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D 000	Initial Comments The Adult Care Licensure Section and Mecklenburg County Department of Social Services conducted a complaint investigation on January 30, 2024 through February 02, 2024 and February 05, 2024, with a desk review from February 06, 2024 through February 09, 2024 and an onsite exit on February 12, 2024.	D 000		
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: TYPE A1 VIOLATION Based on interviews and record reviews the facility failed to ensure physician's orders were implemented for 2 of 5 sampled residents (#1 and #5) related to taking blood pressures twice daily (#1) and taking finger stick blood sugars (FSBS) twice daily (#5). The findings are: 1. Review of Resident #1's current FL2 dated 08/21/23 revealed diagnoses included hypertension, chronic congestive heart failure, and severe chronic kidney disease stage 4. Review of Resident #1's Primary Care Provider's (PCP) order dated 09/13/23 revealed staff were	D 276		

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to obtain Resident #1's blood pressure twice daily and record it on the electronic Medication Administration Record (eMAR).

Review of Resident #1's October 2023, November 2023, and December 2023 eMARs revealed there were no entries for blood pressures twice daily.

Review of Resident #1's Gastrologist's note dated 12/26/23 revealed:
-The resident was scheduled on 12/26/23 to have an esophagogastroduodenoscopy (EGD) for variceal screening (a procedure to screen for enlarged veins in the esophagus, stomach and beginning of small intestines).
-Resident #1's blood pressures on 12/26/23, while at the procedure, were 183/87 at 7:58am, 180/90 at 8:42am, 189/86 at 8:52am, and 197/90 at 9:20am (According to the American Heart Association a normal blood pressure should be less than 120/80).

Telephone interview with Resident #1's family member on 02/02/24 at 10:10am revealed after the EGD, Resident #1 was not feeling well, and she was transported across the street to the ED.

Review of Resident #1's Emergency Department (ED) provider's note dated 12/26/23 revealed:
-Resident #1 had crackles (abnormal lung sounds) on inspiration and was significantly hypertensive (blood pressures greater than 120/80).
-Resident #1's blood pressures on 12/26/23 were 198/84 at 10:02am and 204/94 at 11:01am.
-There was concern Resident #1 had congestive heart failure (CHF) (a condition when the heart cannot pump blood well enough to meet the body's needs) and the clinical impression was

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hypertensive emergency (a condition where the blood pressure was very high with potentially life-threatening symptoms).
-Resident #1 was admitted to the hospital.

Review of Resident #1's hospital discharge summary dated 01/02/24 revealed:
-Resident #1 was admitted on 12/26/23 for hypertensive emergency and acute on chronic diastolic heart failure (when the left ventricle of the heart cannot fill properly due to stiffness).
-Resident #1 had multiple hospitalizations for CHF and uncontrolled hypertension recently.
-Resident #1 was discharged to a skilled nursing facility on 01/02/24.

Telephone interview with Resident #1's PCP on 01/18/24 at 3:20pm revealed she ordered the resident's blood pressure to be checked twice daily because Resident #1 had hypertension and she wanted to monitor Resident #1's blood pressure.

A second telephone interview with Resident #1's PCP on 01/31/24 at 2:35pm revealed:
-She was not aware her order for Resident #1's blood pressure to be obtained twice daily was not implemented until she spoke to the surveyor on 01/18/24 at 3:20pm.
-She ordered Resident #1's blood pressure readings to be placed on the eMAR so she could review them when she visited the facility.

Interview with the Resident Care Coordinator (RCC) on 02/05/24 at 10:54am revealed:
-Resident orders were placed on the eMAR by the RCC, Special Care Unit Coordinator (SCC), facility compliance nurse, the Administrator or a few MAs that were trained in medication order entry.

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-Resident #1's order for blood pressures twice daily was entered into the eMAR but was entered incorrectly.
-Because it was entered incorrectly, it did not show up on Resident #1's eMAR for MAs to complete it.
-There was no process in place to ensure orders were entered correctly.

Interview with the facility's Compliance Nurse on 02/12/24 at 3:18pm revealed:
-She was hired as the facility Compliance Nurse in October 2023.
-The RCC, SCC, or a few trained MAs were trained and responsible for entering orders into the eMAR system.
-The RCC and the SCC were trained on order entry by a corporate nurse.
-After orders were to be entered into the eMAR system, the order was to be placed in the red box in the copy room.
-She was responsible for comparing/reviewing the orders placed in the red box to the orders entered in the eMAR system for accuracy.
-Resident #1's blood pressure twice daily order would have had to be entered correctly for it to show up for the MAs to see the order.
-She was not aware of Resident #1's blood pressure order because it was prior to her employment at the facility.
-She had not audited this resident's record since she began in October 2023.

Interview with the Regional Director of Operations (RDO) on 01/05/24 at 4:02pm revealed:
-Resident #1's orders were to be entered on the eMAR by the RCC, SCC, Compliance Nurse, or a few MAs that were trained in medication order entry.
-He was not aware there was a red box in the

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copy room in which to place orders that had been entered into the eMAR system for the entered order to be reviewed for accuracy.
-He did not know the Compliance Nurse had not audited Resident #1's record since she began working at the facility in October 2023.

2. Review of Resident #5's current FL2 dated 06/19/23 revealed diagnoses included dementia, hypertension, type 2 diabetes, and anxiety.

Review of Resident #5's physician order dated 12/12/23 revealed to check finger stick blood sugar (FSBS) daily before breakfast and before supper.

Review of Resident #5's December 2023 and January 2024 eMAR revealed:
-There was an entry to check FSBS daily at 8:00am.
-There was no entry to check FSBS daily before supper.

Review of Resident #5's Emergency Department (ED) note on 01/26/24 revealed:
-Resident #5 was admitted to the ED for a blood sugar of 45 in the facility after receiving the wrong insulin.
-Oral glucose was given by EMT's (emergency medical technician) prior to Resident #5 being admitted to the ED.
-Resident #5 blood glucose was stabilized and she was returned to the facility on 01/26/24.

Interview with a MA on 02/01/24 at 10:20am revealed:
-She did not know Resident #5 was to have a FSBS before breakfast and before supper.
-The eMAR showed Resident #5 was to have them done daily at 8:00am.

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-The SCC entered the orders on the eMAR, and she followed the orders.
-She did not do any cart audits on orders and thought the SCC did them.

Interview with the SCC on 02/02/24 at 11:10am revealed:
-He did not know Resident #5 was to have a FSBS before breakfast and supper.
-He entered physician orders for the residents in the SCC, but he did not recall seeing an order for Resident #5's FSBS before breakfast and supper.
-Sometimes the orders were entered in by the corporate office and they must have been put into the eMAR wrong.
-We do medication cart audits twice a week, but the audits are for medications.

Interview with the Compliance Nurse on 01/31/24 at 3:35pm revealed:
-She did not do the audits.
-The results and any issues of the audits were given to the Administrator and discussed in the morning meetings.

Telephone interview with Resident #5's PCP on 02/05/24 at 2:39pm revealed:
-She was not aware Resident #5 was not getting a FSBS as ordered before breakfast and supper.
-When she reviewed Resident #5's record, she saw there were no FSBS being completed.
-She wrote an order on 12/12/23 for a FSBS to be done daily before breakfast and supper.
-She would expect the staff to follow orders.
-She was aware Resident #5 went to the emergency department (ED) for a medication error and a low FSBS on 01/26/24.
-Resident #5 could have a drop in her blood sugar due to the medication error but did not see any detriment with not having the FSBS done

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D 276	Continued From page 6 twice daily before breakfast and before dinner. Interview with the RDO on 02/05/24 at 4:02pm revealed: -He was not aware Resident #5 was not getting a daily FSBS before breakfast and supper. -Whoever put it in the system did not put it in correctly, so the FSBS did not show up on the eMAR to have them done. -The Compliance Nurse received the medication cart and resident record audits after completion by the SCC and RCC and brought them to the morning meetings. -He did not know what audits were being completed. _____ The facility failed to ensure the implementation of a physician's orders for blood pressures twice daily for Resident #1 who was hospitalized after she had a hypertensive emergency with heart failure and eventually was discharged to a skilled nursing facility and Resident #5 who had an order for FSBS before breakfast and supper who was later hospitalized for a medication error. The failure resulted in serious physical harm and constitutes a Type A1 violation. _____ The facility provided a plan of protection in accordance with GS 131D-34 on JANUARY 31, 2024. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 13, 2024.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights	D 338		

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An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled residents (Resident #2 and #3) were free from neglect, abuse and exploitation related to reports of a male staff member inappropriately touching, hugging, and kissing while staff observed the behaviors and did not intervene to protect the residents.

The findings are:

Review of the facility Reporting Abuse, Neglect, or Financial Exploitation policy with an effective date of 08/01/21 revealed:
-A resident currently living in the community must be free from mental, verbal, sexual and physical abuse, neglect, involuntary seclusion, and financial exploitation.
-If abuse, neglect, or financial exploitation is witnessed, associates are to remove the resident from the situation immediately, bring the resident to a safe location within the community and immediately notify your supervisor, Health and Wellness Director, Executive Director or 911 if the resident is injured.
-Do not leave the resident alone, stay with the resident until they can be assessed to ensure they are out of harm's way.
-The Executive Director will immediately (but no later than 24 hours) notify orally or in writing the County Department of Social Services and the

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HCPR.
-The resident's responsible party or contact person, as indicated on the Resident Register, will be notified immediately by the Executive Director.
-The Executive Director will notify the Health Care Personnel Registry (HCPR) within 24 hours of knowledge of all instances of abuse.
-A thorough investigation of all allegations must take place and thorough documentation must be completed by the Executive Director.

1. Review of Resident #3's current FL2 dated 11/10/23 revealed:
-Diagnoses included dementia, hypertension, and anemia.
-She was semi-ambulatory.
-She was intermittently disoriented.
-Recommended level of care was assisted living.

Interview with Resident #3's family member on 01/31/24 at 2:30pm revealed:
-Resident #3 was unable to answer questions due to her dementia.
-She was contacted on 01/02/24 at 5:35pm by the Administrator to report an incident with Resident #3.
-The Administrator told her the former Maintenance Director was seen applying lotion to Resident #3's feet.
-She had met the former Maintenance Director previously but did not realize he was not a personal care staff member/employee.
-She asked the Administrator if Resident #3 was okay, if Resident #3 had been sexually abused and the Administrator said no and that she just needed to let the family know of the incident.
-At 5:43pm, she received another call from the Administrator stating it was protocol to take the resident to the emergency department (ED) and

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that the Resident #3's Primary Care Provider (PCP) had recommended an ED evaluation.
-She asked if she could call the Administrator back due to her wanting to discuss this with another family member.
-She called the Administrator back at 6:08pm and said unless she knew of anything more serious than lotion being applied to resident's feet, pain, bleeding or if the Administrator suspected anything further had happened to Resident #3, she did not wish for Resident #3 to go to the ED.
-The Administrator stated no suspicion of anything further than the maintenance director applying lotion to resident's feet.
-She received a phone call from a Detective with the local police department on 01/03/24 at 3:07pm who asked for consent to send Resident #3 to the ED for an evaluation.
-The detective asked for an ED evaluation due to possible sexual assault.
-She was told the former Maintenance Director had been seen applying lotion to Resident #3's feet by the Administrator and nothing else was mentioned even when the family member specifically asked.
-She spoke with a second detective several times afterwards.
-She met with the second detective at the facility at 8:00pm or later, on 01/04/24 who had a search warrant.
-Evidence was taken from Resident #3's person along with clothing and bedding.
-She again notified the Detectives that she was only informed of lotion being applied to Resident #3 by the former Maintenance Director or she would have agreed to send Resident #3 to the ED for an evaluation.
-A detective informed her that a staff member had taken a video of the incident where it was mentioned to him by the Administrator that

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Resident #3's pants were pulled down.
-She called the Administrator to ask her about the above and the Administrator stated this was the first time she had heard about Resident #3's pants being pulled down.

Review of Resident #3's Resident Register revealed an admission date of 10/25/22.

Review of Resident #3's Accident and Incident Report dated 01/02/24 revealed:
-There was an electronic fax confirmation to the County Department of Social Services with a timestamp of 4:04pm.
-The report was completed by the facility Compliance Nurse with the incident time documented at 9:00am.
-Under section for the description of the accident, documentation stating the Administrator notified the facility Compliance Nurse that a staff member who was not qualified to provide personal care was observed in the Resident #3's room with his hands on her genital area and staff member was escorted out of the community and suspended pending an investigation.
-There was documentation of Resident #3's PCP being notified at 11:11am.
-There was no documentation that Resident #3's family member was notified.
-There was no documentation that Law Enforcement was notified.

Telephone interview with a former personal care aide (PCA) on 02/05/24 at 10:45am revealed:
-She had reported to the Administrator in early November 2023 that she had seen the former Maintenance Director kiss Resident #3 on the forehead.
-The Administrator told her it was creepy behavior but not necessarily inappropriate.

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-On 01/02/24 around 8:30am she walked into Resident #3's room where she witnessed the former Maintenance Director rubbing lotion on the Resident's face.
-She noticed that the Resident's pants were pulled down to the ankles and states she had changed the Resident around 7:30am and had pulled her pants all the way up to her waist at that time.
-She did not ask the former Maintenance Director to leave.
-She left Resident #3's room and notified the MA.
-She and the MA returned to Resident #3's room where the resident's pants were now pulled up to her knees.
-She and the MA immediately notified the current SCC, leaving the former Maintenance Director unsupervised in the room with Resident #3.
-All three of them returned to Resident #3's room and asked the former Maintenance Director to leave.
-She was asked to write a statement which she did and gave to the Administrator.

Review of the former agency PCA's signed statement dated 01/02/24 revealed:
-She walked into Resident #3's room to give her a nutritional supplement and noticed the former Maintenance Director rubbing lotion on her face.
-She noticed Resident #3's pants were at her ankles which were not left like that when she had left earlier.
-She noticed Resident #3's blinds were closed when they were initially open.
-After giving out room trays, she returned to Resident #3's room, saw the former Maintenance Director was still there and asked him to leave four times.
-The former Maintenance Director kissed the Resident on the forehead and rubbed her feet

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when he was leaving the room.

Interview with a medication aide (MA) on 01/30/24 at 4:44pm revealed:
-She witnessed the former Maintenance Director in the middle of November kiss Resident #3 in the mouth in the dining room.
-She reported this to the SCC who told her to keep an eye on the former Maintenance Director.
-She was never asked about this situation or interviewed by management or the Administrator.
-On 01/02/24 around 8:30am she was notified by a PCA that the former Maintenance Director was in Resident #3's room with his hand underneath the resident's covers.
-When she and the PCA entered Resident #3's room, she decided to record using her cellular device, where she witnessed the former Maintenance Director sitting in the resident's wheelchair, beside the resident laying in her bed with his hand rubbing her underneath the covers, over her private area.
-She asked the former Maintenance Director if Resident #3 needed anything in which the former Maintenance Director stated no.
-She and the PCA then left Resident's #3 room, leaving the former Maintenance Director in the room alone with Resident #3.
-She and the PCA immediately notified the current SCC.
-She, the PCA and the SCC all went to Resident #3's room where the former Maintenance Director was still sitting beside the resident.
-All three of them left Resident #3's room to call the Administrator.
-The former Maintenance Director was not asked to leave the room, and no one stayed in the room with the resident or tried to remove Resident #3 from the room.
-She and the PCA then returned to Resident #3's

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room after the Administrator was notified and asked the former Maintenance Director to leave.
-She was asked to write a statement which she did and gave the statement to the Administrator.
-She was later questioned by two law enforcement detectives on 01/04/24.

Review of the MA's signed statement dated 01/02/24 revealed:
-She was in the dining room when a staff member came and reported to her that two residents were being touched inappropriately.
-She immediately went down the hall to Resident #3's room, took out her phone to record, and noticed the former Maintenance Director rubbing Resident #3 under the covers.
-She asked the former Maintenance Director if the resident needed any assistance and the former Maintenance Director said no.
-She left the room and got management to make sure she was seeing things correctly.
-The resident was being mistreated by the staff member.
-She then asked the former Maintenance Director to leave.
-She sat by Resident #3's door to make sure the staff member didn't return into the resident's room.

Interview with the special care coordinator (SCC) on 01/30/24 at 4:08pm and on 02/12/24 at 11:45am revealed:
-He reported to the Administrator that a staff member had witnessed the former Maintenance Director kiss Resident #3 in the mouth, but he did not know what happened after he reported it.
-The former Maintenance Director was witnessed taking residents to the bathroom which was reported to the Administrator.
-He did not document any of these reported

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incidents or any notification to the Administrator.
-The Administrator held a stand-up meeting, he was uncertain of the date, with the former Maintenance Director present in which Administrator informed everyone that non-care staff were not to provide personal care to residents.
-On 01/02/24 he was asked to come to Resident #3's room by an MA and a PCA where he witnessed the former Maintenance Director with his hand under the resident's blanket rubbing over her private area.
-He left the room to call the Administrator and inform her that he and two other staff had witnessed the former Maintenance Director with his hand under the resident's blanket rubbing over her private area.
-The MA and PCA asked the former Maintenance Director to leave the room.
-The Administrator came to the facility shortly after and suspended the former Maintenance Director.
-He was asked to write a statement which he did and gave the statement to the Administrator.

Review of the SCC's signed statement dated 01/02/24 revealed:
-A MA came and got him due to her being concerned that the former Maintenance Director in Resident #3's room.
-When he approached Resident #3's room, he witnessed the former Maintenance Director with his hand under the blanket rubbing in Resident #3's private area.
-He asked the former Maintenance Director if he was okay, and the former Maintenance Director answered yes.
-He then left the room and called the Administrator.

