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D 000	Initial Comments The Adult Care Licensure Section and the Macon County Department of Social Services conducted a follow-up survey and complaint investigation on 02/07/24 through 02/09/24. The complaint investigation was initiated by the Macon County Department of Social Services on 01/24/24.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff B's, personal care aide (PCA), personnel record on 02/09/24 revealed: -There was a hire date of 08/29/23. -There was no documentation of a HCPR check upon hire. Interview with the Business Office Manager (BOM) on 02/09/24 at 9:44am revealed: -The HCPR checks were completed during the hiring process. -She and the Administrator were responsible for ensuring the HCPR checks were complete and	D 137		

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the documentation was in the record.
-She did not know why Staff B did not have a HCPR check.
-She audited personnel records at least every six months when she "had time".

Interview with the Administrator on 02/09/24 at 9:50am revealed:
-The HCPR checks were completed upon hire and annually.
-She and the BOM were responsible for ensuring the HCPR were completed.
-The personnel records were audited every six months.
-She did not know why Staff B did not have a HCPR check.

Review of Staff B's HCPR check dated 02/09/24 revealed there were no substantiated findings.

D 273 | 10A NCAC 13F .0902(b) Health Care | D 273

10A NCAC 13F .0902 Health Care
(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.

This Rule is not met as evidenced by:
Type B Violation

Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the acute health care needs for 4 of 5 residents related to a resident who missed doses of a nerve pain medication not being reported to the primary care provider (PCP) (Resident #5) and residents on a Special Care Unit (SCU) having sexual encounters (Resident #1, Resident #3 and Resident #6) and the PCP

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was not notified.

The findings are:

Review of the facility's policy "Sexual Activity of Residents Policy" dated September 2001 revealed:
-The facility does not permit or support indiscreet sexual activity between residents.
-The facility is not authorized to act as a law official and they do not act in any way to violate the rights of residents, including their right to privacy.

a. Review of Resident #1's current FL2 dated 11/04/23 revealed:
-Diagnoses included dementia without behavioral disturbances.
-The resident was constantly disoriented.
-The resident was ambulatory with wandering behaviors.
-Recommended level of care was documented as SCU.

Review of Resident #1's Resident Register revealed:
-There was an admission date of 08/16/22.
-There was documentation of a Power of Attorney (POA)/Health Care POA.

Review of Resident #1's Care Plan dated 12/06/23 revealed:
-There was documentation the resident had wandering behaviors.
-There was no documentation of any sexual encounters with female residents.
-There was no documentation of interventions to address behaviors or adequate supervision.

Review of Resident #1's Resident Progress

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Notes dated 09/13/23 at 6:15pm revealed:
-Staff witnessed Resident #3 in Resident #1's room after the dinner meal.
-Upon entering the room staff observed Resident #1 with his mouth on Resident #3's breast.
-Both residents immediately stopped and Resident #3 was redirected to her room.
-There was documentation the Primary Care Physician (PCP) was not notified.
-There was documentation the PCP was not given or sent a copy of the behavior report (report documenting behaviors not an incident report) for Resident #1.
-There was an intervention to redirect female residents to their respected rooms.
-There was documentation the Executive Director (ED) was notified.

Review of Resident #1's Resident Progress Notes dated 09/15/23 at 11:21am revealed:
-There was documentation Resident #1 and Resident #3 were found in Resident #1's room with his mouth on her breast.
-Resident #3 was redirected to her room.
-There was documentation the PCP was not notified.
-There was documentation the PCP was not given or sent a copy of the behavior report.

Interview with Resident #1 on 02/07/24 at 4:20pm revealed:
-Residents sometimes wandered into his room.
-Sometimes female residents came into his room for sex.
-There were 2-3 female residents he had sex with on a recurring basis.

Interview with Administrator on 02/08/24 at 9:20am revealed there were no incident reports for 09/13/23, 09/15/23 or for the month of

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September 2023 for Resident #1.

Telephone interview with a personal care aide (PCA) on 02/08/24 at 1:57pm revealed:
-Resident #1 tried to get different female residents to come into his room by asking them repeatedly to come in.
-There had been multiple sexual incidents when female residents were in Resident #1's room.
-She had observed at least 3 sexual incidents with Resident #1 and Resident #3 and had to Redirect Resident #3 back to her room.
-Staff had been told to redirect the female residents out of or away from Resident #1's room by the previous Executive Director (ED).

