Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0300	A. BUILDING: ______ B. WING ______	C 06/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY WELLNESS CENTER INC	2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The survey team entered the facility on 5/30/19 to conduct a licensure complaint survey and exited on 5/30/19. Additional information were obtained on 6/4/19 and 6/17/19. Therefore, the exit date was changed to 6/17/19.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observation, resident interview, family interview, staff interview, and record review the facility failed to provide the supervision necessary to prevent repeated sexual behavior between 2 of 3 sampled residents (Resident #1 and Resident #2) reviewed for alleged abuse. Findings included: Record review revealed Resident #1 was admitted to the facility on 02/04/19. His documented diagnoses included dementia with behavioral disturbances and Parkinson's disease. A 02/05/19 nurse's note documented Resident #1 made inappropriate sexual comments to female staff members. "Resident needs to be carefully	D 270	Tag D270 □ Personal Care and Supervision Preparation and submission of this plan of correction is in response to the State Form 2567 from the 06/17/2019 survey. It does not constitute an agreement or admission by Woodbury Wellness Center of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility□s credible allegation of compliance	6/27/19

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 06/27/19

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D 270	Continued From page 1 watched and monitored around all residents, especially the women due to the comments he made to staff." Resident #1's 02/06/19 Adult Care Home Care Plan documented the resident exhibited disruptive and socially inappropriate behavior. "(Resident #1) is alert and cooperative with care. (Resident #1) attempts to occasionally act inappropriate with other female residents. He is redirected with effect by staff. (Resident #1) is followed for dementia with behaviors, Parkinson's disease. (Psychiatric) consult is ordered. (Family member) involved in all aspects of his care." An undated Mini-Mental State Examination documented Resident #1 scored 24 out of 30 which constituted mild cognitive impairment (scores in the range of 20 - 24). A 02/11/19 Nurse Practitioner (NP) progress note documented that Resident #1 was having sexual behaviors towards other female residents, and psychiatry was consulted. A 02/25/19 10:00 AM nurse's note documented Resident #1 grabbed a female resident's breast. A 03/01/19 1:40 AM nurse's note documented Resident #1 tried to grab residents and walk the ladies into a closed room. A 03/02/19 11:20 AM nurse's note documented Resident #1 touched a female resident inappropriately, but was easily redirected. A 03/04/19 10:00 PM nurse's note documented Resident #1 kissed a female resident on the lips. A 03/05/19 psychiatric consult documented	D 270	# 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; For Resident #1 " On May 27, 2019, staff removed resident #1 from room of resident #2 and was placed on 1:1 supervision " Medical Provider was notified by Director of Resident Care Services/Designee on May 27, 2019, with no new orders received at that time. " Responsible party was notified by Director of Resident Care Services/Designee for awareness of resident□s behaviors on May 27, 2019 and initiation of 1:1 supervision. " Mental Health provider was notified by Director of Resident Care Services/Designee for awareness of resident□s behaviors on May 27, 2019 " Medical Provider assessment visit completed on May 28, 2019 with new orders received. " Investigation initiated related to behaviors beginning on May 26, 2019, with submission of Initial Allegation Report to Health Care Personnel Registry by Director of Nursing. Investigation was completed, to include local authority report, with submission of Investigation Report on May 31, 2019 by Director of Nursing.	

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D 270	Continued From page 2 Resident #1's recent behaviors included trying to bring female residents back to his room, inappropriately touching female residents/having them touch him inappropriately, and kissing another female resident. A 03/07/19 5:51 PM nurse's note documented Resident #1 was grabbing female residents by the arm and trying to pull them into empty rooms. A 03/11/19 progress note documented the Resident Care Coordinator (RCC) and Director of Nursing (DON) held a discussion with Resident #1's family member about the resident's sexually aggressive behaviors. "He (Resident #1) has been exposing himself to staff and other residents and trying to get them to touch him inappropriately. Reached out to resident's (family member) this morning via telephone. She is aware of his behaviors, and has stated that he has been removed from other facilities for them in the past. We advised her that resident has not been compliant with taking his medications and his behaviors are escalating as a result. We told her we would like to discuss a referral to ____ (name of a behavioral health unit outside the facility) ....She agrees to allow us to make the referral." During a telephone interview with the Admissions Coordinator on 06/04/19 at 12:40 PM she stated several days after the 03/11/19 meeting with Resident #1's family member she made contact with the behavioral health unit, but they had no beds available. She reported the facility felt comfortable keeping Resident #1 in the Memory Care unit after medication adjustments were made on 02/11/19, 03/10/19, and 03/11/19 which seemed to be effective in lowering Resident #1's libido.	D 270	" Care Plan reviewed and updated by Director of Nursing/Designee on May 29, 2019. " Continued Care Plan review and update by Director of Nursing/Designee with Interdisplinary Team with ongoing review and update related to sexual behaviors as indicated For Resident #2: " On May 27, 2019, staff removed resident #1 from room of resident #2 and was placed on 1:1 supervision " Resident # 2 was assessed by Medication Tech and Licensed Nurse on May 27, 2019 for signs and symptoms of physical or emotional trauma, stress or anxiety with none noted. " Medical Provider was notified by Director of Resident Care Services/Designee on May 27, 2019, with no further orders received at that time. " Responsible party was notified by Director of Resident Care Services/Designee on May 27, 2019 for awareness of occurrence of behaviors with Resident #1. " Mental Health provider contacted by Director of Resident Care Services for awareness of resident□s behaviors on May 27, 2019. " Provider assessment visit conducted	