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Telephone interview with a law enforcement detective on 01/31/23 at 4:39pm revealed:
-On 01/02/24, the facility Administrator waited until after normal business hours, between 5:30pm and 6:00pm, to notify law enforcement of a possible sexual assault crime which was observed by staff on 01/02/24 between 8:30am and 9:00am which had been immediately reported to the Administrator.
-He expected the Administrator to immediately notify law enforcement on 01/02/24 to reduce the opportunity for any evidence to be contaminated or discarded.
-He interviewed the former Maintenance Director in January 2024.
-A PCA had been interviewed and felt the former Maintenance Director had spent too much time in residents' rooms without a need for maintenance services.
-He felt the former Maintenance Director's behavior was inappropriate.

Telephone interview with a second law enforcement detective on 02/01/24 at 11:30am revealed:
-He conducted numerous interviews with facility staff after an incident on 01/02/24 which involved the former Maintenance Director.
-He had conducted an interview with the former Maintenance Director in January 2024 related to an allegation of sexual assault to a resident.
-He said the former Maintenance Director had admitted to applying lotion to Resident #3's face, feet, legs and massaging her thighs to help with circulation.
-He said the former Maintenance Director had admitted to kissing Resident #3 on the forehead.
-He said the former Maintenance Director admitted to feeding Resident #3.
-The detective stated the facility should have

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notified law enforcement immediately on 01/02/24.
-He stated crucial evidence could have been obtained prior to resident receiving a bath, change of clothing or change of bedding.
-He felt the former Maintenance Director's behavior was inappropriate.

Review of a video recording by a MA from 01/02/24 with a timestamp of 8:33am on 02/01/24 at 3:36pm revealed:
-The former Maintenance Director in Resident #3's room, sitting in a wheelchair on the left side of resident and resident's bed.
-Resident #3 was lying flat on her back in the bed with her head turned towards the left.
-Resident #3 had a blanket laying over the top of her body which had been folded under, exposing her left side.
-Resident #3's pants covered her left leg, up to her left knee, leaving her left knee, thigh and hip completely exposed, uncovered and bare.
-The former Maintenance Director was leaning forward in the wheelchair.
-Resident #3's left hand was crossed over her right hand, on top of the blanket, over her chest area with the former Maintenance Director's left hand placed on top/over resident's hands.
-The former Maintenance Director's right arm was viewed under the blanket, arm leading from just above resident's exposed hip area to her lower abdominal area.

Telephone interview with the former Maintenance Director on 02/01/24 at 3:50pm revealed:
-He was the facility's Maintenance Director between 07/03/23 and 01/03/24.
-He frequently greeted residents daily with hugs, scratching their backs over their shirts, and kissing foreheads.

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-He stated he provided Resident #3 care by giving her juice and water, feeding her, applying chapstick to her lips and putting lotion on her face, hands, feet, legs, and thighs.
-He admitted that he would massage her thighs to help with circulation.
-He did not tell any staff he had been applying chapstick, lotion or he was feeding Resident #3.
-He assisted Resident #3 with sitting up in the bed due to her not being able to sit up on her own.
-He visited her five to six times a day for around ten minutes per visit.
-In October 2023, the Administrator notified him that a PCA had a concern for how he showed affection towards residents.
-In October 2023, the Administrator talked with him about 'being mindful' of how he showed affection towards residents could be uncomfortable for care staff.

Telephone interview with the Chief Operations Officer (COO) on 02/02/24 at 1:00pm revealed:
-On 01/02/24 at approximately 10:30am, she had a telephone call with the Administrator, and she instructed the Administrator to call law enforcement related to the allegation of sexual assault to Resident #3 by the former Maintenance Director.
-She expected the Administrator to immediately call law enforcement on 01/02/24.
-She was unaware until late January 2024, that the Administrator had waited till after 5:00pm on 01/02/24 to notify law enforcement of an allegation of sexual assault to Resident #3 by the former Maintenance Director.
-She was unaware the Administrator only told Resident #3's family member that the former Maintenance Director was seen rubbing lotion to resident's feet.

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-She said Resident #3's family member should have been notified of what was documented in the Accident and Incident report.

Review of Resident #3's progress note dated 01/02/24 revealed:
-The Administrator entered the documentation.
-Late entry was documented with an effective date of 01/02/24 at 5:25am.
-The Administrator spoke with the Department of Social Services about the incident filed, instructed to file a 24-hour report.
-The 24-hour report was filed, faxed, and emailed with confirmation.
-Law enforcement was contacted at 5:25pm and did not arrive until after 10:40pm.
-The family was contacted at 5:42pm notifying them of the incident.
-The PCP sent an update stating it would not hurt to send Resident #3 out for an evaluation.
-Family refused to send out resident, stating that if no signs of injury were seen they did not want her in the Emergency Department where she could catch an infectious virus that is going around and due to her age, it was likely.

Interview with the Regional Director of Operations on 02/02/24 at 3:55pm revealed:
-He did not know staff had documented written statements from 11/01/23.
-He stated due to content of the staff's written statements constituted grounds for immediate termination of the former Maintenance Director.
-He stated the facility should have notified law enforcement and began a 24-Hour report for the HCPR.

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

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2. Review of Resident #2's current FL2 dated 11/10/23 revealed:
-Diagnoses included Alzheimer's disease, bursitis of left hip, major depression, and other symptoms and signs involving cognitive functions and awareness.
-She was ambulatory and constantly disoriented.
-Resident #2's recommended level of care was Special Care Unit (SCU).
-Resident #2 was admitted to the SCU on 07/26/21.

Review of Resident #2's signed Resident Register revealed Resident #2 was admitted to the facility on 07/26/21.

Review of a signed dietary aide's statement dated 11/01/23 revealed:
-She observed the former Maintenance Director on numerous occasions touch female residents, mainly Resident #2, where residents shouldn't be touched.
-The former Maintenance Director was observed taking Resident #2 from the Living room and walked somewhere no one could see them.
-The former Maintenance Director entered Resident #2's room and took her hair out of the style it was in.

Interview with a dietary aide on 01/30/24 at 11:46am revealed:
-She reported to the previous Special Care Coordinator (SCC) towards the end of October 2023 that she was uncomfortable with the former Maintenance Director hugging and kissing Resident #2 who resided in the SCU.
-She witnessed the Maintenance Director hug and kiss Resident #2 three or more times.
-She reported this to the Administrator in October

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2023, but stated nothing was done as far as she was aware of.
-She was asked to provide a written statement along with two other staff who had witnessed the former Maintenance Director's inappropriate behavior and gave the written statement to the SCC.

Review of a signed PCA's statement dated 11/01/23 revealed:
-She observed the former Maintenance Director on numerous occasions touch female residents, mainly Resident #2, where residents shouldn't be touched.
-The former Maintenance Director was observed taking Resident #2 from the living room and walked somewhere no one could see them.
-The former Maintenance Director entered Resident #2's room and took her hair out of the style it was in.

Telephone interview with a first shift PCA on 02/01/24 at 10:40am revealed:
-She witnessed the former Maintenance Director take Resident #2, to the bathroom where he stood beside the resident as she sat on the toilet but was uncertain of the date.
-She witnessed the former Maintenance Director almost every time he worked, take Resident #2's hair down and witnessed him playing with the resident's hair which she felt was inappropriate.
-She reported the former Maintenance Director's inappropriate behavior to the former SCC several times and to the Administrator starting at the end of October 2023.
-She was asked to provide a written statement along with two other staff who had witnessed the former Maintenance Director's inappropriate behavior and gave the written statement to the SCC.

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D 338	Continued From page 21 Review of a signed MA's statement 11/01/23 revealed: -She observed the former Maintenance Director inappropriately touch Resident #2 on SCU. -The former Maintenance Director appeared to show extra attention to Resident #2 and would rub her back and hair. Telephone interview with a former MA on 02/01/24 at 12:40pm revealed: -In the fall of 2023, the former Maintenance Director would massage Resident #2's head, give her back rubs and kiss her on her cheek. -In the fall of 2023, she had observed the former Maintenance Director escort Resident #2 to her bedroom but did not know why he did this with Resident #2. -She provided a written statement to the Administrator related to the former Maintenance Director on 11/01/23. -She was never interviewed by the Administrator or management staff related to her written statement dated 11/01/23. -In the fall of 2023, she told the Administrator of staff concerns related to the former Maintenance Director's behavior towards Resident #2 and the Administrator, "would laugh it off". -She never tried to intervene due to the Administrator already being made aware by multiple staff of the former Maintenance Director's inappropriate behaviors which he had continued. Telephone interview with the former Maintenance Director on 02/01/24 at 3:50pm revealed: -He was the Maintenance Director between 07/03/23 and 01/03/24. -He frequently greeted residents in the SCU daily with hugs, scratching their backs over their shirts,	D 338		

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and kissing foreheads.
-In the fall of 2023, on one occasion, he was in Resident #2's room repairing a telephone and Resident #2 entered the room while she was pulling her pants down and was defecating on the floor, he assisted her to the toilet and left the room to locate a PCA.
-In October 2023, the Administrator notified him that a PCA had a concern for how he showed affection towards residents.
-In October 2023, the Administrator talked with him about 'being mindful' of how he showed affection towards residents that could be uncomfortable for care staff.

Telephone interview with Resident #2's Power of Attorney on 02/05/24 at 9:18am revealed:
-Resident #2 was admitted to the SCU in July 2021.
-Resident #2 required assistance with bathing, toileting, dressing, and grooming.
-Resident #2 was ambulatory and constantly disoriented.
-She was not aware of any allegations of abuse, neglect, or exploitation involving Resident #2.

Telephone interview with a former agency PCA on 02/05/24 at 10:50am revealed:
-She occasionally worked in the SCU.
-When she worked in the SCU, the former Maintenance Director was frequently there spending time with Resident #2.
-Resident #2 was frequently hugged, had her back rubbed over her clothing, and walked down the hallway holding the former Maintenance Director's hand.
-She did not observe the former Maintenance Director in Resident #2's room.
-She did not feel comfortable with the amount of affection the former Maintenance Director

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provided to Resident #2.
-She did not intervene when she witnessed the former Maintenance Director's inappropriate behaviors towards Resident #2.

Telephone interview with a PCA on 02/07/24 at 11:30am revealed:
-She worked first and second shift.
-She worked in the SCU.
-Between September 2023 and October 2023, she notified the Administrator of a concern because she had observed the former Maintenance Director changing Resident #2's brief at her bedside.
-She was not aware of any investigation which involved the former Maintenance Director between September 2023 and November 2023, until an incident occurred with the former Maintenance Director on 01/02/24.

Interview with a first shift MA on 01/03/24 at 11:30am revealed:
-She had concerns about the former Maintenance Director's level of physical contact with residents.
-She had notified the former SCC and the current SCC of her concerns for the former Maintenance Director's physical contact with residents.
-She had frequently observed the former Maintenance Director rub residents' backs, kiss female residents on their cheek close to their mouths.
-She felt uncomfortable around the former Maintenance Director due to him constantly hugging residents.
-On 01/02/24, around 7:00am, she observed the former Maintenance Director rubbing Resident #2's feet in the Living room.
-She did not intervene when she witnessed the former Maintenance Director rubbing Resident #2 feet.

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D 338	Continued From page 24 Interview with a first shift MA on 01/30/24 at 4:45pm revealed: -Sometime in the Fall of 2023, she attended a staff meeting directed by the Administrator. -The Administrator notified staff that facility employees were permitted to touch residents' shoulders and that it was not to be considered inappropriate. Telephone interview with the former SCC on 01/31/24 at 4:20pm revealed: -She worked in the SCU between October 2023 and December 2023. -She and facility staff were concerned the former Maintenance Director favored Resident #2 over other residents. -Staff had observed the former Maintenance Director frequently holding hands with Resident #2 while walking down the hallway, and rubbing her back, and would occasionally observe the former Maintenance Director walking out of Resident #2's bedroom and he was not in there to perform maintenance repairs. -In early November 2023, staff wrote statements in reference to their concerns related to the former Maintenance Director's inappropriate behaviors. -In early November 2023, she provided the written statements to the Administration. -She was unaware of the Administrator interviewing staff related to the written statements. Interview with the SCC on 01/30/24 at 4:10pm revealed: -The former SCC had provided the Administrator with staff statements related to the former Maintenance Director's inappropriate behaviors. -He did not know what was written in the staff	D 338		

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statements.
-In the fall of 2023, some staff had informed him they witnessed the former Maintenance Director show affection towards Resident #2, including kissing the resident on the cheek and forehead.
-In the fall of 2023, the Administrator did not interview him related to the former Maintenance Director's interactions with residents.
-In the fall of 2023, the Administrator was aware of staff concerns for the former Maintenance Director providing care to residents because she notified all department managers during meetings to ensure only staff assigned to resident care, performed resident care needs.

Interview with the facility Compliance Nurse on 01/31/24 at 5:35pm revealed:
-Prior to 01/02/24, she was not aware staff had expressed concerns about the former Maintenance Director's physical interactions with residents.
-Sometime prior to 01/02/24, during management meetings, the Administrator had instructed non-care staff to avoid assisting residents with care.
-The former Maintenance Director was not responsible for providing resident care.

Interview with the Administrator on 02/02/24 at 2:55pm revealed:
-On 10/19/23, a dietary aide reported she felt uncomfortable with the former Maintenance Director providing hugs to residents, and kissing residents on their foreheads.
-She interviewed additional staff and was told the former Maintenance Director was often observed giving hugs to Resident #2.
-She determined the former Maintenance Director's hugging of Resident #2 was not inappropriate due to Resident #2 frequently

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having episodes of crying where she sought out staff for hugs.
-She did not document the staff concerns or interviews.
-On 10/20/24, she met with the former Maintenance Director and notified him staff felt uncomfortable with his physical expressions of affection towards residents and to be careful how he interacted with residents.
-On 10/20/24, she notified the former Maintenance Director that kissing of residents was not permitted.
-Between 10/19/23 and 01/02/24, staff had not provided any written statements related to the former Maintenance Director.
-She did not know of any written statements provided by staff concerning the former Maintenance Director dated 11/01/23.
-Between 10/19/23 and 01/02/24, she was not notified of any additional concerns related to the former Maintenance Director, or any other staff related to allegations of inappropriate behaviors.

Telephone interview with the Chief Operating Officer (COO) on 02/01/24 at 1:00pm revealed:
-She was not aware of any signed staff statements in reference to any of the staff's inappropriate behaviors.
-From her perspective she did not feel if staff hugged a resident, it would be considered inappropriate and would not violate residents rights.
-She did feel it was inappropriate for staff to kiss a resident.
-In late January 2024, she learned that the Administrator had waited until after 5:00pm on 01/02/24 to notify law enforcement of an allegation of sexual assault by the former Maintenance Director to a resident.

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D 338	Continued From page 27 The facility failed to ensure two female residents were free of neglect, abuse and explotation including inappropriate touching, hugging and kissing by a male staff member that staff observed and did not intervene or attempt to remove the residents from during the incidents or ensure the male staff was not allowed to continue the inappropriate behavior which included an incident involving Resident #3 where she was inappropriately exposed and the male staff was touching her genitalia. The facility's failure resulted in serious neglect and exploitation which constitutes a Type A1 Violation. The facility provided a plan of protection on January 30, 2024, and on February 12, 2024, in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 13, 2024.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record	D 358		

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reviews, the facility failed to ensure medications were administered as ordered for 4 of 6 sampled residents (#1, #2, #4, and #5) which included a medication to lower blood pressure (#1, #4), a medication to treat an intestinal disorder (#1), a medication to treat vaginal dryness (#1), a medication to treat depression (#2), a medication to treat Alzheimer's disease (#2), a medication to prevent blood clots (#4), and a medication used to control high blood sugars (#5).

The findings are:

1. Review of Resident #1's current FL2 dated 08/21/23 revealed:
-Diagnoses included hypertension, chronic congestive heart failure, severe chronic kidney disease stage 4, and irritable bowel syndrome without diarrhea.
-There was an order for hydralazine (a medication to treat high blood pressure) 50mg, one tablet three times daily.
-There was an order for linaclotide (a medication to treat irritable bowel syndrome) 290mcg, one capsule daily.
-There was an order for estrone vaginal cream (a medication to treat vaginal dryness) 0.1mg/mg, 2gms vaginally daily.

a. Review of Resident #1's Primary Care Provider's (PCP) orders dated 09/07/23 revealed an order for hydralazine 50mg, one tablet three times daily.

Review of Resident #1's December 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for hydralazine 50mg, one tablet three times daily, at 8:00am, 2:00pm and 8:00pm.