Telephone interview with Resident #1's HCPOA/POA on 02/08/24 at 4:27pm revealed:
-Two months ago a PCA informed the her Resident #3 frequently went into Resident #1's room.
-Resident #1 and Resident #3 had been found in sexual encounters at least three times prior to the 09/13/23 incident that the PCA was aware of prior to the PCA telling the HCPOA/POA.
-She confronted the previous ED about the sexual encounters.
-She was "livid" no one notified her of the incident and she told the previous ED that she did not want Resident #3 or other female residents in Resident #1's room.
-The previous ED told her that staff were "watching" the situation and she would speak to the Area Director of Operations and get back in touch with her.
-The previous ED never called back nor has anyone called or spoken to her about the sexual encounters.
-Resident #1 told her Resident #3 frequently came into his room after dinner.

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-Two weeks ago Resident #3 told her that she frequently went to Resident #1's room to "check on him".

Interview with a second PCA on 02/09/24 at 6:30am revealed:
-Resident #1 told her he would put the trash can in front of his door so he can hear staff/anyone coming into his room.
-When staff removed Resident #3 out of Resident #1's room Resident #1 would get angry and yell at staff.
-The previous ED was aware of what was happening and told staff to just "keep an eye" on Resident #1.
-She tried to tell the newer staff to keep the female residents out of Resident #1's room because of the sexual encounters.

Telephone interview with Resident #1's PCP on 02/09/24 at 9:45am revealed:
-Staff had never mentioned any sexual encounters with Resident #1 and some of the female residents on the SCU.
-The previous ED had not mentioned Resident #1 exhibiting any sexual behaviors but would have suggested medications to reduce Resident #1's urges if she had known.

Refer to the interview with the Special Care Coordinator (SCC) on 02/09/24 at 8:20am.

Refer to the interview with the Administrator on 02/09/24 at 9:05am.

b. Review of Resident #3's current FL2 dated 11/04/23 revealed diagnoses included dementia without behavioral disturbance, major depressive disorder, and anxiety disorder.

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Review of Resident #3's Resident Register revealed:
-There was an admission date of 03/10/23.
-There was documentation of a court appointed legal guardian.

Review of Resident #3's Care Plan dated 11/24/23 revealed:
-Resident #3 had a history of wandering behaviors with the use of a wheelchair.
-The resident had a cognitive status documented as forgetful.
-Resident #3 was hard of hearing.

Review of Resident #3's Resident Progress Notes dated 09/13/23 at 8:45pm revealed:
-Staff witnessed Resident #3 in Resident #1's room after the dinner meal at 6:15pm.
-Upon entering room staff observed Resident #1 with his mouth on breast of Resident #3.
-Both residents immediately stopped, and Resident #3 was redirected to her room.
-There was documentation that the incident was reported to the Executive Director on 09/13/23.
-There was documentation the Primary Care Physician (PCP) was not notified.
-There was documentation the PCP was not given or sent a copy of the behavior report.
-The intervention was to redirect the female residents to their respected rooms.

Review of Resident #3's Resident Progress Notes dated 09/15/23 at 11:25am revealed:
-Resident #3 was still trying to get into Resident #1's room to "mess around with him"
-There was documentation the Primary Care Physician (PCP) was not notified.
-There was documentation the PCP was not given or sent a copy of the behavior report.
-There was documentation that a Safety

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Intervention was not put in place.

Interview with Administrator on 02/08/24 at 9:20am revealed there were no incident reports for 09/13/23, 09/15/23 or for the month of September for Resident #3.

Telephone interview with the previous ED on 02/08/24 at 4:05pm revealed:
-She heard "rumors" from staff of Resident #1 having female residents in his room and she had told staff to "kept an eye" on Resident #1.
-She did not call Resident #1's PCP to notify of the incident.

Telephone interview with Resident #3's PCP on 02/09/24 at 9:45am revealed:
-Staff had never made her aware of Resident #3 and Resident #1's sexual encounters.
-The previous ED had not mentioned Resident #3 exhibiting any sexual behaviors but would have suggested medications if she had known.
-She woul;d have wanted to have known about the enounters.

Based on observations, interviews and record reviews it was determined Resident #3 was not interviewable.

Refer to the interview with the Special Care Coordinator (SCC) on 02/09/24 at 8:20am.

Refer to the interview with the Administrator on 02/09/24 at 9:05am.

c. Review of Resident #6's current FL2 dated 01/29/24 revealed:
-Diagnoses included Alzheimer's type dementia.
-The resident was constantly disoriented.
The resident was ambulatory with wandering

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behaviors.
-Recommended level of care was documented as Special Care Unit.

Review of Resident #6's Resident Register revealed:
-There was an admission date of 01/08/24.
-There was documentation of a Power of Attorney(POA)/Health Care POA.

Review of Resident #6's Care Plan dated 01/08/24 revealed:
-There was documentation the resident had wandering behaviors.
-There was no documentation addressing the sexual encounters with Resident #1.
-There was no documentation of interventions to address behaviors or adequate supervision.

Interview with Resident #1 on 02/07/24 at 4:20pm revealed:
-There there were 2-3 female residents that he had sex with.
-He identified Resident #6 as one of the females he had sex with.

Interview with the Administrator on 02/08/24 at 9:20am revealed there was no incident report for 02/07/24 for Resident #6.

Interview with a second PCA on 02/09/24 at 6:30am revealed:
-Resident #6 was constantly disoriented and had difficulty completing full sentences.
-On 02/07/24 between 7-8 pm staff did not see Resident #6 in her room or in the common areas on the SCU.
-Staff attempted to enter Resident #1's room.
-Resident #1 stated Resident #6 was not in his room and told staff they could not come in his

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room.
-After a few minutes she observed Resident #6 coming out of Resident #1's room with Resident #1's slippers on.
-When she asked Resident #6 where she had been she pointed to Resident #1's room.
-Shortly after redirecting Resident #6 to the living room she was assisting Resident #6 in getting ready for bed and realized she did not have her underwear on which she did earlier in the evening.
-When she spoke to Resident #1 later in the evening about Resident #6 being in his room, he told her repeatedly it was none of her business.

Telephone interview with Resident #6's PCP on 02/09/24 at 9:45am revealed:
-Resident #6 was a new resident and she had only one visit with Resident #6.
-Staff had never mentioned any sexual encounters related to Resident #6 and Resident #1 but would have recommended medication if she had known.
-She would have wanted to have know about any behavioral issues.

Based on observations, interviews and record reviews it was determined Resident #6 was not interviewable.

Refer to the interview with the Special Care Coordinator (SCC) on 02/09/24 at 8:20am.

Refer to the interview with the Administrator on 02/09/24 at 9:05am.

Attempted interview with Responsible Party for Resident #6 on 02/08/24 at 10:53am was unsuccessful.

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d. Review of the facility's Policy and Procedure for missed medications dated 09/2021 revealed the primary care provider (PCP) would be notified of missed medications.

Review of Resident #5's current FL2 dated 12/14/23 revealed diagnoses included diabetes and spinal stenosis.

Review of physician's orders for Resident #5 dated 12/14/23 revealed gabapentin (used to treat nerve pain) 300mg three times daily.

Review of Resident #5's electronic Medication Administration Record (eMAR) for January 2024 revealed:
-There was an entry for gabapentin 300mg three times daily with administration times of 8:00am, 2:00pm, and 8:00pm.
-There was documentation the gabapentin was not administered on 01/03/24 at 8:00am and 2:00pm, 01/05/24 - 01/07/24, 01/10/24, 01/13/24 - 01/14/24, 01/20/24 - 01/21/24, 01/25/24, 01/27/24 -01/28/24, and 01/31/24 at 2:00pm due to "resident not available".

Review of Resident #5's eMAR for 02/01/24 - 02/07/24 revealed:
-There was an entry for gabapentin 300mg three times daily with administration times of 8:00am, 2:00pm, and 8:00pm.
-There was documentation the gabapentin was not administered on 02/07/24 at 2:00pm due to "resident not available".