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D 270	Continued From page 3 Review of nurse's notes and progress notes between 03/12/19 and 05/25/19 revealed no documentation that Resident #1 exhibited inappropriate sexual behaviors. Record review revealed Resident #2 was admitted to the facility on 02/28/19, and her documented diagnoses included dementia. Resident #2's 02/28/19 Adult Care Home Care Plan documented the resident wandered. "(Resident #2) is alert, pleasant, speaks some English, mostly Spanish. (Resident #2) wanders in and out of hallways and other resident rooms, with some effect from staff redirecting. She is stating today that she wants to go home. Family is with resident today, and is involved in all aspects of care." The facility documented psychiatric consults would be initiated for Resident #2. A 02/28/19 Mini-Mental State Examination documented Resident #2 scored 0 out of 30 which constituted severe cognitive impairment. During a telephone interview with Nursing Assistant (NA) #1/Med Tech on 05/30/19 at 3:08 PN she stated around 5:00 PM on 05/26/19 she entered Resident #1's room to administer medications to his roommate. She reported she found Resident #2 in bed with Resident #1. She commented both residents had their briefs down around their knees, and Resident #1 quickly tired to pull his pants up once she entered the room. She remarked that neither resident was upset or fearful upon and after discovery. NA #1 stated she separated the two residents and was told the DON wanted 15-minute checks begun immediately on the male resident. According to NA #1, Resident #1's cognition was more intact	D 270	on May 29, 2019. " Investigation initiated related to behaviors beginning on May 26, 2019, with submission of Initial Allegation Report to Health Care Personnel Registry by Director of Nursing. Investigation was completed, to include local authority report, with submission of Investigation Report on May 31, 2019 by Director of Nursing. " Care Plan reviewed and updated by Director of Nursing on May 29, 2019. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; " Director of Nursing/Designee to audit all in-house secure care unit residents records to identify any other residents with encounters of sexual behavior that might have been affected. Audit completed by June 4, 2019 with no additional concerns noted. " Attending Physician to be notified by Director of Nursing/Designee by June 4, 2019 should any concerns have been revealed on audit. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	

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D 270	Continued From page 4 than most of the other residents on the Memory Care unit with the resident being able to follow directions, having good recall, and knowing about the dosage and number of medications he received. She reported Resident #2 had a lower cognitive function, but would let staff know when she did not want to do something by raising her voice and gesturing with her hands. She commented Resident #2 would only speak in Spanish, but seemed to understand English. She also remarked that Resident #2 wandered throughout the unit, up and down the hall and into other resident rooms. According to NA #1, she worked until 11:00 PM on 05/26/19, and there were no further problems with Resident #1 acting inappropriately. During an interview with NA #2/Med Tech on 05/30/19 at 4:26 PM she stated since she spoke Spanish NA #1 asked her to talk to Resident #2 immediately after she found the resident in bed with Resident #1 on 05/26/19. She commented Resident #2 was not fearful, but reported to her that Resident #1 "tricked her" and made her touch his penis. Resident #2 said she covered her midsection, and then Resident #1 rubbed his penis against her left buttocks. According to NA #2, Resident #2 stated she felt safe and would be okay before NA #2 returned to work on her assigned hall outside of the unit for the rest of the evening. A 05/26/19 6:14 PM progress note documented the facility's management team informed Resident #2's responsible party (RP) that Resident #2 was found in bed with Resident #1 engaging in inappropriate heavy petting. "(Resident #2) was not fighting and was a willing participant. There was no sexual intercourse, however, each resident was checked thoroughly	D 270	" Facility Policy Supervision Involving Resident to Resident Occurrences developed by Director of Nursing on June 4, 2019, to include supervision procedures for residents observed having encounters of sexual behavior. " All nursing staff to be educated by Director of Nursing/Staff Development Coordinator/Designee beginning June 4, 2019 on Facility Policy Supervision Involving Resident to Resident Occurrences. Any nursing staff not educated by June 27, 2019 will be inserviced on their next scheduled work date. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. " Audit Tool developed by Director of Nursing on June 5, 2019 to audit for compliance with new facility policy Supervision Involving Resident to Resident Occurrences of any residents placed on 1:1 supervision related to observed encounters of sexual behaviors, to include appropriate update of care plans. " Director of Nursing inserviced Director of Resident Care Services on Audit tool on June 5, 2019, with implementation. " Director of Nursing/Director of	

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D 270	Continued From page 5 by nursing to ensure nothing additional happened." The RP expressed that he understood that things like this could happen in nursing homes and that he was not upset ...." During a telephone interview with NA #3 on 05/30/19 at 12:25 PM she stated as she and NA #4 were making rounds to check on residents in the unit she noticed Resident #1 was not in his room or bathroom, but NA #4 stated Resident #1 just walked by her and was sitting on the couch in the living room/sitting area watching television. NA #3 stated she and NA #4 then went to finish incontinent rounds together on the last three residents in the unit. She remarked that when they finished the care on these three residents, Resident #1 was no longer sitting on the couch. She explained that 15 - 20 minutes had elapsed since Resident #1 was seen in the sitting area. According to NA #3 she immediately went to Resident #2's room (at approximately 2:00 AM on 05/27/19), and found Resident #2 on her back in her bed with her legs up. She stated Resident #1 was on his knees with his body positioned between Resident #2's legs. She reported Resident #1 was thrusting with his hips, and both residents had their briefs off. However, she commented she could not tell for sure if penetration had occurred. She explained that Resident #1 did not want to get off Resident #2 at first, and then refused to leave the room, standing at the door with his hand on his erect penis until other staff arrived in the room. NA #3 stated neither resident seemed fearful, distraught, or tearful. According to NA #3, NA #4 spoke Spanish and talked to Resident #2 as Resident #1 was escorted back to his room. NA #3 reported she was told after her observation that a staff member needed to keep their eyes on Resident #1 at all times, but that was difficult	D 270	Resident Care Services to complete audit 5 times weekly for four weeks, then 3 times weekly for four weeks, then 2 times weekly for four weeks for a total of twelve weeks. Audits will be reviewed weekly in Risk Meeting by the Interdisciplinary Team and forwarded to the next scheduled Quality Assurance Committee meetings until auditing is completed for assessment of results and to modify action plan as needed to ensure continued compliance. Completion Date: June 27, 2019	

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since they had a whole unit of residents to take care of. She explained that they did the best they could, leaving resident doors open as they conducted final rounds on the unit so they could see Resident #1 if he was out in the hallway while they were providing care. NA #3 stated she was PRN (as needed) and worked all shifts. She reported when she had worked with Resident #1 before on third shift he was usually in his room when she did initial rounds at 11:00 PM, and did not leave his room until around 4:00 - 5:00 AM when he would approach the med tech about his medications.

During a telephone interview with NA #4 on 05/30/19 at 1:15 PM she stated 05/26/19 was her first night in the Memory Care unit, and she was supposed to be orienting for the med tech position. However, due to staff call outs, starting at 11:00 PM, she was assigned to care for residents in the unit with NA #3. She recalled Resident #2 wandered in the unit until about 1:30 AM when she was put to bed, and remained in bed until Resident #1 was observed in her room at approximately 2:00 AM. She reported she was not told about the first sexual encounter between Resident #1 and Resident #2 which occurred during the evening of 05/26/19 until after the second encounter had transpired. She estimated about 10 - 15 minutes elapsed between the time she saw Resident #1 in the sitting area watching television and when she and NA #3 finished rounds on the last three residents in the unit to find Resident #1 gone out of the sitting area. NA #4 stated she talked with Resident #2 after Resident #1 was removed from her room on 05/27/19. According to NA #4, she asked Resident #2 multiple times if there was penetration, and the resident kept stating "rapido" (quick). She commented she was unsure

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whether sexual penetration happened quickly or whether the sexual encounter happened so quickly Resident #2 was unsure if penetration occurred. NA #4 reported she asked Resident #2 if Resident #1 came to her again would she fight him off, and Resident #2 stated she would not do that. NA #4 commented from their conversation it seemed to her that Resident #2 would allow Resident #1 to be with her again. She reported she and NA #3 were told to keep an eye on Resident #1 at all times during the rest of the night/morning, and they did the best they could.

