | | | |
| Division of H | ealth Service Regulation | | μ | | | 1 |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 08/24/2020 | |
|---------------|--|--|---------------------------|--|--|-----------------|
| | | | A. BUILDING: | | | |
| | | HAL096049 | B. WING | | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| COUNTR | | | 117 NORTH LE, NC 27863 | | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF | | (X5) |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | COMPLET DATE |
| D980 | Continued From pa | age 59 | D980 | | | |
| | continued to have of spacing was not po- serious neglect white Violation. The facility provide accordance with G- addendum. CORRECTION DA | ts to wear masks and communal dining when 6 ft pssible. This failure resulted in ich constitutes a Type A1 d a plan of protection in .S. 131D-34 on 08/21/20 with TE FOR THE TYPE A1 _ NOT EXCEED SEPTEMBEF | 8 | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |