

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041086	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/31/2024
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NAME OF PROVIDER OR SUPPLIER HARMONY AT GREENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WHITEHURST ROAD GREENSBORO, NC 27410
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D 000	Initial Comments The Adult Care Licensure Section and the Guilford County Department of Social Services (DSS) conducted an annual and follow-up survey, and complaint investigation from January 18-19; January 22-26; and on January 30-31, 2024. The complaint investigation was initiated by the Guilford County DSS on January 16, 2024.	D 000		
D 105	<p>10A NCAC 13F .0311(a) Other Requirements</p> <p>10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure the building was maintained in a safe condition related to 9 windows in the secured assisted living (AL) were not locked and the two courtyard gates that were accessible to residents who resided in the secured AL unit were not locked.</p> <p>The findings are:</p> <p>Observation of the facility on 01/18/24 at 8:45am revealed the facility was a multi-floor assisted living with residents residing on 3 floors of the facility.</p> <p>Interview on 01/18/24 at 8:45am with the morning Supervisor revealed the first floor was the secured assisted living (AL) unit for residents with 34 resident rooms who were cognitively impaired</p>	D 105		

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

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D 105	<p>Continued From page 1</p> <p>with dementia.</p> <p>Review of the facility's residency agreement contract dated 06/29/22 revealed the facility was responsible for supplying reasonable security to the community on a 24 hour a day, 7 days a week basis with exterior lockable doors and windows and may have interior and exterior video surveillance in some areas.</p> <p>1. Review of the facility's 24 hour report dated 01/15/24 revealed: -On 01/15/24, an intruder was discovered undressed in the shower with a resident. -The intruder gained entrance through a resident's first floor ground level bedroom window.</p> <p>Interview with the Administrator on 01/16/24 at 6:14pm revealed: -On 01/15/24, an entry was added to all residents' electronic medication administration records (eMARs) if they resided in the secured AL unit for medication aides (MAs) on the third shift to check every window to ensure they were locked. -On 01/15/24, the Administrator stayed from the first through third shift for a meeting to inform all staff of the incident that occurred on 01/15/24 and that third shift would have the tasks of checking on residents' windows.</p> <p>Review of the electronic medication administration records (eMAR) for 5 sampled residents, who resided on the secured AL, from 01/01/24-01/18/24 revealed: -There was an entry for a window check order dated 01/16/24 to please check that the windows were locked on the 11:00pm- 7:00am shift. -There was documentation that windows were checked and the windows were locked on</p>	D 105		

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D 105	<p>Continued From page 2</p> <p>01/17/24 and 01/18/24.</p> <p>Observation of windows on the secured AL unit on 01/23/24 from 9:00am to 9:40am revealed: -There were 78 windows with the closures in the locked position but the lower panes of 9 windows in the locked position could be lifted 3-4 inches, meaning the windows were not locked. -The window locks were a latch type lock that connected the 2 sashes of the window and prevented either window pane from moving.</p> <p>A second observation of windows on the secured AL unit on 01/24/24 at 4:36pm revealed: -There was one window in a resident's room with closures in the locked position but the lower panes could be raised to 4 inches, meaning the windows were not locked. -There were 11 common room windows with closures in the locked position but the lower panes on 7 windows could be raised to 4 inches, meaning the windows were not locked.</p> <p>Confidential interview with 3 staff members revealed: -Staff had training on 01/15/24 with the Administrator and Unit Coordinator of the secured AL. -Staff did not receive instruction to check to make sure the windows were locked by trying to open the window when the window latch locking system was in the locked position.</p> <p>Confidential interviews with 3 additional staff members revealed: -Staff had training on 01/15/24 with the Administrator and the Unit Coordinator of the secured AL. -Staff were instructed during this training to lift the lower window panes to ensure the windows could</p>	D 105		

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D 105	<p>Continued From page 3</p> <p>not be lifted.</p> <p>Interview with the Unit Coordinator of the secured AL unit on 01/19/24 at 9:00am revealed there was no checks entered on the eMAR prior to 01/15/24 and no system in place for documenting the staff were routinely checking secured AL unit residents rooms windows to ensure the windows were locked.</p> <p>Interview with the Administrator on 01/23/24 at 5:00pm revealed:</p> <ul style="list-style-type: none"> -Prior to 01/15/24, there was no system in place for routinely checking the windows in the secured AL unit resident rooms to ensure windows were locked and could not be raised when window closures were in the locked position. -On 01/15/24, the Unit Coordinator for the secured AL unit entered an order to check the resident's windows were "locked" on the 11:00pm to 7:00am shift in the secured AL unit rooms to the eMAR for documentation the night shift had checked the windows. -On 01/15/24, the Administrator met with the staff in the secured AL unit to provide in-service training related to adding documentation to the eMAR for the night shift to check residents' windows in the secured AL unit. -She trained staff on the first and second shifts and stayed over to the evening shift to go over the process of checking to ensure the residents' windows were all the way down and the closures were in the locked position. -She thought all staff were checking the windows in the secured AL unit as trained. <p>Interview with the Maintenance Director on 01/23/24 at 4:35pm:</p> <ul style="list-style-type: none"> -She and the assistant Maintenance Director checked to make sure the windows were closed 	D 105		

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D 105	<p>Continued From page 4</p> <p>in all resident rooms on the secured AL unit on 01/16/24 and 01/17/24.</p> <p>-Prior to 01/15/24, she had not routinely checked the windows in the secured AL unit to ensure all windows were closing and locking properly.</p> <p>Telephone interview with the Unit Coordinator for the secured AL unit on 01/24/24 at 4:32pm:</p> <p>-After the incident on 01/15/24, she knew some windows looked as if they were locked but were able to be opened.</p> <p>-On 01/15/24, staff were trained to check that windows were locked.</p> <p>-Staff were to check windows by lifting up on the windows to see that the window did not come up.</p> <p>2. Observation of the facility on 01/18/24 at 9:00am revealed:</p> <p>-The first floor secured assisted living (AL) unit had a ground level fenced in courtyard.</p> <p>-The dining room and sitting room had doors that opened into the courtyard.</p> <p>-The resident room windows were 2 feet off the ground.</p> <p>Observation of the facility's secured AL unit gate #1 and gate #2 in the courtyard on 01/23/2024 between 9:18am and 9:39am revealed:</p> <p>-There were 2 exit gates from the secured AL unit courtyard area with one gate (#1) exiting next to the main building leading toward a patio used by residents residing in the independent living and AL unit; and a second gate (#2) exiting to the back parking lot and dumpster area.</p> <p>-At 9:21am, gate #1 was slightly opened and not latched.</p> <p>-Gate #1 had an unpainted board holding the gate hinges in place.</p> <p>-Gate #1 had a keypad on the inside and outside of the gate used to release the magnetic</p>	D 105		

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D 105	<p>Continued From page 5</p> <p>push-bar closure on the inside of the gate.</p> <p>-Gate #1 had a red alarm box affixed to the top of the gate with contacts on the gate and the fence where the gate closed.</p> <p>-The red box was labeled "stop alarm will sound" with the symbol of a siren with sound waves emitting.</p> <p>-The red box had a switch which was in the "on" position but was not sounding while the gate was open.</p> <p>-Gate #1 had a large rock pushed against the lower part of the gate on the outside of the gate on the side to keep it closed.</p> <p>-At 9:39am, gate #2 had the same type of magnetic push-bar closure and red plastic box at the top of the gate.</p> <p>-Gate #2 was unlatched, opened more than 6 inches, and not locked.</p> <p>-Gate #2 had a red alarm box affixed to the top of the gate with contacts on the gate and the fence where the gate closed.</p> <p>-Gate #2's red alarm box was in the "on" position but was not sounding while the gate was open.</p> <p>-The rear parking lot, dumpster area, and the outside patio area were not enclosed in the courtyard and were not locked.</p> <p>Observation of the Maintenance Director testing the secured AL unit courtyard gates on 01/23/2024 at 10:00am revealed:</p> <p>-She inspected both courtyard gates and observed they were opened and unlocked.</p> <p>-She closed and latched Gate #2 but had to push hard on the door to close it.</p> <p>-She tested both gate doors and unlatched both doors with no difficulty after she pushed the crash bars.</p> <p>-The Maintenance Director examined the red alarm boxes connected to the top of both gate doors.</p>	D 105		

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D 105	<p>Continued From page 6</p> <p>-Both red alarm boxes on top of the gate doors were in the "on" position with the alarms not sounding when opened.</p> <p>Confidential interview with a staff member revealed:</p> <p>-There was a red plug at the nurse's station that was connected to the alarm on the secured AL unit courtyard doors.</p> <p>-Staff would unplug the secured AL dining room door to silence the alarm that kept going off.</p> <p>Interview with the Maintenance Director on 01/23/24 at 9:55am revealed:</p> <p>-She was responsible for maintaining the building and grounds of the facility campus, including the secured AL courtyard.</p> <p>-She repaired both gates for not closing properly several times since she became the Maintenance Director in August 2023.</p> <p>-The repairs included replacing hinge attachments, adjusting the sagging gates to ensure the magnetic push-bar closure contacted the locking mechanism on the adjoining fence, and ensuring the gate would close and lock.</p> <p>-She had gotten some quotes for repairing or replacing the gates because the gates would not close properly but was not sure of the exact date.</p> <p>-She was not aware of the large rock propped against the outside of gate #1 keeping it closed.</p> <p>-She has not observed gate #2 was open and the red alarm box not sounding today (01/23/24).</p> <p>-Both courtyard gate doors had keypads that were synced to the staffs' walkie-talkies but were not working.</p> <p>-The magnetic push-bar closure was connected to an alarm sensor located at the secured AL unit nurse's desk.</p> <p>-She had contacted contractors for estimates to fix the gate issues (did not provide estimates or</p>	D 105		

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D 105	<p>Continued From page 7</p> <p>appraisals).</p> <ul style="list-style-type: none"> -The red alarm boxes were supposed to emit an exterior audible alarm when the secured AL unit gates were opened. -The red alarm boxes should have sounded, but the batteries must be dead and she needed to replace them. -She did not recall the last time the batteries were replaced and did not have any documentation. -She did not know how long the red alarm boxes on top of the courtyard gate doors had not been sounding. -The Maintenance Director and the assistant Maintenance Director were responsible to check gates and the outer premises every day. -There was not documentation for premises checks available for review. -Both gates were supposed to activate a relay alarm box located at the secured AL unit nurse's station whenever the courtyard gates were opened; as well as activate the outside red alarm boxes. <p>Observation with the Maintenance Director 01/25/2024 at 3:40pm revealed:</p> <ul style="list-style-type: none"> -The power supply to the gates' relay alarm box located at the secured AL unit nurse's station was unplugged. -The Maintenance Director plugged the power supply for the relay alarm box into the electrical outlet. -The red alarm boxes connected to the top of both courtyard gates did not sound when both gates were opened by the assistant Maintenance Director. -She did not know why the power supply to the alarm on the secured AL unit courtyard gates was disconnected. -The secured AL staff were supposed to keep the alarm always activated to alert staff if a resident 	D 105		

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D 105	<p>Continued From page 8</p> <p>was trying to get out of the courtyard or if an intruder was trying to get inside the courtyard.</p> <p>Interview with the Maintenance Director on 01/25/2024 at 3:55pm revealed: -She was aware the red alarm boxes connected to the top of both courtyard gate doors were not sounding. -She was not aware of how long the red alarm boxes on top of the courtyard gate doors had not been sounding.</p> <p>Interview with the Maintenance Director on 01/26/2024 at 8:26am revealed: -She had installed batteries in both red alarm boxes for the courtyard gates. -Both courtyard gates were tested with the red box alarms and the mag lock alarms sounding.</p> <p>Interview with the Maintenance Director on 01/31/24 at 11:25am revealed: -Staff from every shift had used gate #2 when they took trash to dumpster. -Staff were given the security codes for the magnetic push-bar closure keypads. -The alarm had sounded for the courtyard gate doors even when staff had entered the security code.</p> <p>Interview with the Activities Director on 01/31/24 at 9:27am revealed gate #1 would not stay closed last summer and staff had placed a big rock on the outside of the gate to keep it closed, but she did not tell anyone.</p> <p>_____</p> <p>The facility failed to establish and maintain procedures to ensure the windows on the secured AL unit and the courtyard gates to the secured AL unit were maintained in a safe and operating condition; this failure was detrimental to</p>	D 105		

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D 105	Continued From page 9 the health, safety and welfare of the residents, who resided on the secured AL unit and had cognitive impairment, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/23/24 and an amended plan of protection on 01/24/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 16, 2024.	D 105		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to respond immediately in accordance with the facility's policy and procedure to an incident involving 1 of 1 sampled resident to provide care and intervention after the	D 271		

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D 271	<p>Continued From page 10</p> <p>resident was found undressed in the shower with an unidentified male.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 01/17/24 revealed there was no documentation of her orientation or her ambulation status.</p> <p>Review of an incident report dated 01/15/24 revealed:</p> <ul style="list-style-type: none"> -The incident was reported by the Unit Coordinator on the secured Assisted Living (AL). -The incident time was 8:15am and the time reported within the secured AL was 9:30am. -Resident #1 was listed as the resident affected by sexual abuse. -Information was entered electronically by the Administrator. -There was no description of the details of the incident entered. <p>Review of the facility's Abuse Prevention, Intervention, Reporting, and Investigation Policy revealed:</p> <ul style="list-style-type: none"> -The policy was dated 05/01/20. -Upon receiving reports of alleged or witnessed abuse, the Administrator or Administrator-in-Charge (AIC) would immediately take actions to protect the resident(s) and follow procedures to notify necessary individuals and agencies, investigate allegations, and follow up with all involved. -Upon receiving reports of physical or sexual abuse, the Administrator or AIC were immediately notified and arranged for the examination of the resident. -The physical examination was to be conducted by an appropriately trained/licensed professional (attending physician, emergency room physician). 	D 271		

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D 271	<p>Continued From page 11</p> <p>-Sexual abuse can mean penetration, verbal harassment, or physical contact without penetration.</p> <p>-If penetration occurred: Do not bathe the resident or allow her/him to shower, do not have the resident change their clothing or wash the resident's clothing or linens, do not take items from the area in which the incident occurred, contact police immediately, and arranged for examination in the emergency room with an escort.</p> <p>-Any individual accused and not employed by the community would be denied access to the resident or may be required to have access with supervision only.</p> <p>Review of Resident #1's revised residency agreement dated 06/29/22 revealed:</p> <p>-Additional services on page 4 included: the community shall provide reasonable security for the Community on a twenty-four hour, seven days a week basis with exterior lockable doors and windows and may have interior and exterior video surveillance in some areas.</p> <p>-The residency agreement was signed by Resident #1's power of attorney (POA) and the facility's Administrator and dated 10/19/23.</p> <p>Telephone interview with a medication aide (MA) on 01/24/24 at 5:05pm revealed:</p> <p>-She entered Resident #1's room on 01/15/24 in the secured AL to administer medications at 9:00-9:15am.</p> <p>-She heard the shower running and thought another staff was giving Resident #1 a shower.</p> <p>-She heard a man's voice and pulled back the shower curtain revealing Resident #1 and an unidentified man showed his face from behind the shower curtain.</p> <p>-The unidentified man said he was Resident #1's</p>	D 271		

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D 271	<p>Continued From page 12</p> <p>relative and was giving her a bath.</p> <p>-She could not see the unidentified man's hands and did not remove Resident #1 because it was not clear whether he had a weapon.</p> <p>-She said she would come back and then left the room, leaving Resident #1 and the unidentified man in the shower.</p> <p>-She saw a personal care aide (PCA) in the hall and told them there was a man in Resident #1's shower.</p> <p>-She and the PCA went in Resident #1's room and the unidentified man and Resident #1 were still in the shower.</p> <p>-The PCA began questioning the unidentified man as she went through items on Resident #1's bed.</p> <p>-The PCA then went out of the secured AL doors by the AL elevators and then came back to the secured AL.</p> <p>-She did not have her radio and went out to get it from the medication cart just outside of Resident #1's bedroom door and called for the facility Nurse to come to the secured AL.</p> <p>-She did not go back into Resident #1's room and so she did not know how long Resident #1 was left undressed in the shower with the unidentified man.</p> <p>-She then called 911 to report an intruder in the facility, she was unsure of the time.</p> <p>-After she called 911, the Administrator and the facility's Nurse were in the secured AL.</p> <p>-She did not know when the ambulance was called to take Resident #1 for a medical evaluation, but she knew it was after the Administrator and the facility's Nurse spoke to Resident #1's family member.</p> <p>Interview with a PCA on 01/23/24 at 9:55am revealed:</p> <p>-She completed a walk-through round of Resident #1's room on 01/15/24 in the secured AL around</p>	D 271		

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NAME OF PROVIDER OR SUPPLIER HARMONY AT GREENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WHITEHURST ROAD GREENSBORO, NC 27410
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D 271	<p>Continued From page 13</p> <p>7:15-7:20am.</p> <ul style="list-style-type: none"> -Resident #1 was lying in her bed under her covers and did not wake up. -She returned to Resident #1's room on 01/15/24 at 8:30-8:45am and Resident #1 was still lying in bed and said she was not ready to get up for breakfast. -She then left Resident #1's room and went upstairs for supplies. -She guessed she returned to the secured AL after approximately 6 minutes. -When she returned, the MA told her there was an unidentified man in Resident #1's shower. -She went into Resident #1's bathroom and pulled back the shower curtain revealing Resident #1 holding on to the shower bar and the unidentified man in the shower with her. -The unidentified man said he was Resident #1's relative and she called and asked him to come and give her a shower. -She could not see the unidentified man's hands and did not remove Resident #1 because she did not know if the man would hurt one or both of them. -She saw a "dildo" and what she thought to be petroleum jelly in a medicine bottle on Resident #1's bed. -She then left Resident #1's room and used her radio to request help with an emergency in the secured AL and left the secured AL to get other staff to help. -The MA was standing in the secured AL hallway by Resident #1's room and the unidentified man came out of the bathroom and slammed the bedroom door shut with him and Resident #1 inside Resident #1's room. -There was no staff in Resident #1's room with Resident #1 and the unidentified man at that time. -She thought the MA then called 911 (she was unsure what time 911 was notified.) 	D 271		

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D 271	<p>Continued From page 14</p> <ul style="list-style-type: none"> -She met another PCA by the elevators outside of the secured AL and told them to call 911 because there was an intruder in Resident #1's shower. -The facility's Nurse and another staff member then entered the secured AL and went into Resident #1's room. -She returned to Resident #1's room where Resident #1 was still standing in the bathroom and the unidentified man was sitting on the bed asking staff for privacy to get dressed. -Staff continued to question the unidentified man as he got dressed. -The unidentified man then wrapped the "dildo" in a shirt and went out of Resident #1's room. -After the unidentified man left, the staff noticed a breeze at Resident #1's window and pulled the blinds up. -The window was open; the screen was missing, and the 4 inch window stop was bent. -She was not sure how much time went by from the time Resident #1 was first found by staff in the shower with the unidentified man until Resident #1 was removed from the presence of the unidentified man by staff. <p>Confidential interview with a second PCA revealed:</p> <ul style="list-style-type: none"> -A staff member called for help in the secured AL over the radio on the morning of 01/15/24, she was not sure of the time of the call for help. -When she entered Resident #1's room with the facility's Nurse, Resident #1 and the unidentified man were standing in the bathroom undressed. -Resident #1 had a skin tear on her right wrist that was bleeding. -The unidentified man asked for privacy and stepped in the bedroom area of Resident #1's room, outside of the bathroom door, where the facility's Nurse was standing. -She then went into the bathroom and stayed with 	D 271		

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D 271	<p>Continued From page 15</p> <p>Resident #1 while the facility's Nurse questioned the unidentified man in the bedroom area.</p> <ul style="list-style-type: none"> -Resident #1 did not display any concerning behavior and seemed her normal self. -She guessed the unidentified man was in the room for another 5 minutes getting dressed while Resident #1 was still in the bathroom alone. -Once the room was clear (she was not sure what time), she patted Resident #1 dry and proceeded to get her dressed. -She did not bathe or shower Resident #1. <p>Interview with a third PCA on 01/16/24 at 5:45pm revealed:</p> <ul style="list-style-type: none"> -On 01/15/24 she was working in the AL on second floor and responded to a staff member's call for help over the radio in the secured AL . -As she exited the elevators outside of the secured AL on first floor, another staff member told her to call police because there was an unidentified man in the shower with Resident #1 . -She called 911 at 9:32am. -While still on the call, she went into the secured AL where the unidentified man was in the hall in front of Resident #1's door with a "dildo" under his right arm. -She went into Resident #1's room where Resident #1 was in her bathroom with another staff member. -The facility's Nurse told the unidentified man how to get out and entered the access code for the secured AL doors. -She followed the facility's Nurse and the unidentified man out and remained on the phone and provided 911 operators the description of the intruder's vehicle as he drove out of the facility parking lot. -The call time on her cellular phone to 911 was 4 minutes long. 	D 271		

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D 271	<p>Continued From page 16</p> <p>Review of the county 911 communications event report dated 01/15/24 revealed:</p> <ul style="list-style-type: none"> -A call was received from a staff member of the facility at 9:32am requesting response to a rape/sexual assault. -The caller's statement was that an unknown male came into the facility and got into the shower with a resident and was presently undressed. -At 9:34am, the caller advised the male was becoming aggressive and trying to leave. -At 9:35am, the caller advised the male was walking out of the building. -At 10:04am, the responding officer requested the crime scene investigation unit. -At 10:43am, the responding officer requested Emergency Medical Services (EMS). -At 10:45am, EMS was en-route to and arrived at the facility 10:57am. -The victim was transported out of the facility at 11:28am and arrived at the local hospital at 11:37am. <p>Review of the local law enforcement incident/investigation report dated 01/15/24 revealed:</p> <ul style="list-style-type: none"> -Officers responded at 9:40am to a report by facility staff of a sex offense against Resident #1 on 01/15/24 at 9:32am. -Once in the facility, the facility Nurse took the responding officer to a conference room and explained the nature of the incident and that the victim was a resident in a secured part of the facility that housed residents with memory problems or cognitive decline. -The officer was then escorted to Resident #1's room where he noted a laceration to her hand. -The officer was unable to get a statement from her. -Resident #1 was then escorted by AL staff to a 	D 271		

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D 271	<p>Continued From page 17</p> <p>chair outside of her room and the door was locked to preserve evidence until Crime Scene Investigation arrived (time not documented). -Resident #1's POA arrived and facility staff informed him of the incident (time not documented). -After Resident #1's POA was informed of the details of the incident, it was agreed that EMS would transport Resident #1 for a Sexual Assault Nurse Examiner (SANE) examination (time not documented). -A second officer followed Resident #1 in the ambulance to the local hospital for examination.</p> <p>Telephone interview with the responding police officer on 01/26/24 at 9:49am revealed: -Resident #1, the victim, was not sent out to the hospital for treatment immediately. -There was a discussion between the Administrator and Resident #1's family member, after he and the Administrator explained the details of the incident, as to if he wanted to take Resident #1 to the hospital or have an ambulance take her. -Officers did not ask the facility staff not to send Resident #1 for medical evaluation or request that her medical evaluation be delayed. -He radioed for an ambulance, but he was unsure of the time.</p> <p>Telephone interview with the investigating police detective on 01/24/24 at 10:10am revealed: -He arrived at the facility after 10:00am on 01/15/24. -He was advised by his supervisor that the victim, Resident #1, was already taken to the hospital. -He was surprised that she was still sitting in a chair outside of her room when he arrived.</p> <p>Interview with Resident #1's family member on</p>	D 271		

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D 271	<p>Continued From page 18</p> <p>01/18/24 at 10:15am and 01/23/24 at 9:56am revealed:</p> <ul style="list-style-type: none"> -He was the POA for Resident #1. -Resident #1 had a mental decline for the past 3 years or so. -The Administrator called him on the morning of 01/15/24 and asked if Resident #1 had a relative by a specific name. -She then told him there was an intruder in Resident #1's room and asked him to come to the facility. -When he arrived officers and crime scene investigators were already at the facility. -He was unsure of the time he arrived at the facility on 01/15/24. -Upon arrival to the facility, he saw Resident #1 was clothed and wearing someone else's jacket and sitting in a chair in the hall outside of her room. -The Administrator took him into a conference room and she and the police told him that the intruder entered the resident's room through her window and was found undressed in the shower with her. -An hour or more had passed after his arrival to the facility on 01/15/24 until the Administrator asked him if he wanted to take her to the hospital or if EMS should take her for medical evaluation. <p>Interview with the facility Nurse on 01/26/24 at 10:03am revealed:</p> <ul style="list-style-type: none"> -She received a call on the radio on 01/15/24 around 9:28am to call 911 and to go to the secured AL unit. -She rushed downstairs to the secured AL unit and entered Resident #1's room around 9:30am. -When she entered the room, the intruder was still in the bathroom with Resident #1, but they were no longer in the shower. -She began questioning the unidentified man, 	D 271		

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D 271	<p>Continued From page 19</p> <p>asking who he was and what he was doing.</p> <p>-He stepped out into the bedroom area and said he was her relative and he was just giving her a shower.</p> <p>-She then noticed a "dildo" on Resident #1's bed.</p> <p>-Resident #1 was in the bathroom alone and undressed with the door open, after the unidentified man stepped into the bedroom where the facility's nurse was standing.</p> <p>-The unidentified man sat on Resident #1's bed, began to get dressed and continued to say how embarrassing this was and to ask Resident #1 who he was.</p> <p>-The unidentified man became agitated flailing his arms in the air and shouting.</p> <p>-Once the unidentified man was dressed, he wrapped the "dildo" in a shirt and went out of the room.</p> <p>-She guessed she had been in the room 10 minutes before the unidentified man was dressed and left Resident #1's.</p> <p>-She followed him to the door and put the access code in and then followed him out of the closest set of double doors outside of the secured AL.</p> <p>-When she returned to Resident #1's room, she saw a skin tear on Resident #1's right wrist.</p> <p>-She told a PCA to dress Resident #1.</p> <p>-By then, the Administrator and police came into the secured AL.</p> <p>-Resident #1 was placed in a chair outside of her room and was provided coffee to drink and fruit to eat.</p> <p>-Resident #1 was not sent out to the emergency department for examination immediately because she was not in any distress; she was just cold.</p> <p>-The Administrator spoke privately with the POA and Resident #1 was sent by EMS to the emergency department to be examined.</p> <p>-She did not know what time Resident #1 was sent to the emergency department.</p>	D 271		

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D 271	<p>Continued From page 20</p> <p>Interview with the Unit Coordinator of the secured AL on 01/30/2024 at 12:05pm revealed: -The 01/15/24 incident was not handled correctly. -Staff had not been trained on how to respond to an incident like this. -She expected the resident to be removed from the shower and escorted away from the unidentified man immediately. -She expected a resident should not be left alone such as in the incident that had occurred on 01/15/2024.</p> <p>Telephone interview with Resident #1's PCP on 01/23/24 at 7:38am revealed: -The facility Nurse called her on 01/15/24 at 9:54am and informed her that Resident #1 had been sexually assaulted. -The facility Nurse asked her if Resident #1 needed to go out to the hospital. -At that time, she informed the facility Nurse that Resident #1 needed to be evaluated in the emergency department since she was attacked. -Resident #1 did have cognitive decline and may not have understood what had happened, but she should have been removed from her attacker as soon as staff found her with him. -She would have expected Resident #1 to have been sent out for evaluation as soon as she was safe from the attacker.</p> <p>Interview with the Administrator on 01/24/24 at 6:15pm revealed: -She was in the facility's morning stand up meeting on 01/15/24 that started at 9:30am. -She was unaware of the incident involving Resident #1 until after 911 had been called and the unidentified man had left the facility. -The staff called the 911 operator. -The 911 system called the police and did not</p>	D 271		

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D 271	<p>Continued From page 21</p> <p>send an ambulance.</p> <p>-When police responded to the 911 call without an ambulance, she did not call for an ambulance or ask someone to call at that time.</p> <p>-The facility's Nurse had assessed Resident #1 and so an ambulance was not requested immediately.</p> <p>-The responding officer said he would call for the EMS ambulance around 10:00am.</p> <p>-She felt the staff followed the facility's policy for responding to the intruder and sexual assault of Resident #1.</p> <p>-Resident #1 was assessed by the facility's nurse and was not in danger and staff escorted the unidentified man out of the facility to keep him from harming any one.</p> <p>-She was unsure of the time that Resident #1 was left in the presence of her attacker, but felt like there were discrepancies in the times given in staff interviews.</p> <p>Review of the responding ambulance report for 01/15/24 revealed:</p> <p>-A non-emergency ambulance was requested at 10:45am for an assault of Resident #1 and arrived at the facility at 10:57am.</p> <p>-The ambulance left the facility with Resident #1 at 11:28am and arrived at the local hospital at 11:37am.</p> <p>Review of Resident #1's emergency department provider notes for 01/15/24 revealed:</p> <p>-Resident #1 arrived at the emergency department via EMS at 11:40am for evaluation after a sexual assault.</p> <p>-A SANE examination was requested, and any laboratory testing and genital and rectal exams were deferred to the SANE nursing team.</p> <p>-Upon examination by the SANE nurse, Resident #1 had a small abrasion oozing blood inside the</p>	D 271		

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D 271	<p>Continued From page 22</p> <p>vagina, left sided facial bruising due to blunt trauma, a skin tear on her right wrist with bruising, and possible exposure to sexually transmitted diseases (STD).</p> <p>-A head and maxillofacial computed tomography (CT) were performed with evidence of ischemic changes but no evidence of fractures or hematoma but did have a suspected soft tissue injury.</p> <p>-A right wrist radiography was performed with no evidence of fracture.</p> <p>-Resident #1 received a tetanus vaccine and was discharged to the facility with an antibiotic for STD prophylaxis and instructions to follow up with her Primary Care Provider (PCP).</p> <p>Based on observations and record review it was determined Resident #1 was not interviewable.</p> <p>_____</p> <p>The facility failed to respond immediately and in accordance with their policy when Resident #1 was found by staff in the shower with an unidentified male intruder; both the resident and intruder were undressed. Resident #1 was known by staff to have cognitive impairment and resided in the secured AL. Staff failed to immediately remove Resident #1 from the shower, leaving her alone with the intruder. After the intruder was escorted out of the facility, Resident #1 was not sent to the hospital immediately for medical evaluation and treatment; she was sent to the hospital approximately 2 hours later and treated for vaginal abrasions, left facial bruising, and a skin tear on her wrist with bruising. This failure resulted in serious physical harm and serious neglect, which constitutes a Type A1 Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/17/24 with</p>	D 271		

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D 271	Continued From page 23 addendums on 01/30/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 1, 2024.	D 271		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents (#1) with orders for laboratory tests and a psychiatric referral. The findings are: Review of Resident #1's current FL2 dated 01/17/24 revealed diagnoses included metabolic encephalopathy, deep vein thrombosis and acute renal failure. a. Review of Resident #1's physician's orders revealed: -There was an order dated 10/27/23 for the following laboratory tests: complete blood count (CBC), comprehensive metabolic panel (CMP), vitamin D and B12 levels, lipid panel, hemoglobin A1C and thyroid stimulating hormone (TSH).	D 276		

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D 276	<p>Continued From page 24</p> <p>-There was a 2nd order dated 11/09/23 requesting that the laboratory tests be reordered because they were still pending in the computer system.</p> <p>Review of Resident #1's record revealed:</p> <p>-There were no laboratory results related to tests ordered on 10/27/23 and 11/09/23 or notes regarding obtaining the laboratory tests.</p> <p>-Upon inquiry, the Administrator provided results for a CBC, CMP, lactic acid, and blood culture dated 10/26/23 from a local hospital clinical laboratory and a typed page with no resident's name of identifier or letter head containing 2 short paragraphs.</p> <p>-The second paragraph was dated 11/02/23 and read in part "Labs from request have been done at the hospital."</p> <p>-The page was signed by the Administrator and dated 11/02/23.</p> <p>Review of Resident #1's hospital provider notes revealed laboratory tests performed were 2 blood cultures, lactic acid, PT/INR, Blood Bank sample, CBC and CMP on 10/26/23.</p> <p>Based on observations and record review it was determined Resident #1 was not interviewable.</p> <p>Refer to interview with the Unit Coordinator for the secured assisted living (AL) on 01/22/24 at 12:15pm.</p> <p>Refer to telephone interview with Resident #1's primary care provider (PCP) on 01/23/24 at 7:38am.</p> <p>Refer to interview with Resident #1's family member on 01/19/24 at 11:26am.</p>	D 276		

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D 276	<p>Continued From page 25</p> <p>Refer to interview with the Administrator on 01/24/24 at 6:15pm.</p> <p>b. Review of Resident #1's physician's orders revealed: -There was an order dated 11/02/23 for a psychiatric consult. -There was a 2nd order dated 11/09/23 requesting a psychiatric consult for dementia and agitation.</p> <p>Review of Resident #1's record revealed: -There were no psychiatric consult visit notes. -Upon inquiry, the Administrator provided a typed page with no resident's name or identifier or letter head containing 2 short paragraphs. -The second paragraph was dated 11/02/23 and read in part "Refusal of psych services at this time." -The page was signed by the Administrator and dated 11/02/23.</p> <p>Interview with the facility's mental health provider (MHP) on 01/24/24 at 10:40am revealed she had not received a referral from the facility to evaluate Resident #1 for dementia and agitation.</p> <p>Based on observations and record review it was determined Resident #1 was not interviewable.</p> <p>Refer to interview with the Unit Coordinator for the secured AL on 01/22/24 at 12:15pm.</p> <p>Refer to telephone interview with Resident #1's PCP on 01/23/24 at 7:38am.</p> <p>Refer to interview with Resident #1's family member on 01/19/24 at 11:26am.</p> <p>Refer to interview with the Administrator on</p>	D 276		

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D 276	<p>Continued From page 26</p> <p>01/24/24 at 6:15pm.</p> <p>Interview with the Unit Coordinator of the secured AL on 01/22/24 at 12:15pm revealed:</p> <ul style="list-style-type: none"> -She was responsible for ensuring PCP orders were implemented. -She began working as the Unit Coordinator of the secured AL in late November 2023 or early December 2023 part time. -She was not aware Resident #1 had orders for laboratory blood work on 10/27/23 and again on 11/09/23. -She was not aware Resident #1 had orders for a psychiatric referral on 11/02/23 and again on 11/09/23. -She did know who would have been responsible to ensure that PCP orders were implemented before she started as the Unit Coordinator of the secured AL. <p>Telephone interview with Resident #1's PCP on 01/23/24 at 7:38am revealed:</p> <ul style="list-style-type: none"> -She ordered routine admission laboratory tests for Resident #1 on 10/27/23 that included a CBC, CMP, lipid panel, vitamin D and B12 levels, hemoglobin A1C and a TSH and a psychiatric referral. -She expected her orders to be implemented so that laboratory tests were performed, and referrals were made. -She noticed on her visits to the facility on 11/02/23 and 11/09/23 that the laboratory results were still not in her computer system, and she did not see a note from the facility's MHP. -She wrote a second order on 11/09/23 for the staff to reorder the laboratory tests she ordered on 10/27/23 and made another psychiatric referral. <p>Interview with Resident #1's family member on</p>	D 276		