During a telephone interview with Nurse #1 on 05/30/19 at 5:46 PM she stated she was called to the Memory Care unit in the early morning hours to do a vaginal exam on Resident #2. She reported no trauma was noted to the vaginal orifice, including redness or skin irritation. In a written statement, Nurse #1 stated when asked about Resident #1, Resident #2 stated, "that it was her husband, did not voice sexual penetration, fear, or rape."

A 05/27/19 7:11 PM progress note documented more conversation with Resident #2's RP. "RP wanted to speak with family and make decisions as to whether or not they were comfortable with allowing (Resident #2) and (Resident #2) to engage in what seemed to be a mutually accepted sexual encounter ....RP did not feel the sexual encounter between the two was 'forced'. Moving forward to err on the side of caution and not really being able to establish resident thoughts, RP is requesting that no further sexual encounters take place between (Resident #2) and (Resident #1) ...RP made aware at one point, today, (Resident #2) was believed to have been seeking (Resident #1) out. Did not want any legal authorities notified ..."

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During an interview with NA #5/Med Tech on 05/30/19 at 6:38 PM she stated Resident #1 was alert and oriented, and knew what he was doing. She reported she was told by other staff that the resident referred to himself as what might be considered a "macho man" in Spanish. She commented Resident #1 was fluent in both English and Spanish, but Resident #2 only spoke Spanish. However, she remarked Resident #2 understood what the staff wanted by the staff speaking English, gesturing, and calling the RP to translate. According to NA #5, Resident #2 was not hesitant about yelling, slapping at staff, and pushing staff away if she did not want to do something. According to NA #5, between third shift on 05/26/19 and going into the morning of 05/27/19 and the afternoon of 05/28/19, staff were told that a staff member needed to keep an eye on Resident #1 all the time. She stated the staff did the best they could, but they still had to provide care and supervision for all the other residents on the unit. She reported beginning on the afternoon of 05/28/19 a sitter was assigned to Resident #1, and the sitter had to follow the resident wherever he went in the unit. She explained this allowed for better supervision of the resident.

During an interview with the Memory Care RCC on 05/30/19 at 1:40 PM she stated prior to the sexual encounters between Resident #1 and Resident #2 on 05/26/19 and 05/27/19 the two residents only engaged in conversation with one another, speaking in Spanish. She reported Resident #1 did kiss another female resident, walked out in the hall and exposed himself to staff and other residents, and tried to encourage other female residents to go to his room and other closed rooms. However, she stated the sexual

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encounters with Resident #2 were the first time Resident #1 was found in bed with female residents. According to the RCC, supervision of Resident #1 transitioned between 15-minute checks after 5:30 PM on 05/26/19 to 1:1 supervision beginning on 05/28/19.

Review of sign-in sheets associated with the monitoring of Resident #1 revealed 15-minutes checks were initialed off as being completed from 05/26/19 5:30 PM through 05/28/19 at 3:00 PM. Beginning on 05/28/19 at 3:15 PM it was initialed off that a sitter was assigned to observe Resident #1 at all times.

During initial tour of the Memory Care unit on 05/30/19, beginning at 10:18 AM, a sitter was positioned outside of Resident #1's room.

During an interview with Resident #1 on 05/30/19 at 7:12 PM he was in bed with a sitter outside his room. He complained that his medications were being changed because he was found in another resident's room where he was not supposed to be. He reported he went to visit a Spanish lady with whom he was friends. He commented they talked, and did not do anything inappropriate.

During a telephone conversation with Resident #2's RP on 06/17/19 at 5:50 PM he stated Resident #1 and Resident #2 really enjoyed conversing with one another in Spanish and sharing their Hispanic culture and heritage. He reported the two residents enjoyed each other's company, and there seemed to be a mutual attraction between the two. He commented that in conversation with Resident #2 she never expressed fear, regret, or unhappiness in regard to the sexual behaviors she shared with Resident #1. According to the RP, he requested the

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D 270	Continued From page 10 facility not to involve the police or the hospital after each episode of sexual behavior between Resident #1 and Resident #2 because he felt like these sexual encounters between the residents were consensual.	D 270		