Observation of Resident #5's medications available for administration on 02/07/24 at 4:08pm revealed one bottle of 90 capsules labeled gabapentin 300mg take 1 capsule three times daily with a dispense date of 02/05/24.

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D 273	Continued From page 11 Interview with the medication aide (MA) on 02/07/24 at 4:00pm revealed: -Resident #5 left the facility for the day every Wednesday, Saturday, and Sunday to visit her cat at her privdate home and did not arrive back to the facility until 4:00pm or 4:30pm. -The 8:00am and 2:00pm doses were not administered when Resident #5 was not in the facility during the day. -She did not know if the PCP was notified of the missed doses of gabapentin because it was not her responsibility, it was managements responsibility. -She did not notify the RCC of the missed doses of gabapentin because it was "common knowledge" in the facility that Resident #5 was not available for some of the doses of gabapentin. Interview with the RCC on 02/08/24 at 8:45am revealed: -She did not know Resident #5 missed doses of gabapentin. -She knew Resident #5 left the facility three days per week. -The MAs were trained to notify her and the PCP of missed medications. -She did not know why the PCP was not notified. -She did not know if the eMARs were audited for accuracy and missed medications. Interview with the Special Care Coordinator (SCC) on 02/08/24 at 8:03am revealed: -The MAs should have notified management and the PCP that Resident #5 missed doses of gabapentin. -Management reviews eMARs every six months for accuracy unless there is an issue reported by staff.	D 273		

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-She did not know why the MAs did not notify the PCP or management.

Telephone interview with Resident #5's PCP on 02/08/24 at 9:30am revealed:
-Resident #5 was prescribed gabapentin to treat diabetic neuropathy (nerve damage that can cause pain and numbness).
-Resident #5 could have an immediate increase in pain due to missed doses of gabapentin.
-He expected to be notified that Resident #5 missed her doses of gabapentin.

Interview with Resident #5 on 02/08/24 at 9:40am revealed:
-She was ordered gabapentin for diabetic neuropathy in her feet.
-She left the facility three times weekly for the day.
-Some MAs gave her the dose of gabapentin to take with her and some did not.

Interview with the Administrator on 02/08/24 at 9:53am revealed:
-She expected the MAs to notify the PCP when a resident missed medications.
-She did not know why the PCP was not notified that Resident #5 missed gabapentin doses.

Attempted telephone interview with a second MA on 02/09/24 at 9:34am was unsuccessful.

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Interview with the Special Care Coordinator (SCC) on 02/09/24 at 8:20am revealed:
-If staff saw any resident displaying inappropriate behavior, they were to notify management immediately.
-Management would do an incident report, notify the family and the PCP and then put interventions in place.

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(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
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Continued From page 13

-Resident #1 stayed in his room mainly except for meals and would occasionally come to the living room to watch a football game.
-She was unaware of any incidents of Resident #1 having any sexual encounters with any female resident.
-No staff had informed her of any sexual encounters between Resident #1 and Resident #3 nor Resident #1 and Resident #6.

Interview with the Administrator on 02/09/24 at 9:05am revealed:
-The PCAs were supposed to report incidents to the MAs, and the MAs report it to the SCC and then the SCC was supposed to report it to her.
-If staff had reported it as they should have, they would have completed an incident report, called the families, the PCP and sent a report to Department of Social Services.
-No staff informed her of any incidents of sexual encounters with Resident #1 and Resident #3 or Resident #1 and Resident #6.

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The failure of the facility to ensure residents on a SCU with diagnoses of Alzheimer's and/or dementia related to sexual encounters involving Resident #1 and Resident #3, Resident #1 and Resident #6, where the PCP was not notified allowing the sexual encounters to become an ongoing issue, and a resident (Resident #5) who missed doses of a nerve pain medication not being reported to the primary care provider. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

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The facility provided a plan of protection on 02/29/24 in accordance with G.S. 131D-34 for this violation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056006	A. BUILDING: ______ B. WING ______	R-C **02/09/2024**

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FRANKLIN HOUSE	**186 ONE CENTER STREET** **FRANKLIN, NC 28734**

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D 273	Continued From page 14 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 25, 2024.	D 273		