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D 276	<p>Continued From page 27</p> <p>01/19/24 at 11:26am revealed: -He was Resident #1's Power of Attorney (POA) due to her declining mental status. -He was not aware she needed laboratory tests and a psychiatric referral ordered by the facility PCP after she was admitted near the end of October 2023. -He had not refused any laboratory tests for her. -He had not refused or discussed a psychiatric referral with the facility's PCP or Administrator. -She had some laboratory tests during hospital visits since 10/26/23, but he did not know what they were.</p> <p>Interview with the Administrator on 01/24/24 at 6:15pm revealed: -Referrals and laboratory orders should be implemented and followed up on by the clinical staff Nurse. -Until the current Unit Coordinator of the secured AL was hired, she and various corporate employees helped review orders intermittently. -The Unit Coordinator of the secured AL was responsible for ensuring orders were implemented for residents in the secured AL.</p>	D 276		
D 449	<p>10A NCAC 13F .1211 (b) Written Policies And Procedures</p> <p>10A NCAC 13F .1211Written Policies And Procedures</p> <p>(b) In addition to other training and orientation requirements in this Subchapter, all staff shall be trained within 30 days of hire on the policies and procedures listed as Subparagraphs (3), (4), (6), (7), (8), (9), (10) and (11) in Paragraph (a) of this Rule.</p>	D 449		

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D 449	<p>Continued From page 28</p> <p>This Rule is not met as evidenced by: TYPE A1 VIOLATION</p> <p>Based on record review and interviews, the facility failed to ensure all staff were trained within 30 days of hire on the policies and procedures regarding responding to incidents and accidents.</p> <p>The findings are:</p> <p>Review of the facility's Abuse Prevention, Intervention, Reporting, and Investigation Policy revealed:</p> <ul style="list-style-type: none"> -The policy was dated 05/01/20. -Upon receiving reports of alleged or witnessed abuse, the Administrator or Administrator-in-Charge (AIC) would immediately take actions to protect the resident(s) and follow procedures to notify necessary individuals and agencies, investigate allegations, and follow up with all involved. -Upon receiving reports of physical or sexual abuse, the Administrator or AIC was immediately notified and arrange for the examination of the resident. -The physical examination was conducted by an appropriately trained/licensed professional (attending physician, emergency room physician). -Sexual abuse can mean penetration, verbal harassment, or physical contact without penetration. -If penetration has occurred: Do not bathe the resident or allow her/him to shower, do not have the resident change their clothing or wash the resident's clothing or linens, do not take items from the area in which the incident occurred, contact police immediately, arrange for examination in emergency room with an escort. 	D 449		

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D 449	<p>Continued From page 29</p> <p>-Any individual accused and not employed by the community is denied access to the resident or may be required to have access with supervision only.</p> <p>Review of the revised residency agreement dated 06/29/22 revealed the community shall provide reasonable security for the Community on a twenty-four hour, seven days a week basis with exterior lockable doors and windows and may have interior and exterior video surveillance in some areas.</p> <p>Review of the facility's 24-hour report dated 01/15/24 revealed on 01/15/24 an intruder was discovered in the shower with a resident having gained entrance through a first floor ground level window.</p> <p>Review of local police reports, emergency medical services logs, and 911 call logs for the incident that occurred at the facility on 01/15/24, a resident at the facility was found in the shower with an intruder at 9:32am, and did not receive immediate medical attention (per facility policy) at a local hospital emergency department until 11:40am.</p> <p>Review of the personnel records for 3 staff members who were on duty 01/15/24 revealed: -All staff members had been employed by the facility more than 30 days. -There was a staff Orientation Check-off list used with the subtopic of Detecting and Reporting Abuse, Neglect, or Exploitation with reference to be completed within 30 days in each record. -There was no documentation of completion of training on the facility's Abuse Prevention, Intervention, Reporting, and Investigation Policy available for review in the 3 staff personnel</p>	D 449		

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D 449	<p>Continued From page 30</p> <p>records.</p> <p>Review of the personnel record for the facility's Nurse on 01/30/24 revealed:</p> <ul style="list-style-type: none"> -The facility Nurse was hired on 11/20/23. -There was a staff Orientation Check-off list with the subtopic of Detecting and Reporting Abuse, Neglect, or Exploitation with reference to be completed within 30 days. -There was no documentation of completion of training on the facility's Abuse Prevention, Intervention, Reporting, and Investigation Policy. <p>Confidential interview with a staff member revealed:</p> <ul style="list-style-type: none"> -The staff had been employed at the facility for more than 30 days. -There was no emergency policy training for an intruder. -The staff member did not have training on responding to a sexual assault, such as calling police and ambulance. -The staff member did not remember any abuse response training. -The staff member remembered training on looking for signs of abuse and thought it was in the facility's computer based training or maybe at with a previous employer. -The facility had provided no training on security or handling intruders or violence in the workplace. -The facility was supposed to have monthly training meetings, but the scheduled meetings were canceled by management staff. -The December 2023 staff meeting was canceled. <p>Confidential interview with a second staff member revealed:</p> <ul style="list-style-type: none"> -The staff had been employed at the facility for more than 30 days. 	D 449		