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D 358	Continued From page 29 -The entry was documented as administered three times daily from 12/01/23 through 12/21/23, on 12/22/23 at 8:00am, on 12/24/23 at 8:00pm and on 12/25/23 at 8:00pm. -The entry was documented with "09" indicating "other/see nurse notes", on 12/22/23 at 2:00pm and 8:00pm, on 12/23/23 at 8:00am, 2:00pm and 8:00pm and on 02/26/23 at 8:00am and 2:00pm. -The entry was documented with "05" indicating "hold/see nurse notes" on 12/24/23 at 8:00am and 2:00pm and on 12/25/23 at 8:00am and 2:00pm. -The entry was documented with "06" indicating the resident was hospitalized from 12/26/23 at 8:00pm through 12/31/23 at 8:00pm. -Hydralazine 50mg was documented as not administered 9 out of 12 opportunities from 12/22/23 to 12/26/23. Review of Resident #1's nurse notes revealed: -Hydralazine 50mg was not administered to Resident #1 on 12/22/23 at 2:00pm because it was on order. -Hydralazine 50mg was not administered to Resident #1 on 12/22/23 at 8:00pm, 12/23/23 at 8:00pm, 12/24/23 at 8:00am and 2:00PM and on 12/25/23 at 2:00pm because of waiting on pharmacy. -Hydralazine 50mg was not administered on 12/23/23 at 8:00am because the medication could not be located in the medication cart, in the medication room or in overstock. -Hydralazine 50mg was not administered on 12/23/23 at 2:00pm and 12/25/23 at 8:00am because the medication was not in the building. -Hydralazine 50mg was not administered on 12/26/23 at 8:00am because the resident was out for a procedure that morning and was only to receive her blood pressure medications.	D 358		

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Review of Resident #1's Gastrologist's note dated 12/26/23 revealed:
-The resident was scheduled to have an esophagogastroduodenoscopy (EGD) for variceal screening (a procedure to screen for enlarged veins in the esophagus, stomach and beginning of small intestines).
-Resident #1's blood pressures, while at the procedure, on 12/26/23 were 183/87 at 7:58am, 180/90 at 8:42am, 189/86 at 8:52am, and 197/90 at 9:20am (According to the American Heart Association a normal blood pressure should be less than 120/80).
-Anesthesia was consulted on 12/26/23 at 9:20am at Resident #1's bedside and made aware the resident was administered only one of her blood pressure medications that morning.

Review of Resident #1's Emergency Department (ED) provider note dated 12/26/23 revealed:
-Resident #1 had crackles (abnormal lung sounds) on inspiration and was significantly hypertensive (blood pressure greater than 120/80).
-Resident #1's blood pressures on 12/26/23 were 198/84 at 10:02am and 204/94 at 11:01am.
-There was concern Resident #1 had congestive heart failure (CHF) (a condition when the heart cannot pump blood well enough to meet the body's needs) and the clinical impression was hypertensive emergency (a condition where the blood pressure was very high with potentially life-threatening symptoms).
-Resident #1 was admitted to the hospital.

Review of Resident #1 hospital discharge summary dated 01/02/24 revealed:
-Resident #1 was admitted on 12/26/23 for hypertensive emergency and acute on chronic diastolic heart failure (when the left ventricle of

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the heart cannot fill properly due to stiffness).
-Resident #1 had multiple hospitalizations for CHF and uncontrolled hypertension recently.
-Resident #1's hydralazine dose was increased for better blood pressure control.
-Resident #1 was discharged to a skilled nursing facility on 01/02/24.

Observations of medications on hand for Resident #1 on 01/05/24 revealed:
-There were three bubble packs containing hydralazine 50mg for Resident #1.
-All three bubble packs had a fill date of 12/25/23.
-The first bubble pack contained 30 tablets of hydralazine 50mg with no medications missing from the pack.
-The second bubble pack contained 30 tablets of hydralazine 50mg with no medications missing from the pack.
-The third bubble pack contained 9 tablets of hydralazine 50mg with no medications missing from the pack.

Telephone interview with a representative from the facility's contracted pharmacy on 01/31/24 at 10:03am revealed:
-The facility was on cycle fill which meant the residents' medications were dispensed to the facility every 28 days.
-Resident #1's hydralazine 50mg, one tablet three times daily, 84 tablets were dispensed to the facility on 09/28/23.
-Resident #1's hydralazine 50mg should have run out around 10/25/23 or 10/26/23 from the 09/28/23 dispensed date.
-Hydralazine 50mg was not automatically dispensed on 10/25/23 because the pharmacy needed a new order.
-She notified the facility by email each month of residents needing a new order for the

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medications to be dispensed for the next cycle.
-The facility received the new order on 12/13/23 for Resident #1's hydralazine 50mg, three times daily.
-The order dated 12/13/23 was not automatically dispensed to the facility because it was received outside of the window for the cycle fill.
-The facility would have needed to request the medication to be dispensed to catch them up to the date when the cycle-fill would begin again.
-Hydralazine 50mg, 69 tablets were dispensed on 12/25/23 for Resident #1.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/31/24 at 10:14am revealed:
-Hydralazine was a medication used to lower blood pressure.
-If Resident #1 did not receive her hydralazine 50mg as ordered it could lead to elevated blood pressures and possibly a stroke.
-Resident #1's PCP should have been notified of any missed doses of hydralazine 50mg.

Telephone interview with Resident #1's family member on 02/02/24 at 10:10am revealed:
-Resident #1 was prescribed two different blood pressure medications, one to be administered once daily and the other to be administered three times daily.
-Resident #1 was scheduled for an EGD on 12/26/23 and was instructed to only take her blood pressure medications prior to the procedure with a sip of water.
-She could not remember when, but she informed the Administrator of the medication instructions prior to the EGD.
-She was at the facility on 12/26/23 before 6:30am because she was taking Resident #1 out of the facility to her EGD appointment.

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-She observed one blood pressure medication administered to Resident #1 prior to leaving the facility for the EGD procedure.
-She did not know Resident #1 was to receive two blood pressure medications in the morning.
-When Resident #1 was being prepared for her EGD her blood pressure was high, with the systolic number (top number of a blood pressure) being over 200 (normal systolic pressure is less than 120).
-After the EGD, Resident #1 was not feeling well, and she was transported across the street to the ED.
-Resident #1 told the ED physician she was not being administered the blood pressure medication she received three times daily.
-Resident #1 informed the ED physician that facility staff were telling her it was not available for administration.

Telephone interview with Resident #1's PCP on 01/18/24 at 3:20pm revealed:
-Resident #1 was ordered hydralazine 50mg three times daily for hypertension.
-Hydralazine is a short acting medication and that was the reason it was prescribed three times daily.
-If Resident #1 did not receive hydralazine 50mg, three times daily as ordered she could have elevated blood pressures and possibly a vascular accident (stroke).
-Resident #1's hypertensive crisis on 12/26/23 could be related to not receiving her hydralazine 50mg.
-The facility did not notify her Resident #1 was not receiving hydralazine 50mg as ordered.

Interview with the Resident Care Coordinator (RCC) on 02/05/24 at 10:54am revealed she was unsure why Resident #1's hydralazine 50mg was

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not available for administration.

Refer to the interview with the Resident Care Coordinator (RCC) on 02/05/24 at 10:54am.

Refer to the interview with the facility Compliance Nurse on 02/05/24 at 2:39pm.

Refer to the interview with the Regional Director of Operations (RDO) on 01/05/24 at 4:02pm.

b. Review of Resident #1's PCP orders dated 09/07/23 revealed an order for linaclotide 290mcg, one capsule daily.

Review of Resident #1's December 2023 eMAR revealed:
-There was an entry for linaclotide 290mcg, one capsule daily at 8:00am.
-The entry was documented as administered daily from 12/01/23 through 12/10/23 and from 12/15/23 through 12/25/23.
-The entry was documented with "09" indicating "other/see nurse notes", from 12/11/23 through 12/14/23 and on 12/26/23.
-The entry was documented with "06" indicating the resident was hospitalized from 12/27/23 through 12/31/23.
-Linaclotide 290mcg was documented as not administered 4 out of 4 opportunities from 12/11/23 to 12/14/23.

Review of Resident #1's nurse notes revealed:
-Linaclotide 290mcg was not administered on 12/11/23 because the facility was awaiting an order.
-Linaclotide 290mcg was not administered on 12/12/23 because it was unavailable.
-The facility's pharmacy was contacted on 12/13/23 and informed linaclotide 290mcg was

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not available for Resident #1 because the pharmacy needed a new script.
-Linaclotide 290mcg was not administered on 12/14/23 because it was unavailable.

Observations of medications on hand for Resident #1 on 01/05/24 revealed:
-There was a bubble pack containing linaclotide 290mcg for Resident #1.
-The label indicated linaclotide 290mcg, 30 capsules were dispensed on 12/13/23.
-There were 19 capsules remaining.

Telephone interview with a representative from the facility's contracted pharmacy on 02/05/24 at 9:10am revealed:
-Linaclotide 290mcg, 30 capsules were dispensed for Resident #1 on 11/04/23 and 12/13/23.
-If Resident #1 did not receive linaclotide 290mcg as ordered it could result in diarrhea or constipation.

Refer to the interview with the RCC on 02/05/24 at 10:54am.

Refer to the interview with the facility Compliance Nurse on 02/05/24 at 2:39pm.

Refer to the interview with the RDO on 01/05/24 at 4:02pm.

c. Review of Resident #1's PCP orders dated 09/07/23 revealed an order for estrone cream 1%, insert 2 grams vaginally daily.

Review of Resident #1's December 2023 eMAR revealed:
-There was an entry for estrone cream 1%, insert 2 grams vaginally daily.

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D 358	Continued From page 36 -The entry was documented as administered daily from 12/01/23 through 12/02/23, from 12/08/23 to 12/09/23, from 12/14/23 through 12/23/23, and on 12/25/23. -The entry was documented with "09" indicating "other/see nurse notes", from 12/03/23 through 12/07/23 and from 12/10/23 through 12/13/23. -The entry was documented with "02" indicating refused on 12/24/23. -The entry was documented with "06" indicating the resident was hospitalized from 12/26/23 through 12/31/23. Review of Resident #1's nurse notes revealed: -Resident #1's estrone cream 1%, 2 grams was not administered on 12/03/23 because it was not available, and the pharmacy was sending that night (12/03/23). -On 12/04/23, 12/10/23, 12/11/23, and 12/13/23 the nurse notes revealed the estrone cream 1% was not available for administration. -On 12/05/23, 12/06/23, and 12/12/23 the nurse notes did not specify why the estrone cream 1% was not administered to Resident #1. -On 12/07/23 the nurse note revealed the provider had been contacted for a new script and it would be escribed to the pharmacy. Observations of medications on hand for Resident #1 on 01/05/24 revealed there was a partial tube of estrone cream 1% with a pharmacy label with a dispensed date of 12/07/23 on it. Telephone interview with a representative from the facility's contracted pharmacy on 02/05/24 at 9:10am revealed: -Estrone cream 1%, 42.5gm tube was dispensed for Resident #1 on 10/31/23, 12/07/23, and 12/28/23. -A 42.5gm tube of estrone should last about 21	D 358		

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days if 2gms were administered daily as ordered for Resident #1.
-If Resident #1 did not receive estrone cream 1% as ordered it could result in decreased estrogen levels, mood swings and night sweats.

Refer to the interview with the RCC on 02/05/24 at 10:54am.

Refer to the interview with the facility Compliance Nurse on 02/05/24 at 2:39pm.

Refer to the interview with the RDO on 01/05/24 at 4:02pm.

2. Review of Resident #5's current FL2 dated 06/19/23 revealed diagnoses included dementia, hypertension, type 2 diabetes, and anxiety.

Review of Resident #5's PCP orders dated 11/23/23 revealed an order for Lantus 100 unit/ml insulin (a long acting insulin to treat diabetes) inject 17 units subcutaneously in the morning and inject 5 units subcutaneously in the evening.

Review of Resident #5's January 2024 eMAR revealed:
-There was an entry for Lantus 100 unit/ml insulin give 17 units subcutaneously in the morning and 5 units subcutaneously in the evening.
-The entry was documented as administered daily from 01/01/24 through 01/24/24.
-The entry for 01/25/24 was documented with "09" indicating other/see nurse notes.
-The entry for 01/26/24 was documented as "06" indicating other/see nurse notes.

Review of Resident #5's nurse notes revealed:
-Lantus 100 unit/ml insulin was not administered on 01/25/24 because the facility was waiting on

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pharmacy.
-Novolog 17 units (a medication used to control high blood sugar) was administered on 01/26/24 around 8:00am from another resident's insulin because Resident #5 was out of Lantus, 100 unit/ml insulin.
-At 11:30am Resident #5 was not at baseline, and her blood sugar was 45.
-A nurse practitioner for another resident assessed Resident #5 and ordered orange juice followed by sugar water and to call EMS.

Review of Resident #5's emergency department (ED) visit on 01/26/24 revealed:
-She was given oral glucose by EMS.
-She presented to the ED for hypoglycemia secondary to a medication error.
-Blood pressure on admission to the ED was 146/51 and blood sugar was in the 50's.
-Resident #5's blood sugar and blood pressure was stabilized and she was returned back to the facility on 01/26/24.

Observations of medication on hand for Resident #5 on 02/01/24 revealed 2 pens of Lantus, 100 unit/ml insulin. Let's add how many units are in one pen here

Telephone interview with a representative from the facility's contracted pharmacy on 02/02/24 at 4:15pm revealed:
-Lantus 100 unit/ml insulin was dispensed on 11/08/23 for 2 pens, 11/29/23 for 2 pens and 01/26/24 for 2 pens.
-If Lantus 100 unit/ml insulin was not given it could cause her blood sugar to increase.

Attempted telephone interview with Resident #5's guardian on 02/05/24 at 10:57am and 02/08/24 at 3:04pm was unsuccessful.

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D 358	Continued From page 39 Interview with Resident #5's PCP on 02/02/24 at 10:18am revealed: -She was aware the facility ran out of medications. -She was made aware of Resident #5 not getting her Lantus, 100 unit/ml on 01/26/24 because Resident #5 was given another residents insulin. -She was told the facility does cart audits but did not know why Resident #5 did not have any Lantus on the medication cart. -If Resident #5 did not get her insulin, her blood sugar would increase and over time this could cause other complications. Interview with the facility compliance nurse on 01/31/24 at 3:35pm revealed: -She did not know why the insulin was not on the cart for Resident #5. -All staff who administered medication knew they were not to borrow medications from other residents. -Resident #5's Lantus 100 unit/ml insulin was to be reordered by the MAs when there was 1 pen left. Interview with the SCC on 02/02/24 at 9:58am revealed: -The SCC did cart audits 2 or 3 times a week. -The cart audit would identify if any medications were not on the cart. -The cart audit did not have a place to put how many pills were left when the audit was done. -He was not aware Resident #5 did not have any insulin. -When medication was missed, we were to notify the PCP and make her aware and this was not done for Resident #5. Interview with the RDO on 02/05/24 at 4:02pm	D 358		

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revealed:
-The best practice was to do cart audits daily.
-A 24 hour report was run by the facility nurse which identified any medications not given and this report was brought to the morning meeting.
-The facility compliance nurse was responsible for making sure cart audits occurred.
-The facility compliance nurse was responsible for following up with the RCC and SCC to make sure medications were available for the residents.

Refer to interview with the facility Compliance Nurse on 02/05/24 at 2:39pm.

Refer to interview with the RCC on 02/05/24 at 10:54am.

Refer to interview with the RDO on 02/05/24 at 4:02pm.

3. Review of Resident #2's current FL-2 dated 11/10/23 revealed:
-Diagnoses included Alzheimer's disease, bursitis of left hip, major depression, and other symptoms and signs involving cognitive functions and awareness.
-An order for trazodone 50mg (a medication used to treat depression) one tablet daily at bedtime.
-An order for donepezil 5mg (a medication used to treat Alzheimer's disease) one tablet daily.

a. Review of Resident #2's January 2024 eMAR revealed:
-There was an entry dated 09/12/23 for trazodone 50mg tablet daily scheduled for 9:00pm.
-Trazodone 50mg was documented as not administered daily on 01/27/24 and 01/30/24.

Review of Resident #2's January 2024 progress notes revealed:

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D 358	Continued From page 41 -There was an entry dated 01/27/24 at 4:42pm which documented trazodone 50mg medication was not available for administration. -There was an entry dated 01/30/24 at 8:19pm which documented trazodone 50mg medication was not available for administration. Observation of Resident #2's medications available for administration on 01/31/24 at 12:35am revealed trazodone 50mg daily at bedtime was not available for administration. Telephone interview with the facility's contracted pharmacy on 02/02/24 at 12:30pm revealed: -Resident #2's trazodone 50mg medication daily was on a every 28-day cycle fill schedule. -Resident #2's trazodone 50mg medication was filled on 11/16/23 for 28 doses and delivered to the facility on 11/20/23. -Resident #2's trazodone 50mg medication was filled on 12/15/23 for 28 doses and delivered to the facility on 12/18/23. -The facility requested a refill of Resident #2's trazodone 50mg medication on 01/31/24. -Resident #2's trazodone 50mg medication was filled on 01/31/24 for 14 doses and delivered to the facility on 01/31/24. -Resident #2's trazodone 50mg was used to assist with sleeping throughout the night. Telephone interview with Resident #2's Nurse Practitioner on 02/02/24 at 10:18am revealed: -Resident #2 was prescribed trazodone 50mg medication to be administered every night to aid in staying asleep. -She was not aware Resident #2's trazodone 50mg medication was unavailable for administration in January 2024. -She expected the facility to administer Resident #2's trazodone 50mg medication as ordered.	D 358		

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D 358	Continued From page 42 Interview with a first shift MA on 01/31/24 at 12:30pm revealed: -Resident #2's had an order for trazodone 50mg medication to be administered every night. -Resident #2's trazodone 50mg medication was not available for administration. -Resident #2's trazodone 50mg medication was refilled by the facility's contracted pharmacy monthly for 28 doses. -She did not know why Resident #2's trazodone 50mg medication was not available for administration. b. Review of Resident #2's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry dated 07/28/21 for donepezil 5mg tablet daily scheduled for 9:00am. -Donepezil 5mg medication was documented as not administered daily on 01/28/24 and 01/29/24. Review of Resident #2's January 2024 progress notes revealed: -There was an entry dated 01/28/24 at 8:21am which documented donepezil 5mg medication was 'awaiting pharmacy'. -There was an entry dated 01/29/24 at 9:17am which documented donepezil 5mg medication was 'awaiting pharmacy'. Telephone interview with the facility's contracted pharmacy on 02/02/24 at 12:30pm revealed: -Resident #2's donepezil 5mg medication daily was on a every 28-day cycle fill schedule. -Resident #2's donepezil 5mg medication was filled on 11/17/23 for 28 doses and delivered to the facility on 11/20/23. -Resident #2's donepezil 5mg medication was filled on 12/15/23 for 28 doses and delivered to	D 358		

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the facility on 12/18/23.
-The facility requested a refill of Resident #2's donepezil 5mg medication on 01/30/24.
-Resident #2's donepezil 5mg medication was filled on 01/30/24 for 15 doses and delivered to the facility on 01/30/24.
-Resident #2's donepezil 5mg was used to treat memory impairment.
-Resident #2's donepezil 5mg was on a 28 day cycle fill.
-The facility should not run out of donepezil 5 mg unless the facility was using the new 28 day cycle fill to replenish the old 28 day cycle fill.

Interview with a first shift MA on 01/31/24 at 12:30pm revealed:
-Resident #2's had an order for donepezil 5mg medication to be administered daily.
-Resident #2's donepezil 5mg medication was refilled by the facility's contracted pharmacy monthly for 28 doses.
-She did not know why Resident #2's donepezil 5mg medication was not available for administration on 01/28/24 and 01/29/24.
-MAs and the SCC were responsible to audit residents' medications on a weekly basis.

Telephone interview with Resident #2's Nurse Practitioner on 02/02/24 at 10:18am revealed:
-Resident #2 was prescribed donepezil 5mg medication to be administered daily.
-Resident #2's donepezil 5mg was used to treat symptoms of dementia related memory loss.
-She was not aware Resident #2's donepezil 5mg medication was not available for administration in January 2024.
-She expected the facility to administer Resident #2's donepezil 5mg medication as ordered.
4. Review of Resident #4's current FL2 dated 11/09/23 revealed diagnoses included essential

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hypertension, vascular dementia, cardiopulmonary disease, hyperlipidemia, and peripheral vascular disease.

a. Review of Resident #4's PCP orders dated 11/09/23 revealed an order for order for amlodipine besylate (a medication to treat high blood pressure) 10mg tablet daily.

Review of Resident #4's January 2024 eMAR revealed:
-There was an entry for amlodipine besylate 10 mg, one tablet daily scheduled for 8:00am.
-The entry was documented with "09" indicating "other/see nurse notes" on 01/06/24 to 01/07/24, and 01/09/24-01/11/24.
-Amlodipine besylate 10mg was documented as not administered 5 out of 6 opportunities from 01/06/24 to 01/11/24.

Review of Resident #4's nurses notes revealed:
-On 01/06/24 amlodipine besylate 10mg tablet was not administered because the medication was unavailable.
-On 01/07/24 amlodipine besylate 10mg tablet was not administered because the medication was unavailable.
-On 01/09/24 amlodipine besylate 10mg tablet was not administered because the medication was pending delivery.
-On 01/10/24 amlodipine besylate 10mg tablet was not administered, the note read; "MA called in medication for refills last week, family was notified this MA will follow up with family again today."
-On 01/11/24 amlodipine besylate 10mg tablet was not administered because waiting for daughter to bring in medication.

Observation of medications on hand for Resident

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D 358	Continued From page 45 #4 on 01/31/24 at 3:50pm revealed there was a bottle of amlodipine besylate 10mg available with a pharmacy label with a dispense date of 01/02/24 on it. Telephone interview with a representative from Resident #4's pharmacy on 02/06/24 at 10:02am revealed: -Resident #4 had an order for amlodipine besylate 10mg 1 tablet daily. -On 01/02/24 there were 30 tablets of amlodipine picked up on 01/11/2024 by Resident #4's Responsible Party. Telephone interview with Resident #4's Responsible Party on 02/02/24 at 12:15pm revealed: -The facility called when Resident #4 was out of medications, and they called consistently. -She could not recall when they notified her the amlodipine besylate 10mg tablets needed refills. -She needed a three-to-four-day turnaround time to get the medication filled, picked up and delivered to the facility. -She picked up the amlodipine besylate and delivered it to the facility on 01/11/24. Interview with a MA on 1/31/24 at 3:54pm and 02/05/24 at 2:55pm revealed: -When Resident #4's medications would get down to 10 to 15 pills the MAs were to notify Resident #4's Responsible Party and she would pick up the medications from her pharmacy and bring them to the facility. -If the medications were not available after notifying the Responsible Party, the MAs called the facility's contracted pharmacy to get the medication and the facility would bill the family for the cost of the medication. -She was not working when Resident #4 ran out	D 358		

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of his amlodipine besylate on 01/06/24.
-She did not call the contracted pharmacy for amlodipine besylate when she worked on 01/11/24 because she contacted the Responsible Party, and she was bringing in the amlodipine besylate to the facility on 01/11/24.
-If the medication was not available, the MAs would document a "09" code and enter a progress note.
-If a Resident missed more than 2 doses, she would call the Responsible Party to get the medication as soon as possible.
-She would notify the PCP, pharmacy, SCC, and the Compliance Nurse of the missing medication.

Interview with the facility Compliance Nurse on 01/31/24 at 4:54pm revealed Resident #4 missed medications because the medications did not arrive on time, the facility waited too long to receive the medication and the facility did not reach out to the facility's contracted pharmacy to get an extra supply of medication for Resident #4.

Refer to the interview with the SCC on 02/02/24 at 9:58am

Refer to the interview with the facility Compliance Nurse on 02/05/24 at 2:39pm.

Refer to the telephone interview with the facility Compliance Nurse on 02/07/24 at 2:31pm.

Refer to the interview with the RDO on 02/05/24 at 4:02pm.

b. Review of Resident #4's PCP orders dated 11/09/23 revealed an order for losartan potassium 25mg 1 tablet daily (a medication to treat high blood pressure and heart failure).

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Review of Resident #4's January 2024 eMAR revealed:
-There was an entry for losartan potassium tablet 25mg one tablet daily scheduled for 8:00am.
-The entry was documented with an "09" indicating "other/see nurse notes" on 01/09/24, 01/10/24 and 01/11/24.

Review Resident #4's nurses notes revealed:
-On 01/09/24 losartan potassium tablet 25mg was not administered because medication was pending delivery."
-On 01/10/24 losartan potassium tablet 25mg was not administered, the note read; "MA called in medication for refills last week, family was notified, this MA will follow up with family again today."
-On 01/11/24 losartan potassium tablet 25mg give 1 tablet daily was not administered, the note read; "waiting for daughter to bring in medication."

Observation of medications on hand for Resident #4 on 01/31/24 at 3:50pm revealed there was a bottle of losartan potassium 25mg tablets available with a pharmacy label with a dispense date of 01/03/24 on it.

Telephone interview with a representative from Resident #4's pharmacy on 02/06/24 at 10:02am revealed:
-Resident #4 had an order for losartan potassium 25mg 1 tablet daily.
-On 01/02/24 there were 30 tablets of losartan potassium picked up on 01/11/2024 by Resident #4's Responsible Party.

Telephone interview with Resident #4's Responsible Party on 02/02/24 at 12:15pm revealed:
-The facility called when Resident #4 was out of

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medications, and they called consistently.
-She could not recall when they notified her the losartan potassium 25mg tablets needed refills.
-She needed a three-to-four-day turnaround time to get the medication filled, picked up and delivered to the facility.
-She picked up the losartan potassium and delivered it to the facility on 01/11/24.

Interview with a MA on 1/31/24 at 3:54pm and 02/05/24 at 2:55pm revealed:
-When Resident #4's medications would get down to 10 to 15 pills the MAs were to notify Resident #4's Responsible Party and she would pick up the medications from her pharmacy and bring them to the facility.
-If the medications were not available after notifying the Responsible Party, the MAs called the facility's contracted pharmacy to get the medication and the facility would bill the family for the cost of the medication.
-She was not working when Resident #4 ran out of his losartan potassium 25mg tablets on 01/09/24.
-She did not call the contracted pharmacy for Resident #4 when she worked on 01/11/24 because she contacted the Responsible Party who told her she was bringing in the losartan potassium to the facility on 01/11/24.
-If the medication was not available, the MAs would document a "09" code and enter a progress note.
-If a Resident missed more than 2 doses, she would call the Responsible Party to get the medication as soon as possible.
-She would notify the PCP, pharmacy, SCC, and the Compliance Nurse of the missing medication.

Interview with the facility Compliance Nurse on 01/31/24 at 4:54pm revealed Resident #4 missed

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medications because the medications did not arrive on time, the facility waited too long to receive the medication and the facility did not reach out to the contracted pharmacy to get an extra supply of medication for Resident #4.

Refer to the interview with the SCC on 02/02/24 at 9:58am

Refer to the interview with the facility Compliance Nurse on 02/05/24 at 2:39pm.

Refer to the telephone interview with the facility Compliance Nurse on 02/07/24 at 2:31pm.

Refer to the interview with the RDO on 02/05/24 at 4:02pm.

c. Review of Resident #4's PCP orders dated 11/09/23 revealed an order for plavix (a medication to prevent blood clots) 75mg one tablet daily.

Review of Resident #4's January 2024 eMAR revealed:
-There was an entry for plavix 75mg one tablet daily scheduled for 8:00am.
-The entry was documented with "09" indicating "other/see nurse notes" on 01/07/24, 01/09/24, 01/10/24 and 01/11/24.

Review of Resident #4's nurses notes revealed:
-On 01/07/24 plavix 75mg was not administered on 01/07/24 because the medication was unavailable.
-On 01/09/24 plavix 75mg was not administered because the medication was pending delivery.
-On 01/10/24 plavix 75mg was not administered, the note read; "Medication Aide (MA) called in medication for refills last week, family was

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notified, this MA will follow up with family again today."
-On 01/11/24 plavix 75mg was not administered because "waiting for daughter to bring in medication."

Observation of Medications on hand for Resident #4 on 01/31/24 at 3:50pm revealed plavix 75mg had a fill date of 01/02/24 medications were present in the pill bottle.

Telephone interview with a representative from Resident #4's pharmacy on 02/06/24 at 10:02am revealed:
-Resident #4 had an order for plavix 75mg 1 tablet daily.
-On 01/02/24 there were 30 tablets of plavix 75mg picked up on 01/11/2024 by Resident #4's Responsible Party.

Telephone interview with Resident #4's Responsible Party on 02/02/24 at 12:15pm revealed:
-The facility called when Resident #4 was out of medications, and they called consistently.
-She could not recall when they notified her the plavix needed refills.
-She needed a three-to-four-day turnaround time to get the medication filled, picked up and delivered to the facility.
-She picked up the plavix and delivered it to the facility on 01/11/24.

Interview with a MA on 1/31/24 at 3:54pm and 02/05/24 at 2:55pm revealed:
-When Resident #4's medications would get down to 10 to 15 pills the MAs were to notify Resident #4's Responsible Party and she would pick up the medications from her pharmacy and bring them to the facility.

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D 358	Continued From page 51 -If the medications were not available after notifying the Responsible Party, the MAs called the facility's contracted pharmacy to get the medication and the facility would bill the family for the cost of the medication. -She was not working when Resident #4 ran out of his plavix 75 mg tablets on 01/07/24. -She did not call the contracted pharmacy for Resident #4 when she worked on 01/11/24 because she contacted the Responsible Party, and she was bringing in the plavix to the facility on 01/11/24. -If the medication was not available, the MAs would document a "09" code and enter a progress note. -If a Resident missed more than 2 doses, she would call the Responsible Party to get the medication as soon as possible. -She would notify the PCP, pharmacy, SCC, and the Compliance Nurse of the missing medication. Interview with the facility Compliance Nurse on 01/31/24 at 4:54pm revealed Resident #4 missed medications because the medications did not arrive on time, the facility waited too long to receive the medication and the facility did not reach out to the contracted pharmacy to get an extra supply of medication for Resident #4. Refer to the interview with the SCC on 02/02/24 at 9:58am Refer to the interview with the facility Compliance Nurse on 02/05/24 at 2:39pm. Refer to the telephone interview with the facility Compliance Nurse on 02/07/24 at 2:31pm. Refer to the interview with the RDO on 02/05/24 at 4:02pm.	D 358		

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D 358	Continued From page 52 Interview with the RCC on 02/05/24 at 10:54am revealed: -The MAs were responsible for ordering the residents' medications when there were about seven days of medication available to administer. -She tried to train the MAs to order medications early in case a new script was needed. -Medication cart audits were to be completed two to three times per week by her and the SCC. -There were times she did not get the medication cart audits completed and she asked the MAs to complete them. -There was a form to fill out when completing the medication audit that was to be reviewed by the facility's compliance nurse. -The cart audits were completed by comparing the resident's eMAR with the medications on hand for that resident. -If a medication was running low or unavailable, she would follow up with the pharmacy and indicate it on the cart audit form. -If a medication was not available on the cart and the pharmacy had an order, she would have them dispense it to the facility immediately. -She was responsible for running a missed medication audit report five times per week for assisted living. Interview with the SCC on 02/02/24 at 9:58am -He stated medication cart audits were being performed 2 to 3 days a week. -The cart audits would identify if the medication was not on the cart. -He did not have a column to indicate how many pills or supply of medication was remaining on the medication cart audit document. -The audit results were given to the facility compliance nurse after they were completed, and she was aware of the resident's missing	D 358		

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medications.
-If the resident's Responsible Party used an outside pharmacy and not the facilities contracted pharmacy, staff were to contact the family when the medications are down to 7 pills.
-When medications are missing, they would notify the PCP and the Responsible Party of the medication missing and a note should have been put in the progress note for that resident.
-If the Responsible Party had not brought in the medication after a week or two, we would call the pharmacy and bill the Responsible Party, but we would try to give the Responsible Party a chance to bring in the medication.

Interview with the facility Compliance Nurse on 02/05/24 at 2:39pm revealed:
-The MAs were responsible for ordering the residents' medications when there was about a week of medication available to administer.
-Prior to the beginning of January 2024, the RCC and SCC were to run two reports each day, the missed medications report and the 24-hour report.
-Since the beginning of January 2024, she was responsible for running the 24-hour report.
-If a medication was not available to administer and a code was put in the eMAR system, such as "09", the medication would not appear on the missed medications report, but it would appear on the 24-hour report.
-If she saw missed medications on the 24-hour report she reported in the morning management meeting.
-Follow up on the missed medications was delegated to the RCC and the SCC.
-The Administrator was responsible for following up to ensure the follow up on missed medications was completed.
-A medication cart audit was to be completed

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every Tuesday and Thursday by the RCC and the SCC.
-The audit compared medications on the residents' eMARs with medications on hand.
-There was a paper document completed during the medication cart audit.
-The paper document did not include the quantity of medication available, just if the medication was in the cart.
-If a medication was not on the cart, she followed up with the RCC and the SCC.
-She saw occasions on the 24-hour report when medications were not available for administration.

Telephone interview with the facility Compliance Nurse on 02/07/24 at 2:31pm revealed:
-If the resident did not use the contracted pharmacy, their Responsible Party should be called to bring in the medication.
-If the medication supply is down to zero, and the Responsible Party had not brought in the medication the medication should be ordered through the contracted pharmacy and the facility would bill the Responsible Party for the medication.
-The PCP should have been notified as well as the Responsible Party after the first dose was missed.
-When the medication was brought to the facility it should be signed that it was delivered and received on a separate piece of paper by the person who received the medication such as a MA or their supervisor.
-If nothing else a progress note stating who brought the medication, the medication prescription and number of pills and the progress note should be scanned into the resident's record.

Interview with RDO on 02/05/24 at 4:02pm

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D 358	Continued From page 55 revealed: -He began coming to the facility the second week of January 2024. -Resident medications were to be re-ordered at the beginning of the fourth row of the bubble pack which was about 8 doses left to administer. -Reordering medications timely seemed to be a problem in the facility. -Medication cart audits were being done twice weekly prior to the middle of January 2024 and now they were to be done daily. -The RCC and the SCC were responsible for the medication cart audits. -The facility Compliance Nurse was responsible for following up on the 24-hour report for missed medications. -When residents chose to use an outside pharmacy and the medication was not brought to the facility by the Responsible Party the SCC was to order the medication from the contracted pharmacy, the facility would pay for the medication and then in turn bill the Responsible Party for the medication. -If medications were brought into the facility by the Responsible Party, the best practice would be to document in the electronic health record how many pills were brought in. _____ The facility failed to ensure medications were administered as ordered for 4 of 6 residents (#1, #2, #4, and #5). Resident #1 did not receive multiple doses of blood pressure lowering medication including on 12/26/23 prior to a scheduled procedure when she had higher than normal blood pressures, was taken to the ED following the procedure, found to have a hypertensive emergency, was admitted to hospital and later discharged to a skilled nursing facility. Resident #5 was administered short acting insulin instead of the physician ordered	D 358		

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D 358	Continued From page 56 long acting insulin resulting in being sent to the ED with a blood sugar of 45. The facility's failure resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection on February 12, 2024, in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 13, 2024.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

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D 367	Continued From page 57 This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, and record reviews, the facility failed to ensure the Medication Administration Records (MAR) were accurate for 2 of 5 residents (#1 and #4) including inaccurate documentation of a medication to treat hypertension (#1, #4), a medication to treat vaginal dryness (#1), and a medication to prevent blood clots (#4). The findings are: 1. Review of Resident #1's current FL2 dated 08/21/23 revealed: -Diagnoses included hypertension, chronic congestive heart failure, and severe chronic kidney disease stage 4. -There was an order for hydralazine (a medication to treat high blood pressure) 50mg, one tablet three times daily. -There was an order for estrone vaginal cream (a medication to treat vaginal dryness) 0.1mg/mg, 2gms vaginally daily. a. Review of Resident #1's Primary Care Provider's (PCP) orders dated 09/07/23 revealed an order for hydralazine 50mg, one tablet three times daily. Review of Resident #1's November 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry for hydralazine 50mg, one tablet three times daily at 8:00am, 2:00pm and 8:00pm. -The entry was documented as administered three times daily except on 11/04/23 at 8:00am and 2:00pm because Resident #1 was	D 367		

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hospitalized.

Review of Resident #1's December 2023 eMAR revealed:
-There was an entry for hydralazine 50mg, one tablet three times daily at 8:00am, 2:00pm and 8:00pm.
-The entry was documented as administered three times daily from 12/01/23 through 12/21/23, on 12/22/23 at 8:00am, on 12/24/23 at 8:00pm and on 12/25/23 at 8:00pm.

Interview with a representative from the facility's contracted pharmacy on 01/31/24 at 10:03am revealed:
-The facility was on cycle fill which meant the residents' medications were dispensed to the facility every 28 days.
-Resident #1's hydralazine 50mg, one tablet three times daily, 84 tablets were dispensed to the facility on 09/28/23.
-Resident #1's hydralazine 50mg should have run out around 10/25/23 or 10/26/23 from the 09/28/23 dispensed date.
-Hydralazine 50mg was not automatically dispensed on 10/25/23 because the pharmacy needed a new order.
-She notified the facility by email each month of residents needing a new order for the medications to be dispensed for the next cycle.
-The facility received the new order on 12/13/23 for Resident #1's hydralazine 50mg, three times daily.
-The order dated 12/13/23 was not automatically dispensed to the facility because it was received outside of the window for the cycle fill.
-The facility would have needed to request the medication to be dispensed to catch them up to the date when the cycle-fill would begin again.
-Hydralazine 50mg, 69 tablets were dispensed on

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D 367	Continued From page 59 12/25/23 for Resident #1. Interview with the Resident Care Coordinator (RCC) on 02/05/24 at 10:54am revealed she was unsure why Resident #1's hydralazine was being documented as administered if it was not in the building. Refer to the interview with the RCC on 02/05/24 at 10:54am revealed: Refer to the interview with the facility Compliance Nurse on 02/05/24 at 2:39pm. Refer to the interview with the Regional Director of Operations (RDO) on 02/05/24 at 4:02pm. b. Review of Resident #1's PCP orders dated 09/07/23 revealed an order for estrone cream 1%, insert 2gms vaginally daily. Review of Resident #1's November 2023 eMAR revealed: -There was an entry for estrone cream 1%, insert 2gms vaginally daily. -There was no scheduled administration time indicated for the estrone 1% entry. -The entry was documented as administered daily except on 11/03/23 because Resident #1 was hospitalized. Review of Resident #1's December 2023 eMAR revealed: -There was an entry for estrone cream 1%, insert 2gms vaginally daily. -There was no scheduled administration time indicated for the estrone 1% entry. -The entry was documented as administered daily from 12/01/23 to 12/02/23, from 12/08/23 to 12/09/23, from 12/14/23 to 12/23/23 and on	D 367		

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D 367	Continued From page 60 12/25/23. Telephone interview with a representative from the facility's contracted pharmacy on 02/05/24 at 9:10am revealed: -Resident #1's estrone cream 1%, 42.5gms were dispensed to the facility on 10/31/23, 12/07/23 and 12/28/23. -Resident #1's order was to insert 2gms vaginally daily and 42.5gms would last about 21 days. Refer to the interview with the RCC on 02/05/24 at 10:54am revealed: Refer to the interview with the facility Compliance Nurse on 02/05/24 at 2:39pm. Refer to the interview with the RDO on 02/05/24 at 4:02pm. 2. Review of Resident #4's current FL2 dated 11/09/23 revealed diagnoses of essential hypertension, vascular dementia, cardiopulmonary disease, hyperlipidemia, and peripheral vascular disease. a. Review of Resident #4's PCP orders dated 11/09/23 revealed an order for order for amlodipine besylate (a medication to treat high blood pressure) 10mg tablet daily. Review of Resident #4's January 2024 eMAR revealed: -There was an entry for amlodipine besylate 10 mg, one tablet daily scheduled for 8:00am. -The entry was documented with "09" indicating "other/see nurse notes" on 01/06/24 to 01/07/24, and 01/09/24-01/11/24.	D 367		

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-Amlodipine besylate 10mg was documented as not administered 5 out of 6 opportunities from 01/06/24 to 01/11/24.

Review of Resident #4's nurses notes revealed:
-On 01/06/24 amlodipine besylate 10mg tablet was not administered because the medication was unavailable.
-On 01/07/24 amlodipine besylate 10mg tablet was not administered because the medication was unavailable.
-On 01/09/24 amlodipine besylate 10mg tablet was not administered because the medication was pending delivery.
-On 01/10/24 amlodipine besylate 10mg tablet was not administered, the note read; "MA called in medication for refills last week, family was notified this MA will follow up with family again today."
-On 01/11/24 amlodipine besylate 10mg tablet was not administered because of waiting for daughter to bring in medication.

Interview with a MA on 02/05/24 at 2:55 am revealed:
-If Resident #4's amlodipine besylate 10mg was pending delivery for 01/06/24, 01/07/24, 01/09/24 through 01/11/24 the medication was not available and should have been documented with an "09" code indicating "other/see nurse notes".
-She could not explain why it was documented as given on 01/08/24.

Interview with the SCC on 02/02/24 at 9:58am revealed:
-When medications were not available for Resident #4 a note should be documented in the resident's record that the medicine was not available, and the MAs should call Resident #4's Responsible Party to get the amlodipine besylate

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refilled.
-He expected the MAs to document medications as administered when the resident took the medication.
-He could not explain why Resident #4's amlodipine besylate was documented as given when the medication was not available on 01/08/24.

Refer to the interview with the RCC on 02/05/24 at 10:54am.

Refer to the interview with the facility Compliance Nurse on 02/05/24 at 2:39pm.

Refer to the interview with the RDO on 02/05/24 at 4:02pm.

b. Review of Resident #4's PCP orders dated 11/09/23 revealed an order for plavix (a medication to prevent blood clots) 75mg one tablet daily.

Review of Resident #4's January 2024 eMAR revealed:
-There was an entry for plavix 75mg one tablet daily.
-The entry was documented as administered from 01/01/24 through 01/06/24, 01/08/24, and 01/12/24 through 01/30/24.
-The entry had a 09 code on 01/07/24, 01/09/24, 01/10/24 and 01/11/24.
-The documented 09 code reasons were "other/see nurses notes."

Review of Resident #4's nurses notes revealed:
-On 01/07/24 plavix 75mg was not administered on 01/07/24 because the medication was unavailable.
-On 01/09/24 plavix 75mg was not administered

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because the medication was pending delivery.
-On 01/10/24 plavix 75mg was not administered, the note read; "MA called in medication for refills last week, family was notified, this MA will follow up with family again today."
-On 01/11/24 plavix 75mg was not administered because "waiting for daughter to bring in medication."

Interview with a MA on 02/05/24 at 2:55 am revealed:
-If Resident #4's plavix 75mg was pending delivery for 01/06/24, 01/07/24, 01/09/24 through 01/11/24 the medication was not available and should have been documented with an "09" code indicating "other/see nurse notes".
-She could not explain why it was documented as given on 01/08/24.

Telephone interview with a representative from Resident #4's pharmacy on 02/06/24 at 10:02am revealed:
-Resident #4 had an order for plavix 75mg 1 tablet daily.
-On 01/02/24 there were 30 tablets of plavix 75mg picked up on 01/11/2024 by Resident #4's Responsible Party.

Interview with the SCC on 02/02/24 at 9:58am revealed:
-When medications were not available for Resident #4 a note should be documented in the resident's record that the medicine was not available, and the MAs should call Resident #4's Responsible Party to get the plavix refilled.
-He expected the MAs to document medications as administered when the resident took the medication.
-He could not explain why Resident #4's plavix was documented as given when the medication

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D 367	Continued From page 64 was not available on 01/08/24. Refer to the interview with the RCC on 02/05/24 at 10:54am. Refer to the interview with the facility Compliance Nurse on 02/05/24 at 2:39pm. Refer to the interview with the RDO on 02/05/24 at 4:02pm. _____ Interview with the RCC on 02/05/24 at 10:54am revealed: -The MAs were responsible to accurately documenting medication administration on the eMAR. -About two months ago, medication cart audits twice weekly became her responsibility. -The MAs were responsible for medication cart audits prior to two months ago. -The medication cart audit process compared the residents' eMARs to medications available on the medication cart. -She thought the MAs sometime accidentally documented a medication was administered when it was not available to administer. Interview with the facility Compliance Nurse on 02/05/24 at 2:39pm revealed: -The MAs were trained upon hire how to accurately document on the eMAR. -If a MA documented a medication was administered when it was not available to administer that was falsifying documentation. -Disciplinary actions related to falsifying documentation varied from being written-up to termination. Interview with the RDO on 02/05/24 at 4:02pm revealed:	D 367		

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D 367	Continued From page 65 -The MAs were trained how to accurately document medication administration. -A MA who marked a medication as given when the medication was not on the medication cart was falsifying information. -He expected the MAs to accurately document the medication as given or not given. _____ The facility failed to ensure the Medication Administration Records were accurate for 2 of 5 residents (#1 and #4) including inaccurate documentation of a medication to treat hypertension (#1, #4) and a medication to prevent blood clots (#4). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on February 12, 2024, for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 28, 2024.	D 367		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the	D 438		

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facility failed to report allegations of alleged abuse by a staff member related to him inappropriately touching, hugging, and kissing 2 of 2 sampled residents (#2 and #3) to the Health Care Personnel Registry (HCPR).

The findings are:

Review of the facility Incident Reports- State Reporting policy dated 10/01/20 with a revised date of 01/01/24 revealed:
-It is policy of the facility to ensure timely reporting to the appropriate authorities for resident incidents.
-The Executive Director or Health Services Director will immediately notify the County Department of Social Services of any mental or physical abuse, neglect, or exploitation of a resident.
-The Executive Director or Health Services Director will report any applicable accident or incident to the state within 24 hours, followed by a subsequent report within the next five days.
-The Executive Director or Health Services Director will assure the notification of a resident's responsible person or contact person as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file.
-The Executive Director/designee will be responsible for ensuring timely and accurate reporting of all critical events.
-Timely and accurate reporting of critical events to state agencies will occur as required by state regulations.

2. Review of Resident #3's current FL2 dated 11/10/23 revealed:
-Diagnoses included dementia, hypertension, and

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anemia.
-She was semi-ambulatory.
-She was intermittently disoriented.
-Her Recommended level of care was assisted living.

Review of Resident #3's resident register revealed an admission date of 10/25/22.

Review of Resident #3's Accident and Incident Report dated 01/02/24 revealed:
-The report was completed by the facility Compliance Nurse with the incident time documented at 9:00am.
-Under section for the description of the accident, documentation stating the Administrator notified the facility Compliance Nurse that a staff member who is not qualified to provide personal care was observed in the Resident #3's room with his hands on her genital area and staff member was escorted out of the community and suspended pending an investigation.
-There was documentation of Resident #3's Primary Care Provider (PCP) being notified at 11:11am.
-There was no documentation that Resident #3's family member was notified.

Telephone interview with a former agency personal care aide (PCA) on 02/05/24 at 10:45am revealed:
-She had reported to the Administrator in early November 2023 that she had seen the former Maintenance Director kiss Resident #3 on the forehead.
-The Administrator told her it was creepy behavior, but it was not necessarily inappropriate.
-On 01/02/24 around 8:30am she walked into Resident #3's room where she witnessed the former Maintenance Director rubbing lotion on the

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resident's face.
-She noticed that the resident's pants were pulled down to her ankles and states she had changed the resident around 7:30am and had pulled her pants all the way up to her waist.
-She left Resident #3's room and notified the medication aide (MA).
-She and the MA returned to Resident #3's room where the resident's pants were now pulled up to her knees.
-She and the MA immediately notified the current SCC and all three returned to Resident #3's room and asked the former Maintenance Director to leave the room.
-She was asked to write a statement which she did and gave it to the Administrator.

Interview with a MA on 01/30/24 at 4:44pm revealed:
-Sometime in the Fall of 2023, she attended a staff meeting directed by the Administrator.
-The Administrator notified staff that facility employees were permitted to touch residents' shoulders and that it was not to be considered inappropriate.
-She witnessed the former Maintenance Director in the middle of November 2023 kiss Resident #3 in the mouth in the dining room.
-She reported this to the current special care coordinator (SCC) who told her to keep an eye on the former Maintenance Director.
-She was never asked about this situation or interviewed by management or the Administrator.
-On 01/02/24 around 8:30am a PCA informed her that the former Maintenance Director was in Resident #3's room with his hand underneath the resident's covers.
-She and the PCA went to Resident #3's room where she witnessed the former Maintenance Director sitting in the resident's wheelchair,

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beside the resident laying in her bed with his hand rubbing her underneath the covers, over her private area.
-She and the PCA left the room after asking the former Maintenance Director if Resident #3 needed anything in which the former Maintenance Director stated no.
-She and the PCA immediately notified the current SCC.
-She, the PCA and the SCC all went to Resident #3's room where the former Maintenance Director was still sitting beside the resident.
-All three left Resident #3's room and called the Administrator to notify the Administrator of the witnessed incident.
-She and the PCA then returned to Resident #3's room and asked the former Maintenance Director to leave.
-She was asked to write a statement which she did and gave it to the Administrator.

Interview with the current SCC on 01/30/24 at 4:08pm and on 02/12/24 at 11:45am revealed:
-He reported to the Administrator that a staff member had witnessed the former Maintenance Director kiss Resident #3 on the mouth, but he did not know what happened after he reported it.
-The former Maintenance Director was witnessed taking residents to the bathroom which was reported to the Administrator.
-The Administrator held a stand-up meeting with the former Maintenance Director present in which she informed everyone that non-care staff were not to provide personal care to residents.
-He did not document any of these reported events or any notification to the Administrator.
-On 01/02/24 he was asked to come to Resident #3's room by a MA and a PCA where he witnessed the former Maintenance Director with his hand under the resident's blanket rubbing

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over her private area.
-He left the room and called the Administrator.
-The MA and PCA asked the former Maintenance Director to leave the room.
-The Administrator came to the facility shortly after and suspended the former Maintenance Director.
-He was asked to write a statement which he did and gave it to the Administrator.
-He was later interviewed by law enforcement.

Review of the former Maintenance Director's HCPR 5-Working Day Report with an incident date of 01/02/24 revealed:
-There was an attached fax confirmation sheet with a documented fax date of 01/09/24 and a received confirmation time at 6:28pm on 01/09/24.
-The report was completed by the Administrator with the incident time documented at 8:57am on 01/02/24.
-Under section for the description of the incident stated, the Maintenance Director was witnessed in Resident #3's room with his hands under her covers rubbing on her lower extremities, he was asked by several care team members to please remove himself and refused, he stated he was putting lotion on her legs.

Interview with the with the facility Compliance Nurse on 01/31/24 at 5:34pm revealed:
-Prior to 01/02/24, she was not aware staff had expressed concerns for the former Maintenance Director's physical interactions with residents.
-She was notified of the incident involving Resident #3 and the former Maintenance Director by the Administrator on 01/02/24 around 9:00am.
-She completed the Accident and Incident report which was faxed to the local Department of Social Services at 5:04pm.

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D 438	Continued From page 71 Telephone interview with the former Maintenance Director on 02/01/24 at 3:50pm revealed: -He frequently greeted residents daily with hugs, scratching their backs over their shirts, and kissing foreheads. -He stated he provided Resident #3 care by giving her juice and water, feeding her, applying chapstick to her lips and putting lotion on her face, hands, feet, legs, and thighs. -He admitted that he would massage her thigh to help with circulation. -He did not tell any staff he had been applying chapstick, lotion or he was feeding Resident #3. -He assisted Resident #3 with sitting up in the bed due to her not being able to sit up on her own. -He visited her five to six times a day for around ten minutes per visit. -In October 2023, the Administrator notified him that a PCA had a concern for how he showed affection towards residents. -In October 2023, the Administrator talked with him about 'being mindful' of how he showed affection towards residents could be uncomfortable for care staff. Interview with the Administrator on 01/30/24 at 1:18pm and on 02/02/24 at 2:53pm revealed: -Staff reported inappropriate behaviors witnessed of the former Maintenance Director on 10/19/23. -On 10/19/23, a staff member notified her that she felt uncomfortable with the former Maintenance Director providing hugs to residents, and kissing residents on their foreheads. -She did not make a report to the HCPR. -She did not document the staff concerns or interviews. -She denied being notified of any allegations of abuse, neglect or exploitation related to the	D 438		

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former Maintenance Director between 10/19/23 and 01/02/24.

2. Review of Resident #2's current FL2 dated 11/10/23 revealed:
-Diagnoses included Alzheimer's disease, bursitis of left hip, major depression, and other symptoms and signs involving cognitive functions and awareness.
-She was ambulatory and constantly disoriented.
-Resident #2's recommended level of care was Special Care Unit (SCU).
-Resident #2 was admitted to the SCU on 07/26/21.

Review of Resident #2's signed Resident Register revealed Resident #2 was admitted to the facility on 07/26/21.

Review of a signed dietary aide statement dated 11/01/23 revealed:
-She observed the former Maintenance Director on numerous occasions touch female residents, mainly Resident #2, where residents shouldn't be touched.
-The former Maintenance Director was observed taking Resident #2 from the Livingroom and walked somewhere no one could see them.
-The former Maintenance Director entered Resident #2's room and took her hair out of the style it was in.

Interview with a dietary aide on 01/30/24 at 11:46am revealed:
-She told the previous Special Care Unit Coordinator (SCC) towards the end of October 2023 that she was uncomfortable with the former Maintenance Director hugging and kissing Resident #2 who resided in the SCU.
-She witnessed the former Maintenance Director

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hug and kiss Resident #2 three or more times.
-She also reported to the Administrator in October 2023, but stated nothing was done as far as she was aware of.
-She was asked to provide a written statement along with two other staff who had witnessed the former Maintenance Director's inappropriate behavior and gave the written statement to the SCC.

Review of a signed personal care aide (PCA) statement dated 11/01/23 revealed:
-She observed the former Maintenance Director on numerous occasions touch female residents, mainly Resident #2, where residents shouldn't be touched.
-The former Maintenance Director was observed taking Resident #2 from the Livingroom and walked somewhere no one could see them.
-The former Maintenance Director entered Resident #2's room and took her hair out of the style it was in.

Telephone interview with a first shift PCA on 02/01/24 at 10:40am revealed:
-She witnessed the former Maintenance Director take Resident #2, to the bathroom where he stood beside the resident as she sat on the toilet but was uncertain of the date.
-She witnessed the former Maintenance Director almost every time he worked, take Resident #2's hair down and witnessed him playing with the resident's hair which she felt was inappropriate.
-She reported the former Maintenance Director's inappropriate behavior to the former SCC several times and to the Administrator starting at the end of October 2023.
-She was asked to provide a written statement along with two other staff who had witnessed the former Maintenance Director's inappropriate

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behavior and gave the written statement to the SCC.

Review of a signed medication aide (MA) statement dated 11/01/23 revealed:
-She observed the former Maintenance Director inappropriately touch Resident #2 on different occasions.
-The former Maintenance Director appeared to show extra attention to Resident #2 and would rub her back and hair.

Telephone interview with a former MA on 02/01/24 at 12:40pm revealed:
-In the fall of 2023, the former Maintenance Director would massage Resident #2's head, give her back rubs and kiss her on her cheek.
-In the fall of 2023, she had observed the former Maintenance Director escort Resident #2 to her bedroom but did not know why he did this with Resident #2.
-She provided a written statement to the Administrator related to the former Maintenance Director on 11/01/23.
-She was never interviewed by the Administrator or management staff related to her written statement dated 11/01/23.
-In the fall of 2023, she told the Administrator of staff concerns related to the former Maintenance Director's behavior towards Resident #2 and the Administrator walked away from her, laughing.
-She never tried to intervene due to the Administrator already being made aware by multiple staff of the former Maintenance Director's inappropriate behaviors which he had continued.

Telephone interview with the former Maintenance Director on 02/01/24 at 3:50pm revealed:
-He was the Maintenance Director between

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D 438	Continued From page 75 07/03/23 and 01/03/24. -He frequently greeted residents in the SCU daily with hugs, scratching their backs over their shirts, and kissing foreheads. -In the fall of 2023, on one occasion, he was in Resident #2's room repairing a telephone and Resident #2 entered the room while she was pulling her pants down and was defecating on the floor, he assisted her to the toilet and left the room to locate a PCA. -In October 2023, the Administrator informed him that a PCA had a concern for how he showed affection towards residents. -In October 2023, the Administrator talked with him about 'being mindful' of how he showed affection towards residents because it could be uncomfortable for care staff. Telephone interview with a former agency PCA on 02/05/24 at 10:50am revealed: -She occasionally worked in the SCU. -When she worked in the SCU, the former Maintenance Director was frequently spending time with Resident #2. -Resident #2 was frequently hugged, had her back rubbed over her clothing, and walked down the hallway holding the former Maintenance Director's hand. -She did not feel comfortable with the amount of affection the former Maintenance Director provided to Resident #2. -She never tried to intervene due to the Administrator already being made aware of the former Maintenance Director's behaviors. -She did not intervene when she witnessed the former Maintenance Director's inappropriate towards Resident #2. Telephone interview with another PCA on 02/07/24 at 11:30am revealed:	D 438		

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D 438	Continued From page 76 -She worked on first and second shift in the SCU. -Between September 2023 and October 2023, she notified the Administrator that she had observed the former Maintenance Director changing residents' briefs from bedside. -She was not aware of any investigation which involved the former Maintenance Director between September 2023 and November 2023, until an incident occurred with the former Maintenance Director on 01/02/24. Interview with a first shift MA on 01/30/24 at 4:45pm revealed: -Sometime in the Fall of 2023, she attended a staff meeting directed by the Administrator. -The Administrator notified staff that facility employees were permitted to touch residents' shoulders and that it was not to be considered inappropriate. Telephone interview with the former SCC on 01/31/24 at 4:20pm revealed: -She worked in the SCU between October 2023 and December 2023. -She and other facility staff were concerned the Maintenance Director "favored Resident #2 over other residents". -Staff had observed the former Maintenance Director frequently holding hands with Resident #2 while walking down the hallway, and rubbing her back, and would occasionally observe the Maintenance Director walking out of Resident #2's bedroom without a maintenance need in the room. -In early November 2023, staff wrote statements with concerns about the former Maintenance Director. -In early November 2023, she provided the written statements to the Administration. -She did not know if the Administrator interviewed	D 438		

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other staff related to the written statements.
-She did not intervene when she witnessed the former Maintenance Director's inappropriate behaviors towards Resident #2, she only reported witnessed behaviors.

Interview with the SCC on 01/30/24 at 4:10pm revealed:
-The former SCC had provided the Administrator with staff statements related to concerns for the former Maintenance Director.
-He did not know what was written in the staff statements.
-In the fall of 2023, some staff informed him they witnessed the former Maintenance Director show affection towards Resident #2, including kissing her on the cheek and forehead.
-In the fall of 2023, the Administrator did not interview him related to the former Maintenance Director's interactions with residents.
-In the fall of 2023, the Administrator was aware of staff concerns about the former Maintenance Director providing care to residents because she notified all department managers during meetings to ensure only staff assigned to resident care, performed resident care needs.

Interview with the Administrator on 02/02/24 at 2:55pm revealed:
-She was responsible for reporting any concerns for resident abuse, neglect, or exploitation to local law enforcement, Department of Social Services, and department of Health Service Regulation (HCPR).
-On 10/19/23, a dietary aide told her that she felt uncomfortable with the former Maintenance Director providing hugs to residents, and kissing residents on their foreheads.
-She interviewed additional staff and was told the former Maintenance Director was often observed

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giving hugs to Resident #2.
-She determined the former Maintenance Director's hugging of Resident #2 was not inappropriate.
-She did not document the staff concerns or interviews.
-She did not initiate a HCPR investigation report related to the former Maintenance Director's alleged behaviors at the time.
-On 10/20/24, she met with the former Maintenance Director and informed him staff felt uncomfortable with his physical expressions of affection towards residents and to be careful how he interacted with residents.
-On 10/20/24, she notified the former Maintenance Director that kissing of residents was not permitted "even though I know you don't mean any harm."
-Between 10/19/23 and 01/02/24, staff had not provided any written statements related to the Maintenance Director.
-She did not know of any written statements provided by staff concerning the former Maintenance Director dated 11/01/23.
-Between 10/19/23 and 01/02/24, she was not notified of any additional concerns for the former Maintenance Director, or any other staff related to allegations of abuse, neglect, or exploitation.

Telephone interview with the Chief Operating Officer (COO) on 02/01/24 at 1:00pm revealed:
-She was at the facility on 10/19/23.
-Staff did not report concerns about the former Maintenance Director kissing or hugging residents.
-She was not aware of any signed staff statements after 10/19/23.
-The Administrator was expected to report allegations of abuse of a resident to the HCPR.
-If a staff statement documented concerns for

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D 438	Continued From page 79 inappropriate touching of a resident, the accused staff should have been immediately suspended and a report made to the NC Department of Health Service Regulations and law enforcement. _____ The facility failed to report allegations of abuse including inappropriate touching, hugging, and kissing of two female residents (#2 and #3) by a male staff that was first reported in October 2023 to the HCPR at that time leaving it uninvestigated for three and a half months. The facility's failure resulted in serious neglect and exploitation and constitutes a Type A1 Violation. _____ The facility provided a plan of protection on January 30, 2024, and on February 12, 2024, in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 13, 2024.	D 438		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident.	D 453		

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D 453	Continued From page 80 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to immediately notify the county Department of Social Services (DSS) and local law enforcement about potential abuse and exploitation of 2 of 2 sampled residents (#2 and #3) who were inappropriately touched by a male staff member. The findings are: Review of the facility Reporting Abuse, Neglect, or Financial Exploitation policy with an effective date of 08/01/21 revealed: -A resident currently living in the community must be free from mental, verbal, sexual and physical abuse, neglect, involuntary seclusion, and financial exploitation. -If abuse, neglect, or financial exploitation is witnessed, associates are to remove the resident from the situation immediately, bring the resident to a safe location within the community and immediately notify your supervisor, Health and Wellness Director, Executive Director or 911 if the resident is injured. -Do not leave the resident alone, stay with the resident until they can be assessed to ensure they are out of harm's way. -The Executive Director will immediately (but no later than 24 hours) notify orally or in writing the County Department of Social Services and the HCPR. -The resident's responsible party or contact person, as indicated on the Resident Register, will be notified immediately by the Executive Director. -The Executive Director will notify the HCPR within 24 hours of knowledge of all instances of	D 453		

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abuse.
-A thorough investigation of all allegations must take place and thorough documentation must be completed by the Executive Director.
-Appropriate action must be taken to prevent further incidents of abuse, neglect, or financial exploitation while the investigation is in progress.
-If there is an allegation of abuse, neglect, or financial exploitation of a resident involving an associate, the associate will be suspended with pay until a thorough investigation has been completed.
-The investigation must be thoroughly documented, and a copy kept on file for the associate and the resident involved.
-Documentation of suspected abuse and investigation outcomes will be documented in the resident's wellness file, including physician and state notification.

Review of the facility Incident Reports- State Reporting policy dated 10/01/20 and a revised date of 01/01/24 revealed:
-It is policy of the facility to ensure timely reporting to the appropriate authorities for resident incidents.
-The Executive Director or Health Services Director will immediately notify the County Department of Social Services of any mental or physical abuse, neglect, or exploitation of a resident.
-The Executive Director or Health Services Director will report any applicable accident or incident to the state within 24 hours, followed by a subsequent report within the next five days.
-The Executive Director or Health Services Director will assure the notification of a resident's responsible person or contact person as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury

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or illness by staff and documented in the resident's file.
-The Executive Director or Health Services Director will immediately report any assault resulting in harm to a resident or other person in the facility to the local law enforcement authority.
-In the event of incident/accident, the resident's responsible party and appropriate authorities are notified when required and as appropriate to the situation.
-The Executive Director/designee will be responsible for ensuring timely and accurate reporting of all critical events.
-Timely and accurate reporting of critical events to state agencies will occur as required by state regulations.

Review of a search warrant motion for employee information and surveillance dated 01/04/24 revealed:
-Request of footage from January 2, 2024, request for other incidents the suspect has been investigated for including the incident in the memory care floor.
-Request the facility provide human resources files and all information involving any and all previous incident involving the former Maintenance Director.

Review of a search warrant for affidavit of law enforcement Detective dated 01/04/24 revealed:
-Law enforcement was conducting an ongoing criminal investigation related to second-degree sexual offense and sexual activity by a custodian.
-On 01/02/24 Resident #3, a resident was touched inappropriately by the maintenance worker while he was on duty at the facility.
-During a follow up investigation to collect evidence it was brought to the Detective's attention that the employee of the facility has

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been suspected of previously committing similar acts, which the staff failed to report to law enforcement.
-Multiple staff members both identified in this order and have access to and care for the victim of this incident.

1. Review of Resident #3's current FL2 dated 11/10/23 revealed:
-Diagnoses included dementia, hypertension, and anemia.
-She was semi-ambulatory.
-She was intermittently disoriented.
-Recommended level of care was assisted living.

Review of Resident #3's Resident Register revealed an admission date of 10/25/22.

Telephone interview with a former agency personal care aide (PCA) on 02/05/24 at 10:45am revealed:
-She had reported to the Administrator in early November 2023 that she saw the former Maintenance Director kiss Resident #3 on the forehead.
-She stated the Administrator told her it was, "creepy behavior but not necessarily inappropriate".
-On 01/02/24 around 8:30am she walked into Resident #3's room where she witnessed the former Maintenance Director rubbing lotion on the resident's face.
-She noticed that the Resident's pants were pulled down to the ankles and states she had changed the Resident around 7:30am and had pulled her pants all the way up to her waist.
-She left Resident #3's room and notified the medication aide (MA).
-She and the MA returned to Resident #3's room where the Resident's pants were now pulled up to

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her knees.
-She and the MA immediately notified the special care coordinator (SCC) and all three returned to Resident #3's room and asked the former Maintenance Director to leave.
-She was asked to write a statement which she did and gave it to the Administrator.

Review of a former agency PCA's signed statement dated 01/02/24 revealed:
-She walked into Resident #3's room to give her a nutritional supplement and noticed the former Maintenance Director rubbing lotion on her face.
-She noticed Resident #3's pants were at her ankles which were not left like that when she had left earlier.
-She noticed Resident #3's blinds were closed when they were initially open.
-After giving out room trays, she returned to Resident #3's room, saw the former Maintenance Director was still there and asked him to leave four times.
-The former Maintenance Director kissed the Resident on the forehead and rubbed her feet when he was leaving the room.

Interview with a MA on 01/30/24 at 4:44pm revealed:
-Sometime in the fall of 2023, she attended a staff meeting directed by the Administrator.
-The Administrator notified staff that facility employees were permitted to touch residents' shoulders and that it was not to be considered inappropriate.
-She witnessed the former Maintenance Director in the middle of November kiss Resident #3 in the mouth in the dining room.
-She reported this to the current SCC who told her to keep an eye on the former Maintenance Director.

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D 453	Continued From page 85 -She was never asked about this situation or interviewed by management or the Administrator. -On 01/02/24 around 8:30am a PCA informed her that the former Maintenance Director was in Resident #3's room with his hand underneath the resident's covers. -She and the PCA went to Resident #3's room where she witnessed the former Maintenance Director sitting in the resident's wheelchair, beside the resident laying in her bed with his hand rubbing her underneath the covers, over her private area. -She and the PCA left the room after asking the former Maintenance Director if Resident #3 needed anything in which the former Maintenance Director stated, "no". -She and the PCA immediately notified the current RCC. -She, the PCA and the RCC all went to Resident #3's room where the former Maintenance Director was still sitting beside the resident. -All three left Resident #3's room and called the Administrator to notify the Administrator of the witness incident. -She and the PCA then returned to Resident #3's room and asked the former Maintenance Director to leave. -She was asked to write a statement which she did and gave it to the Administrator. -She was later questioned by two law enforcement Detectives on 01/04/24. Review of the MA's signed statement dated 01/02/24 revealed: -She was in the dining room when a staff member came and reported to her that two residents were being touched inappropriately. -She immediately went down the hall to Resident #3's room, took out her phone to record, and noticed the former Maintenance Director rubbing	D 453		

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D 453	Continued From page 86 Resident #3 under the covers. -She asked the former Maintenance Director if the resident needed any assistance and the former Maintenance Director said no. -She left the room and got management to make sure she was seeing things correctly. -The resident was being mistreated by the staff member. -She then asked the former Maintenance Director to leave. -She sat by Resident #3's door to make sure the staff member didn't return into the resident's room. Interview with the SCC on 01/30/24 at 4:08pm and on 02/12/24 at 11:45am revealed: -He reported to the Administrator that a staff member had witnessed the former Maintenance Director kiss Resident #3 in the mouth but was uncertain what happened after he reported it. -The former Maintenance Director was witnessed taking residents to the bathroom which was reported to the Administrator. -The Administrator stated in a stand-up meeting with the former Maintenance Director present that non-care staff were not to provide personal care to residents. -He did not document any of these reported events or any notification to the Administrator. -On 01/02/24 he was asked to come to Resident #3's room by a MA and a PCA where he witnessed the former Maintenance Director with his hand under the resident's blanket rubbing over her private area. -He left the room and called the Administrator. -The MA and PCA asked the former Maintenance Director to leave the room. -The Administrator came to the facility shortly after and suspended the former Maintenance Director.	D 453		

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D 453	Continued From page 87 -He was asked to write a statement which he did and gave it to the Administrator. -He was later interviewed by law enforcement. Review of the SCC's signed statement dated 01/02/24 revealed: -A MA came and got him due to her being concerned that the former Maintenance Director in Resident #3's room. -When he approached Resident #3's room, he witnessed the former Maintenance Director with his hand under the blanket rubbing in Resident #3's private area. -He asked the former Maintenance Director if he was okay, and the former Maintenance Director answered yes. -He then left the room and called the Administrator. Review of Resident #3's Accident and Incident Report dated 01/02/24 revealed: -An electronic fax confirmation to the County Department of Social Services with a timestamp of 4:04pm. -The report was completed by the Facility Compliance nurse with the incident time documented at 9:00am. -Under section for the description of the accident, documentation stating the Administrator notified the facility compliance nurse that a staff member who is not qualified to provide personal care was observed in the resident #3's room with his hands on her genital area and staff member was escorted out of the community and suspended pending an investigation. -There was documentation of Resident #3's PCP being notified at 11:11am. -There was no documentation that Resident #3's family member was notified. -There was no documentation that Law	D 453		

