STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056001	A. BUILDING: _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 000	Initial Comments The Adult Care Licensure Section and Macon County Department of Social Services conducted a follow-up survey and a complaint investigation on 12/16/24 through 12/18/24. The complaint investigation was initiated by the Macon County Department of Social Servicies (DSS) on 09/24/24, 11/22/24 and 12/11/24.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure residents received appropriate care for 3 of 5 sampled residents (#2, #3 and #4) related to a resident who was not seen by a physician when she was physically assaulted by Staff F (#2) and 2 residents involved in a possible sexual interaction (#3 and #4). The findings are: 1. Review of Resident #2's current FL2 dated 07/01/24 revealed: -Diagnoses included dementia with behavioral disturbances, abnormal weight loss, chronic kidney disease, and a wedge compression fracture (a type of spinal fracture). -Resident #2's level of care was SCU. -The resident was semi-ambulatory. Review of Resident #2's Resident Register revealed an admission date of 06/27/23.	D 273		

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D 273	Continued From page 1 Interview with the Special Care Coordinator (SCC) on 12/16/24 at 12:28pm revealed: -Around the end of October 2024, the MA shift supervisor reported to her that an unnamed staff member physically assaulted Resident #2 in the SCU. -She and the MA day shift supervisor reported the information to the Manager of the facility and the Administrator. -In this instance the Administrator was responsible for calling the physicians' because of the investigation into the incident. Interview with the day shift MA supervisor on 12/16/24 at 12:36pm revealed: -Around the end of October 2024, a 3rd party staff informed her that one PCA witnessed a second PCA kick and slap Resident #2. -She informed the SCC and the facility Manager of the allegation. -When she found out it was Resident #2, she did not notify the physician because the Administrator would have. Telephone interview with the day shift MA supervisor on 12/17/24 at 12:10pm revealed: -On 10/25/24, Staff B informed her of the incident she witnessed when Staff F kicked and hit Resident #2 while Staff F was trying to get Resident #2 dressed. -She reported the incident to the SCC. -The Administrator was responsible for notification to Resident #2's PCP. Interview with the Administrator on 12/16/24 at 1:20pm revealed: -She was notified by a MA supervisor around the last week of October 2024 about a staff member who laid hands on a resident.	D 273		

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-Staff F told her that Resident #2 kicked her in the face and hit her and as an instinct the Staff F kicked at and hit at Resident #2 but did not make physical contact.
-She did not notify Resident #2's PCP because she believed there was no injury or harm.

2. Review of Resident #3's current FL2 dated 08/23/24 revealed:
-Diagnoses included dementia, hearing loss, arthritis, morbid obesity, hypertension and general debility.
-Resident #3's level of care was SCU.
-The resident was semi-ambulatory.

Review of Resident #3's Resident Register revealed an admission date of 11/30/17.

Review of Resident #3's charting note dated 11/27/24 at 8:00pm revealed:
-The Administrator documented Resident #3 came out of a male resident's room, in her wheelchair.
-Resident #3 was not wearing a brief or pants, and wearing a top and a blanket over her lap.
-Resident #3 was not able to state what was going on.
-There was potential for sexual interaction.
-She would consider moving Resident #3 to a different room.

Interview with Resident #3's PCP on 12/17/24 at 8:07am revealed:
-On 12/16/24 between 2:00pm and 5:00pm, a MA notified him of the sexual interaction between Resident #3 and Resident #4 on 11/27/24.
-Resident #3 was last seen on 12/03/24 and there were no concerns reported by the facility staff.
-Resident #3 was not orientated and could not consent to that type of interaction.

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D 273	Continued From page 3 Refer to interview with the Special Care Coordinator (SCC) on 12/16/24 at 12:28pm. Refer to interview with the Administrator on 12/16/24 at 1:20pm. 3. Review of Resident #4's current FL2 dated 09/03/24 revealed: -Diagnoses included Alzheimer's dementia, hypertension, and osteoarthritis. -Resident #4's level of care was SCU. -The resident was ambulatory. Review of Resident #4's Resident Register revealed an admission date of 11/07/22. Review of Resident #4's charting note dated 11/27/24 at 8:00pm revealed: -The Administrator documented Resident #3 walked out of resident's room, naked. -Resident #4 was not able to state what was going on. -There was potential for sexual interaction. Telephone interview with Resident #4's PCP on 12/17/24 at 3:43pm revealed: -He was not made aware of the possible sexual incident which included Resident #4 on 11/27/24. -His concern was that in order to really know what happened, would have been to have Resident #3 and Resident #4 see a medical provider in order to determine if the substance described in the incidence, was really semen. -If he had he been informed, he would have completed a sexually transmitted disease (STD) test and monitored Resident #4 for and signs or symptoms of an STD. -He would also have ordered the staff to increase monitoring Resident #4 to decrease another	D 273		