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D 449	<p>Continued From page 31</p> <ul style="list-style-type: none"> -There was no training on intruders, abuse, or assault prior to 01/15/24. -The staff member had training only on a resident's right to refuse services on one of her check-off list by a Nurse prior to 01/15/24. <p>Confidential interview with a third staff member revealed:</p> <ul style="list-style-type: none"> -The staff had been employed at the facility for more than 30 days. -The staff member never had training on assault or abuse to a resident or handling an intruder. -The Administrator did some training on 01/15/24 regarding treating residents with respect and residents' rights. <p>Confidential interview with a fourth staff member revealed:</p> <ul style="list-style-type: none"> -The staff had been employed at the facility for more than 30 days. -The staff member had not received any training on the intruder policy prior to the 01/15/24 incident. -The staff member had received training on identifying Resident Abuse in orientation but had not received any training on reporting an incident. -The staff member had not received or been trained on the Resident Abuse and Prevention policy. -The staff member had orientation that included looking for signs of abuse such as bruises, scratches and changes in behavior. -The staff member did not have training on how to respond to a sexual assault prior to 01/15/24. -The staff member thought there should be a policy in the building but she did not know where to find it nor what it said. <p>Confidential interview with a fifth staff member revealed:</p>	D 449		

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D 449	<p>Continued From page 32</p> <ul style="list-style-type: none"> -The staff had been employed at the facility for more than 30 days. -The staff member did not remember training on how to respond to a sexual assault. -The staff member only had training on signs of recognizing signs of abuse in orientation. -The staff member did not know where a policy book is in the building. <p>Confidential interview with a sixth staff member revealed:</p> <ul style="list-style-type: none"> -The staff had been employed at the facility for more than 30 days. -The staff member did not have training at this facility to respond to abuse/sexual assault until last week's staff meeting on 01/25/24. -The staff member had not completed any training in the facility's computer training system pertaining to abuse response. <p>Confidential interview with a seventh staff member revealed:</p> <ul style="list-style-type: none"> -The staff had been employed at the facility for more than 30 days. -The staff member had training on signs of abuse and neglect. -The staff member had not had training on how to respond to physical or sexual assault. <p>Interview with the facility's Nurse on 01/26/24 at 10:03am revealed:</p> <ul style="list-style-type: none"> -She was not familiar with the Abuse and Prevention policy pertaining to responding to an incident involving physical or sexual abuse of a resident. -She did not know their policy was the resident was to be immediately examined by qualified provider such as the attending or emergency department physician. 	D 449		

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D 449	<p>Continued From page 33</p> <p>Interview with the Unit Coordinator of the secured AL unit on 01/30/2024 at 12:05pm revealed: -She was hired as the Unit Coordinator of the secured AL unit in late November 2023 or early December 2023, she could not recall the date of hire. -She had seen the Resident Abuse and Intruder Policies in the initial group of training papers she read and completed during her orientation when she was hired as a department head.</p> <p>Interview with the Unit Coordinator of the secured AL unit on 01/31/24 at 10:28am revealed she did not remember the sexual abuse training being covered during initial orientation.</p> <p>Interview with the Maintenance Director on 01/30/24 at 10:45am revealed: -She presented a portion of the new employee orientation training related to safety training. -She did not cover any specific training regarding responding to sexual abuse or physical abuse. -They had monthly safety meetings on the last Thursday of each month and she went over things like fire drills and elopement prevention at each meeting.</p> <p>Interview with the Administrator on 01/23/24 at 9:30am revealed: -She had a training with the staff at the monthly staff meeting on the last Thursday of each month. -She always went over resident rights, talked about abuse and neglect, and providing care for the residents' needs. -On 01/15/24, the day of the incident, she talked with the staff on all 3 shifts herself related to the incident, policy and procedures for handling an intruder.</p> <p>Interview with the Administrator on 01/30/24 at</p>	D 449		

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D 449	<p>Continued From page 34</p> <p>12:29pm revealed:</p> <ul style="list-style-type: none"> -The facility used a 7 plus hour orientation power point presentation for an overview of the various topics, like residents' rights, abuse and neglect, and workplace violence to newly hired staff. -The training was to make staff aware that of abuse and neglect was to be reported immediately to the highest level of management available at the time. -After completing the orientation power point, staff were told where the policy and procedure manual was located in the clinical office on each floor and available for review, and staff must sign at the bottom of the training form acknowledging that they had received training. -She expected staff to be aware of the white binder that contained policies and procedures and was accessible at each nurse's station. -The binder contained policies and procedures for staff to access on their own for the remainder of their training on policies. -She did not do training on all the topics covered in the Policy and Procedure binder. <p>Second interview with the Administrator on 01/30/24 at 2:30pm revealed:</p> <ul style="list-style-type: none"> -The Administrator and department heads conducted Resident Abuse policy training during staff initial orientation. -The Intruder policy and Resident Abuse policy were not completely covered during staff's initial orientation or within 30 days of employment due to being referenced in 3 bullet points on a Power Point training. -Staff signed an acknowledgement that they were aware of the policies and procedures binder but training on the Intruder and Resident Abuse policies were not actually provided to staff in a structured training class or within 30 days of hire. 	D 449		

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D 449	<p>Continued From page 35</p> <p>Interview with the Administrator on 01/31/24 at 8:44am revealed there was no additional documentation the facility had provided training specific to emergency response for intruders and facility's abuse prevention, intervention, reporting, and investigation policy.</p> <p>[Refer to Tag D0271, 10A NCAC 13F .0901(c) Personal Care and Supervision]</p> <p>_____</p> <p>The facility failed to ensure facility staff were trained within 30 days of hire on the policies and procedures regarding immediately responding to incidents and accidents. The facility's failure to train staff resulted in a female resident, who resided in the facility's secured assisted living and was cognitively impaired, being left alone in the resident's room with an unidentified male after evidence of sexual assault; and a delay of 2 hours before the female resident was sent out of the facility for medical evaluation and treatment. This failure resulted in serious physical harm and serious neglect and constitutes a Type A1 Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on JANUARY 31, 2024 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 01, 2024.</p>	D 449		