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D 453	Continued From page 88 Enforcement was notified. Review of the Maintenance Director's Health Care Personnel Registry (HCPR) 24-Hour Initial Report with an incident date of 01/02/24 revealed: -There was an attached fax confirmation sheet with a documented fax date of 01/03/24 and a received confirmation time at 8:34am on 01/03/24. -There was a documented incident date and time of 01/02/24 at 8:57am. -Under section for allegation description stated, the Maintenance Director was witnessed in resident #3's room with his hands under her covers rubbing on her lower extremities, he was asked by several care team members to please remove himself and refused, he stated he was putting lotion on her legs. -There was documentation of law enforcement being notified on 01/02/24 at 5:25pm. Review of the former Maintenance Director's HCPR 5-Working Day Report with an incident date of 01/02/24 revealed: -There was an attached fax confirmation sheet with a documented fax date of 01/09/24 and a received confirmation time at 6:28pm on 01/09/24. -The report was completed by the Administrator with the incident time documented at 8:57am on 01/02/24. -Under section for the description of the incident stated, the Maintenance Director was witnessed in resident #3's room with his hands under her covers rubbing on her lower extremities, he was asked by several care team members to please remove himself and refused, he stated he was putting lotion on her legs. Interview with Resident #3's family member on	D 453		

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D 453	Continued From page 89 01/31/24 at 2:30pm revealed: -Resident #3 was unable to answer questions due to her dementia. -She was contacted on 01/02/24 at 5:35pm by the Administrator to report an incident with Resident #3. -The Administrator told her the former Maintenance Director was seen applying lotion to Resident #3's feet. -She had met the former Maintenance Director previously but did not realize he was not a personal care employee/staff member. -She asked the Administrator if Resident #3 was okay, if Resident #3 had been sexually abused and the Administrator said no and that she just needed to let the family know of the incident. -At 5:43pm, she received another call from the Administrator stating it was protocol to take the resident to the emergency department (ED) and that the Resident #3's PCP had recommended an ED evaluation. -She asked if she could call the Administrator back due to her wanting to discuss this with another family member. -She called the Administrator at 6:08pm and said unless she knew of anything more serious than lotion being applied to resident's feet, pain, bleeding or if the Administrator suspected anything further had happened to Resident #3, she did not wish for Resident #3 to go to the ED. -The Administrator stated no suspicion of anything further than the maintenance director applying lotion to resident's feet. -She received a phone call from a Detective with the local police department on 01/03/24 at 3:07pm who asked for consent to send Resident #3 to the ED for an evaluation. -The detective asked for an ED evaluation due to possible sexual assault. -She was told the former Maintenance Director	D 453		

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had been seen applying lotion to Resident #3's feet by the Administrator and nothing else was mentioned even when the family member specifically asked.
-She spoke with a second detective several times afterwards.
-She met with the second detective at the facility at 8:00pm or later, on 01/04/24 who had a search warrant.
-Evidence was taken from Resident #3's person along with clothing and bedding.
-She again notified the Detectives that she was only informed of lotion being applied to Resident #3 by the former Maintenance Director or she would have agreed to send Resident #3 to the ED for an evaluation.
-A detective informed her that a staff member had taken a video of the incident where it was mentioned to him by the Administrator that Resident #3's pants were pulled down.
-She called the Administrator to ask her about the above and the Administrator stated this was the first time she had heard about Resident #3's pants being pulled down.

Interview with the with the facility Compliance Nurse on 01/31/24 at 5:34pm revealed:
-Prior to 01/02/24, she was not aware staff had expressed concerns for the former Maintenance Director's physical interactions with residents.
-She was notified of the incident involving Resident #3 and the former Maintenance Director by the Administrator on 01/02/24 around 9:00am.
-She completed the Accident and Incident report which was faxed to the local Department of Social Services at 5:04pm.
-She did ask the Administrator at 4:08pm on 01/02/24 if she had spoken to Resident #3's family member about the incident and the Administrator stated not yet.

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-She was with the Administrator when the Administrator received a call at 5:08pm from the local Department of Social Services who instructed the compliance nurse and the Administrator to notify law enforcement and the resident's family member immediately, after the Administrator stated she had not notified either.
-She was present when the administrator called Resident #3's family member who was told by the Administrator that the former maintenance director was seen in Resident #3's room with his hands on her legs.
-She stated responsible party asked Administrator about any possible sexual assault and Administrator stated nothing was observed.

Review of electronic documentation provided on 01/31/24 at 5:47pm revealed:
-On 01/02/24 at 4:08pm, the facility compliance nurse messaged the Administrator asking if she had notified Resident #3's responsible party of incident.
-Administrators reply was, "not yet" at 4:08pm.
-The facility compliance nurse then asked the Administrator to notify her when she has contacted the responsible so she could send the incident report to the Department of Social Services.
-There was no reply or notification from the Administrator indicating the Administrator had notified Resident #3's family member.

Interview with the Adult Care Home Specialist with the Mecklenburg County Department of Social Services on 01/30/24 at 9:00am revealed:
-He received the Accident and Incident Report for Resident #3 on 01/02/24 at 5:04pm regarding the former Maintenance Director was witnessed in Resident #3's room with his hands under her covers rubbing on her lower extremities

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-At 5:08pm he called the Administrator because he was concerned about the allegations, he asked her what time the incident had occurred, and the Administrator stated around 8:00 - 8:30am.
-He asked the Administrator if she had notified Law Enforcement and Resident #3's family member and the Administrator stated she had not contacted law enforcement or Resident #3's family member.
-He advised the Administrator and the compliance nurse to call local law enforcement and the resident's family member immediately due to incident occurring early in the morning.
-He was concerned that the Administrator did not notify law enforcement or the resident's family member within an appropriate timeframe.

Telephone interview with a Law Enforcement Detective on 01/31/23 at 4:39pm revealed:
-On 01/02/24, the facility Administrator waited until after normal business hours, between 5:30pm and 6:00pm, to notify law enforcement of a possible sexual assault crime which was observed by staff and reported to the Administrator on 01/02/24 between 8:30am and 9:00am.
-He would have expected the Administrator to immediately notify law enforcement on 01/02/24 to reduce opportunities of any evidence to be contaminated or discarded.
-He interviewed the former Maintenance Director in January 2024.
-A PCA had been interviewed and felt the former Maintenance Director had spent too much time in residents' rooms without a need for maintenance services.
-He felt the former Maintenance Director's behavior was inappropriate.
-He would have expected the Administrator to

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immediately notify law enforcement on 01/02/24 to reduce the opportunities of any evidence to be contaminated or discarded.

Telephone interview with a second Law Enforcement Detective on 02/01/24 at 11:30am revealed:
-He conducted numerous interviews with facility staff after an incident on 01/02/24 which involved the former Maintenance Director.
-He had conducted an interview with the former Maintenance Director in January 2024 related to an allegation of sexual assault to a resident.
-He said the former Maintenance Director had admitted to applying lotion to Resident #3's face, feet, legs and massaging her thighs to help with circulation.
-He said the former Maintenance Director had admitted to kissing Resident #3 on the forehead.
-He said the former Maintenance Director admitted to feeding Resident #3.
-He stated the facility should have notified law enforcement immediately on 01/02/24.
-He stated crucial evidence could have been obtained prior to resident receiving a bath, change of clothing or change of bedding.
-He felt the former Maintenance Director's behavior was inappropriate.

Review of a video recording from 01/02/24 with a timestamp of 8:33am on 02/01/24 at 3:36pm revealed:
-The former Maintenance Director in Resident #3's room, sitting in a wheelchair on the left side of resident and resident's bed.
-Resident #3 was lying flat on her back in the bed with her head turned towards the left.
-Resident #3 had a blanket laying over the top of her body which had been folded under, exposing her left side.

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-Resident #3's pants covered her left leg, up to her left knee, leaving her left knee, thigh and hip completely exposed, uncovered and bare.
-The former Maintenance Director was leaning forward in the wheelchair.
-Resident #3's left hand was crossed over her right hand, on top of the blanket, over her chest area with the former Maintenance Director's left hand placed on top/over resident's hands.
-The former Maintenance Director's right arm was viewed under the blanket, with his arm leading from just above resident's exposed hip area to her lower abdominal area.

Telephone interview with the former Maintenance Director on 02/01/24 at 3:50pm revealed:
-He was the Maintenance Director between 07/03/23 and 01/03/24.
-He frequently greeted residents daily with hugs, scratching their backs over their shirts, and kissing foreheads.
-He stated he provided Resident #3 care by giving her juice and water, feeding her, applying chapstick to her lips and putting lotion on her face, hands, feet, legs, and thighs.
-He admitted that he would massage her thighs to help with circulation.
-He did not tell any staff he had been applying chapstick, lotion or he was feeding Resident #3.
-He assisted Resident #3 with sitting up in the bed due to her not being able to sit up on her own.
-He visited her five to six times a day for around ten minutes per visit.
-In October 2023, the Administrator notified him that a PCA had a concern for how he showed affection towards residents.
-In October 2023, the Administrator talked with him about, 'being mindful' of how he showed affection towards residents could be

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uncomfortable for care staff.

Telephone interview with the Chief Operations Officer (COO) on 02/02/24 at 1:00pm revealed:
-On 01/02/24 at approximately 10:30am, she had a telephone call with the Administrator who notified her that the former Maintenance Director was witnessed by staff in Resident #3's room with his hand under her covers rubbing on her, and she instructed the Administrator to call law enforcement.
-She expected the Administrator to immediately call law enforcement on 01/02/24.
-She did not know until late January 2024, that the Administrator had waited till after 5:00pm on 01/02/24 to notify law enforcement of an allegation of abuse by the former Maintenance Director to Resident #3.
-She was unaware the Administrator only told Resident #3's family member that the former Maintenance Director was seen rubbing lotion to resident's feet.
-She said the family member should have been notified of what was documented in the Accident and Incident report.

Interview with the Administrator on 01/30/24 at 1:18pm and on 02/02/24 at 2:53pm revealed:
-She was responsible for reporting any concerns for resident abuse, neglect, or exploitation to local law enforcement, department of social services, and department of health service regulations.
-Staff reported to her inappropriate behaviors by the Maintenance Director on 10/19/23.
-On 10/19/23, a staff member notified her that she felt uncomfortable with the former Maintenance Director providing hugs to residents, and kissing residents on their foreheads.
-She did not make a report to the HCPR.
-She did not document the staff concerns or

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interviews.
-She denied being notified of any allegations of abuse, neglect or exploitation related to the former Maintenance Director between 10/19/23 and 01/02/24.
-She was not aware that the former Maintenance Director had been applying chapstick or lotion to Resident #3.
-She stated she would have suspended the former Maintenance Director if she had known.
-She stated she notified Resident #3's family member around 11:00am to 12:00pm on 01/02/24 of the incident but could not provide documentation.
-She stated she told Resident #3's family member that the former Maintenance Director was found in Resident #3's room with his hands under the cover applying lotion to her hands.

Review of Resident #3's progress note dated 01/02/24 revealed:
-The Administrator entered the documentation.
-Late entry was documented with an effective date of 01/02/24 at 5:25am.
-The Administrator spoke with the Department of Social Services about the incident filed, instructed to file a 24-hour report.
-24-hour report filed, faxed, and emailed with confirmation.
-Law enforcement was contacted at 5:25pm and did not arrive until after 10:40pm.
-Family contacted at 5:42pm notifying them of the incident.
-PCP sent an update stating it would not hurt to send Resident #3 out for an evaluation.
-Family refused to send out resident, stating that if no signs of injury were seen they did not want her in the Emergency Department where she could catch an infectious virus that is going around and due to her age, it was likely.

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D 453	Continued From page 97 Interview with Resident #3's PCP on 02/05/24 at 12:56pm revealed: -The facility notified him of the incident that occurred on 01/02/24 with Resident #3 and the former Maintenance Director sometime, late morning via text message. -He was notified staff had witnessed the former Maintenance Director with his hands under Resident #3's blanket over her genital area. -The facility compliance nurse informed him she had completed an evaluation of Resident #3 who was observed at baseline. -No recommendations were given to the facility. -The facility compliance nurse called him later that afternoon after Resident #3's family member had asked if there was any concern of possible abuse, and he instructed her to send Resident #3 to the Emergency Department for an evaluation. Interview with the Regional Director of Operations on 02/02/24 at 3:55pm revealed: -He did not know staff had documented written statements from 11/01/23. -He stated due to content of the staff's written statements constituted grounds for immediate termination of the former Maintenance Director. -He stated the facility should have notified law enforcement and the HCPR. Based on observations, interviews, and record review, it was determined that Resident #3 was not interviewable. 2. Review of Resident #2's current FL2 dated 11/10/23 revealed: -Diagnoses included Alzheimer's disease, bursitis of left hip, major depression, and other symptoms and signs involving cognitive functions and awareness.	D 453		

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D 453	Continued From page 98 -She was ambulatory and constantly disoriented. -Resident #2's recommended level of care was Special Care Unit (SCU). -Resident #2 was admitted to the SCU on 07/26/21. Review of Resident #2's signed Resident Register revealed Resident #2 was admitted to the facility on 07/26/21. Telephone interview with Resident #2's Power of Attorney on 02/05/24 at 9:18am revealed: -Resident #2 was admitted to the SCU in July 2021. -Resident #2 required assistance with bathing, toileting, dressing, and grooming. -Resident #2 was ambulatory and constantly disoriented. -She was not aware of any allegations of abuse, neglect, or exploitation involving Resident #2. Interview with a dietary aide on 01/30/24 at 11:46am revealed: -She reported to the previous Special Care Coordinator (SCC) towards the end of October 2023 that she was uncomfortable with the former Maintenance Director hugging and kissing Resident #2 who resided in the SCU. -She witnessed the Maintenance Director hug and kiss Resident #2 three or more times. -She reported this to the Administrator in October, but stated nothing was done as far as she was aware of. -She was asked to provide a written statement at the end of October, the beginning of November 2023, along with two other staff who had witnessed the former Maintenance Director's inappropriate behavior, and she gave the written statement to the SCC.	D 453		

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Review of a signed dietary aide's statement dated 11/01/23 revealed:
-She observed the former Maintenance Director on numerous occasions touch female residents, mainly Resident #2, where residents shouldn't be touched.
-The former Maintenance Director was observed taking Resident #2 from the Living room and walked somewhere no one could see them.
-The former Maintenance Director entered Resident #2's room and took her hair out of the style it was in.

Telephone interview with a first shift PCA on 02/01/24 at 10:40am revealed:
-She witnessed the former Maintenance Director take Resident #2, to the bathroom where he stood beside the resident as she sat on the toilet but was uncertain of the date.
-She witnessed the former Maintenance Director almost every time he worked, take Resident #2's hair down and witnessed him playing with the resident's hair which she felt was inappropriate.
-She reported the former Maintenance Director's inappropriate behavior to the former SCC several times and to the Administrator starting at the end of October 2023.
-She was asked to provide a written statement along with two other staff who had witnessed the former Maintenance Director's inappropriate behavior and gave the written statement to the SCC.

Review of a signed PCA's statement dated 11/01/23 revealed:
-She observed the former Maintenance Director on numerous occasions touch female residents, mainly Resident #2, where residents shouldn't be touched.
-The former Maintenance Director was observed

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taking Resident #2 from the Livingroom and walked somewhere no one could see them.
-The former Maintenance Director entered Resident #2's room and took her hair out of the style it was in.

Telephone interview with a former MA on 02/01/24 at 12:40pm revealed:
-In the fall of 2023, the former Maintenance Director would massage Resident #2's head and give her back rubs and kiss her on her cheek.
-In the fall of 2023, she had observed the former Maintenance Director escort Resident #2 to her bedroom but did not know why he did this with Resident #2.
-She provided a written statement to the Administrator related to the former Maintenance Director's inappropriate behaviors on 11/01/23.
-She was never interviewed by the Administrator or management staff related to her written statement dated 11/01/23.
-In the fall of 2023, she told the Administrator of staff concerns related to the former Maintenance Director's behavior towards Resident #2 and the Administrator, "wound laugh it off".
-She never tried to intervene due to the Administrator already being made aware of the former Maintenance Director's behaviors.

Review of a signed MA's statement dated 11/01/23 revealed:
-She observed the former Maintenance Director inappropriately touch Resident #2 on memory care unit.
-The former Maintenance Director appeared to show extra attention to Resident #2 and would rub her back and hair.

Telephone interview with a former PCA on 01/17/24 at 3:04pm revealed:

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D 453	Continued From page 101 -In the Fall of 2023, she had a concern for the former Maintenance Director's physical affection towards residents. -She notified the Administrator sometime in October 2023 that she did not like the former Maintenance Director hugging residents. -Only PCAs and MAs were to provide hands-on care to residents, no other staff. -She resigned from the facility in November 2023 or December 2023. -The Administrator was rarely at the facility and did not engage with residents. Telephone interview with a former agency PCA on 02/05/24 at 10:50am revealed: -She occasionally worked on the SCU. -When she worked in the SCU, the former Maintenance Director was frequently on the unit spending time with Resident #2. -Resident #2 was frequently hugged, had her back rubbed over her clothing, and walked down the hallway holding the former Maintenance Director's hand. -She did not feel comfortable with the amount of affection the former Maintenance Director provided to Resident #2. Telephone interview with a PCA on 02/07/24 at 11:30am revealed: -She worked first and second shift in the SCU. -Between September 2023 and October 2023, she notified the Administrator of a concern she had observed the Maintenance Director changing Resident #2's brief from her bedside. -She was not aware of any investigation which involved the former Maintenance Director between September 2023 and November 2023, until an incident occurred with the former Maintenance Director on 01/02/24.	D 453		

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D 453	Continued From page 102 Interview with a first shift MA on 01/03/24 at 11:30am revealed: -She had concerns about the former Maintenance Director's level of physical contact with residents. -She notified the former SCC and the current SCC of her concerns for the former Maintenance Director's physical contact with residents. -She had frequently observed the former Maintenance Director rub residents' backs, kiss female residents on their cheek close to their mouths. -She felt uncomfortable around the former Maintenance Director due to him constantly hugging residents. -On 01/02/24, around 7:00am, she observed the former Maintenance Director rubbing Resident #2's feet in the Livingroom. Interview with a first shift MA on 01/30/24 at 4:45pm revealed: -Sometime in the Fall of 2023, she attended a staff meeting directed by the Administrator. -The Administrator notified staff that facility employees were permitted to touch residents' shoulders and that it was not to be considered inappropriate. -The Administrators discussion was upsetting to her, and she left the meeting. Telephone interview with a former PCA on 01/31/24 at 4:11pm revealed: -She had worked on the SCU. -Occasionally, she had observed the former Maintenance Director hug Resident #2 which "seemed odd". -She did not report every instance witnessed because the Administrator was already made aware of former Maintenance Director's inappropriate behavior.	D 453		

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Telephone interview with the former SCC on 01/31/24 at 4:20pm revealed:
-She worked in the SCU between October 2023 and December 2023.
-She and facility staff were concerned the former Maintenance Director "favored Resident #2 over other residents".
-Staff had observed the former Maintenance Director frequently holding hands with Resident #2 while walking down the hallway, and rubbing her back, and would occasionally observe the Maintenance Director walking out of Resident #2's bedroom without a maintenance need in the room.
-In early November 2023, staff wrote statements with concerns for the former Maintenance Director.
-In early November 2023, she provided the written statements to the Administration.
-She was unaware if the Administrator interviewed staff related to the written statements.

Interview with the SCC on 01/30/24 at 4:10pm revealed:
-He was promoted to the SCC role in late December 2023.
-The former SCC had provided the Administrator with staff statements related to concerns for the former Maintenance Director.
-He did not know what was written in the staff statements.
-In the fall of 2023, some staff had informed him of concerns for witnessing the former Maintenance Director show affection towards Resident #2, including kissing residents on the cheek and forehead.
-Kissing residents in any manner was inappropriate for any staff to engaged in.
-In the fall of 2023, the Administrator did not interview him related to the former Maintenance

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Director's interactions with residents.
-In the fall of 2023, the Administrator was aware of staff concerns for the former Maintenance Director providing care to residents because she notified all department managers during meetings to ensure only staff assigned to resident care, performed resident care needs.

Telephone interview with the former Maintenance Director on 02/01/24 at 3:50pm revealed:
-He was the Maintenance Director between 07/03/23 and 01/03/24.
-He frequently greeted residents in the SCU daily with hugs, scratching their backs over their shirts, and kissing foreheads.
-In the fall of 2023, on one occasion, he was in Resident #2's room repairing a telephone and Resident #2 entered the room while she was pulling her pants down and was defecating on the floor, he assisted her to the toilet and left the room to locate a PCA.
-In October 2023, the Administrator notified him that a PCA had a concern for how he showed affection towards residents.
-In October 2023, the Administrator talked with him about 'being mindful' of how he showed affection towards residents could be uncomfortable for care staff.

Telephone interview with a Law Enforcement Detective on 01/31/24 at 4:39pm revealed:
-He interviewed the facility former Maintenance Director in January 2024.
-The Maintenance Director had stated there was an incident in which he had observed Resident #2 in the hallway without her pants on, while she was defecating, and assisted her to the toilet, and sought PCAs to assist the resident.
-A PCA had been interviewed and she had observed the former Maintenance Director in

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Resident #2's room and Resident #2 did not have pants on, with no additional details provided about this incident.
-A PCA had been interviewed and felt the Maintenance Director had spent too much time in residents' rooms without a need for maintenance services.
-Based on interviews, the former Maintenance Director was overly friendly towards female residents without evidence of criminal acts.

Telephone interview with a second Law Enforcement Detective on 02/01/24 at 11:30am revealed:
-He conducted numerous interviews with facility staff after an incident on 01/02/24 which involved another resident and the former Maintenance Director.
-He conducted an interview with the former Maintenance Director in January 2024 related to an allegation of sexual assault to a resident.
-During the interviews, staff disclosed concerns because of how the former Maintenance Director interacted with Resident #2 related to hugging her and rubbing her back.
-According to the former Maintenance Director, on one occasion, he had assisted Resident #2 onto the toilet while she was defecating and proceeded to clean up Resident #2's bedroom floor while a PCA assisted Resident #2 in the bathroom.

Interview with the facility Compliance Nurse on 01/31/24 at 5:35pm revealed:
-Prior to 01/02/24, she was not aware staff had expressed concerns for the former Maintenance Director's physical interactions with residents.
-Sometime prior to 01/02/24, during management meetings, the Administrator had instructed non-care staff to avoid assisting residents with

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care.
-The former Maintenance Director was not responsible for providing resident care.

Telephone interview with Resident #2's former facility contracted Nurse Practitioner on 02/02/24 at 10:18am revealed:
-She was Resident #2's healthcare provider between 2022 through December 2023.
-She was not aware of any allegations of abuse, neglect, or exploitation of Resident #2 by facility staff.
-If facility staff had observed a concern for Resident #2 and possible abuse by a facility employee, she expected to be notified immediately.

Interview with the Administrator on 02/02/24 at 2:55pm revealed:
-She was responsible for reporting any concerns for resident abuse, neglect, or exploitation to local law enforcement, department of social services, and department of health service regulations.
-On 10/19/23, a dining staff had her of a concern for the former Maintenance Director.
-On 10/19/23, the dining staff notified her that she felt uncomfortable with the former Maintenance Director hugging her, providing hugs to residents, and kissing residents on their foreheads.
-She interviewed additional staff and was told the former Maintenance Director was often observed giving hugs to Resident #2.
-She determined the former Maintenance Director's hugging of Resident #2 was not inappropriate due to Resident #2 frequently having episodes of crying where she sought out staff for hugs.
-She did not document the staff concerns or interviews.
-She did not initiate a NC Healthcare Personnel

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D 453	Continued From page 107 Initial or Investigation Report related to the former Maintenance Director. -On 10/20/24, she met with the former Maintenance Director and notified him staff felt uncomfortable with his physical expressions of affection towards staff and residents and to be careful how he interacted with staff and residents. -On 10/20/24, she notified the former Maintenance Director that kissing of residents was not permitted "even though I know you don't mean any harm." -Between 10/19/23 and 01/02/24, staff had not provided any written statements related to the Maintenance Director. -She was unaware of any written statements provided by staff concerning the former Maintenance Director dated 11/01/23. -Between 10/19/23 and 01/02/24, she was not notified of any additional concerns for the former Maintenance Director, or any other staff related to allegations of abuse, neglect, or exploitation. Telephone interview with the Chief Operating Officer (COO) on 02/01/24 at 1:00pm revealed: -She was at the facility on 10/19/23. -Staff did not report concerns about the former Maintenance Director kissing or hugging residents. -She was not aware of any signed staff written statements about concerns of the former Maintenance Director's behavior after 10/19/23. -She stated, "from my perspective, staff hugging a resident does not constitute an allegation of abuse or neglect or exploitation." -She said it was inappropriate for the former Maintenance Director to kiss Resident #2. -She stated if signed, dated, written statements from staff after 10/19/23 existed, the Administrator should have reported these statements to the facility's human resource	D 453		

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D 453	Continued From page 108 department. -If a staff statement documented concerns for inappropriate touching of a resident, the accused staff should have been immediately suspended and a report made to the NC Department of Health Service Regulations and law enforcement. -On 01/02/24 at approximately 10:30am, she had a telephone call with the Administrator, and she instructed the Administrator to call law enforcement. -She expected the Administrator to immediately call law enforcement on 01/02/24. -She was unaware until late January 2024, that the Administrator had waited till after 5:00pm on 01/02/24 to notify law enforcement of an allegation of sexual assault by the former Maintenance Director to a resident. _____ The facility failed to ensure law enforcement and the county DSS was contacted when they were made aware of abuse and exploitation by a male staff who hugged, kissed and inappropriately touched two cognitively impaired female residents (#2 and #3) related to staff reporting the male was discovered in the resident's rooms applying lotion under her cover when her genitalia and her low extremities were exposed, staff reporting the male kissing the resident in the mouth (#3) and staff reporting inappropriate kissing and hugging of a resident multiple times (#2). The facility's failure resulted in delayed reporting and investigation of potential cause and prevention of further abuse or exploitation and delayed protection and prevention from staff in care facilities. The facility's failure resulted in serious neglect and exploitation and constitutes a Type A1 Violation. _____ The facility provided a plan of protection on January 30, 2024, and on February 12, 2024, in	D 453		

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D 453	Continued From page 109 accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 13, 2024.	D 453		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations and interviews, the Administrator failed to ensure the management and operation of the facility and implementation of the facility's policies to ensure compliance with rules and statutes regarding Health Care, Resident Rights, Medication Administration, Health Care Personnel Registry, and Reporting of Accidents and Incidents. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for a capacity of 90 beds including 42 Assisted Living beds and 48 Special Care Unit (SCU) beds. Review of the facility's current census on 01/30/24 was 58 residents.	D980		

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D980	Continued From page 110 Interview with a dietary aide on 01/30/24 at 11:46am revealed: -In regard to the incidents related to Resident #2 and Resident #3. -She reported to the previous SCC towards the end of October that she was uncomfortable with the former maintenance director hugging and kissing a female resident who resided in the SCU. -The Administrator asked her to provide a written statement along with other staff who had witnessed the former Maintenance Director's inappropriate behavior but nothing was done about it. Telephone interview with the former Special Care Unit Coordinator (SCC) on 01/31/24 at 4:20pm revealed: -In regard to the incidents related to Resident #2 and Resident #3. -She worked in the SCU between October 2023 and December 2023. -She and facility staff were concerned about the Maintenance Director's inappropriate touching, kissing, and hugging residents. -In early November 2023, she provided the written statements to the Administrator. -She did not know if the Administrator interviewed staff related to the written statements. -The Maintenance Director was still working at the facility when the Administrator resigned. Telephone interview with a law enforcement detective on 01/31/24 at 4:39pm revealed: -In regard to incidents related to Resident #2 and Resident #3. -Based on interviews, the former Maintenance Director was overly friendly towards female residents without evidence of criminal acts. -On 01/02/24, the facility Administrator waited until after normal business hours, between	D980		

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D980	Continued From page 111 5:30pm and 6:00pm, to notify law enforcement of a possible sexual assault crime which was observed by staff on 01/02/24 between 8:30 and 9:00am and immediately reported to the Administrator. -He would have expected the Administrator to immediately notify law enforcement on 01/02/24 to reduce opportunities of any evidence to be contaminated or discarded. Telephone interview with a former MA on 02/01/24 at 12:40pm revealed: -In regard to the incidents related to Resident #2 and Resident #3. -She was never interviewed by the Administrator or management staff related to her written statement dated 11/01/23 with her concerns about the Maintenance Director's inappropriate behaviors. Interview with the Administrator on 02/02/24 at 2:55pm revealed: -In regard to the incidents related to Resident #2 and Resident #3. -She was responsible for reporting any concerns for resident abuse, neglect, or exploitation to local law enforcement, Department of Social Services (DSS), and HCPR. -On 10/19/23, a dining staff notified her that she felt uncomfortable with the former Maintenance Director providing hugs to residents, and kissing residents on their foreheads. -She interviewed additional staff and was told the former Maintenance Director was often observed giving hugs. -She determined the former Maintenance Director's hugging residents was not inappropriate. -She did not document the staff concerns or interviews.	D980		

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D980	Continued From page 112 -She did not initiate the HCPR investigation related to the former Maintenance Director's behaviors. -On 10/20/24, she met with the former Maintenance Director and notified him staff felt uncomfortable with his physical expressions of affection towards staff and residents and to be careful how he interacted with staff and residents. Interview with the Resident Care Coordinator (RCC) on 02/05/24 at 10:54am revealed: -In regard to medications and health care. -She was not aware of issues with the residents' not receiving their medications and physician orders being implemented until this past month. -There was not a system put in place by the Administrator or Regional Management until January 2024 when these issues were discovered. Interview with the facility Compliance Nurse on 02/12/24 at 3:18pm revealed: -In regard to medications and health care. -She was hired as the facility Compliance Nurse in October 2023. -She had not audited all of the residents' records since she began working at the facility because the Administrator never told her to do so. -She just learned there were errors with how staff entered orders into the electronic Medication Administration Record (eMAR). -The results and any issues of the audits completed by the RCC and SCC were supposed be given to the Administrator and discussed in the morning meetings. -The Administrator was responsible for following up on the missed medications. -It became her responsibility in January 2024 because it was not always being done.	D980		

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D980	Continued From page 113 Telephone interview with a first and second shift PCA on 02/07/24 at 11:30am revealed: -Beginning in September 2023, she had to begin purchasing personal care supplies for residents, which included wet wipes, disposable incontinence bed pads, towels, and soap for residents because the facility stopped purchasing the items. -Between September 2023 and December 2023, she frequently notified the Administrator of the lack of personal care supplies and was told the Administrator would investigate the issue. -In the middle of December 2023, the facility began re-supplying personal care items, which included towels, soap, gloves, and incontinence briefs for residents. Telephone interview with a second shift MA on 02/07/24 at 11:55am revealed: -She had concerns for the management of the facility by the Administrator because the Administrator was rarely onsite between September 2023 and December 2023. -Between September 2023 and December 2023, she had to purchase incontinence supplies, bedding, soap, gloves, and towels for residents due to the facility not maintaining a stock of supplies. -Between September 2023 and December 2023, she notified the Administrator of concerns for a lack of resident personal needs supplies and staff purchasing items on their own was told to "keep up the good work." Non-compliance was identified at violation levels in the following rule areas: 1. Based on interviews and record reviews the facility failed to ensure physician's orders were implemented for 2 of 5 sampled residents (#1 and	D980		

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D980	Continued From page 114 #5) related to taking blood pressures twice daily (#1) and taking finger stick blood sugars (FSBS) twice daily (#5). [Refer to tag 0276, 10A NCAC 13F .0902(c) (3-4) Health Care (Type A1 Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled residents (Resident #2 and #3) were free from neglect, abuse and exploitation related to reports of a male staff member inappropriately touching, hugging, and kissing while staff observed the behaviors and did not intervene to protect the residents. [Refer to tag 0338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 4 of 6 sampled residents (#1, #2, #4, and #5) which included a medication to lower blood pressure (#1, #4), a medication to treat an intestinal disorder (#1), a medication to treat vaginal dryness (#1), a medication to treat depression (#2), a medication to treat Alzheimer's disease (#2), a medication to prevent blood clots (#4), and a medication used to control high blood sugars (#5).[Refer to tag 0358, 10A NCAC 13F .10004(a) Medication Administration (Type A1 Violation)]. 4 Based on interviews, and record reviews, the facility failed to ensure the Medication Administration Records (MAR) were accurate for 2 of 5 residents (#1 and #4) including inaccurate documentation of a medication to treat hypertension (#1, #4), a medication to treat vaginal dryness (#1), and a medication to prevent blood clots (#4). [Refer to tag 0367, 10A NCAC 13F .1004(j) Medication Administration (Type B Violation)].	D980		

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D980	Continued From page 115 5. Based on interviews and record reviews, the facility failed to report allegations of alleged abuse by a staff member related to him inappropriately touching, hugging, and kissing 2 of 2 sampled residents (#2 and #3) to the Health Care Personnel Registry (HCPR). [Refer to tag 0438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A1 Violation)]. 6. Based on interviews and record reviews, the facility failed to immediately notify the county Department of Social Services (DSS) and local law enforcement about potential abuse and exploitation of 2 of 2 sampled residents (#2 and #3) who were inappropriately touched by a male staff member. [Refer to tag 0453, 10A NCAC 13F .1212d Reporting Incidents and Accidents (Type A1 Violation)]. _____ The Administrator failed to ensure the overall management, operations and implementation of policies of the facility and maintain substantial compliance with the rules and statutes governing adult care homes as related to health care implementation of orders, residents rights related to keeping residents safe from abuse, medication administration, medication administration related to accurate of the electronic medication administration records, reporting of incidents and accidents to law enforcement and DSS, and not reporting staff with allegations of abuse to HCPR. The Administrator's failure to ensure responsibility for the overall operation, administration, management, and supervision of the facility resulted in serious neglect of the residents which constitutes a Type A1 Violation. _____ The facility failed to provide an acceptable Plan of Protection for GS 131D-25 in relationship to the	D980		

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D980	Continued From page 116 overall management and operations of the facility that would ensure safety and respect to the Residents Rights. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 13, 2024.	D980		