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D 273	Continued From page 4 sexual encounter because Resident #4 was not capable of giving consent. Refer to interview with the Special Care Coordinator (SCC) on 12/16/24 at 12:28pm. Refer to interview with the Administrator on 12/16/24 at 1:20pm. _____ Interview with the Special Care Coordinator (SCC) on 12/16/24 at 12:28pm revealed: -On 11/28/24, she reviewed all the SCU resident's charting notes and that was how she was made aware of an incident where Resident #3 was found coming out of Resident #4's room in her wheelchair with no brief or pants on, only a top and a blanket. -She did not contact the provider about the incident. -The Administrator was responsible for notification to whoever needed to be notified. Interview with the Administrator on 12/16/24 at 1:20pm revealed: -On 11/27/24, a MA called her and informed her that Resident #3 was seen coming out of Resident #4's room in her wheelchair without a brief and pants on. -Resident #3 was wearing a top and had a blanket over her lap. -Resident #3's room was across from Resident #4's room in the SCU before Resident #3 was moved and she did not know to which room. -She completed a charting note about the incident. -In the charting note she documented that the incident was a potential "sexual interaction". -She did not notify Resident #3's and #4's PCP because she felt there was no harm.	D 273		

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D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights 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 all residents were free from physical abuse related to a resident being physically assaulted by a staff member (Resident #2) and neglect related to protecting residents in the Special Care Unit (SCU) from sexual advances (Resident #3) from another SCU resident (#4). The findings are: Review of the facility's undated Employee handbook revealed: -Residents were to be free of mental and physical abuse, neglect and exploitation. -Staff were to treat residents with respect and dignity. -Physical abuse was classified as misconduct. 1. Review of Resident #2's current FL2 dated 07/01/24 revealed: -Diagnoses included dementia with behavioral disturbances, abnormal weight loss, chronic kidney disease, and a wedge compression fracture (a type of spinal fracture). -Resident #2's level of care was SCU. -The resident was semi-ambulatory.	D 338		

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Review of Resident #2's Resident Register revealed an admission date of 06/27/23.

Review of Resident #2's care plan dated 04/30/24 revealed Resident #2 was verbally abusive, physically abusive, resisted care, and displayed disruptive behaviors.

Review of the facility's Health Care Personnel Registry (HCPR) Initial Allegation Report revealed:
-On 10/25/24 at 8:00am the facility became aware of the incident.
-The allegation details were documented as the witness arrived at work at 6:00am, heard Resident #2 yelling and she went to Resident #2's room.
-The witness saw a personal care aide (PCA) trying to put Resident #2's pants on.
-Resident #2 got angry and kicked Staff F, in turn Staff F kicked Resident #2 back.
-At that point the witness told the PCA she would finish helping Resident #2.
-As the PCA was leaving, Resident #2 swung at the PCA and then the PCA reacted by smacking Resident #2 on the shoulder.
-There was no documentation on how residents were being protected.
-There was documentation of no physical or mental harm.
-The notifications to another agency were left blank.
-The facility Manager prepared the report.

Review of the facility's HCPR Investigation Report revealed:
-The employee information section was left blank.
-The allegation/incident type was documented as Resident Abuse.
-The allegation details were documented as an

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update after speaking to who reported a different version of the original report.
-It was unclear what actually happened.
-The PCA was given a written warning and informed that if "another incident" with a resident ever occurred again, she would be terminated and reported to the HCPR.
-The allegations were not substantiated.

Review of Employee Disciplinary Action Form dated 11/21/24 for Staff F revealed:
-After Resident #2 became aggressive and kicked her, she, in turn, kicked Resident #2.
-She continued to assist Resident #2 with activities of daily living (ADL's) and after Resident #2 "smacked" her, she smacked Resident #2.
-There was documentation the accused PCA interacted with a resident "in an inappropriate way."
-There was no documentation the accused PCA was reported to HCPR.
-Her improvement plan included she would never touch a resident again in an inappropriate way or she would be terminated immediately and reported to the HCPR.

Review of Resident #2's record revealed there was no incident report dated 10/25/24.

Interview with the Special Care Coordinator (SCC) on 12/16/24 at 12:28pm revealed:
-Around the end of October 2024, the day shift MA supervisor reported to her that an unnamed staff member physically assaulted Resident #2 in the SCU.
-She and the day shift MA supervisor reported the information to the Manager of the facility and the Administrator.
-They did not have the name of the staff member at that time.

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-When there was an accusation of resident abuse from staff, it was to be reported to the Administrator and the Administrator would determine what reports would be filed and who would be notified.

Interview with the day shift MA supervisor on 12/16/24 at 12:36pm revealed:
-Around the end of October 2024, a 3rd party staff informed her that one PCA witnessed a second PCA kick and slap Resident #2.
-She informed the SCC and the facility Manager of the allegation.
-The facility Manager informed her that she and the Administrator were aware of the allegation and that it was being addressed.
-She did not know at the time of the alleged abuse that it was Resident #2 or she would have checked on Resident #2.

Telephone interview with a PCA on 12/17/24 at 8:32am revealed:
-On 10/25/24, she came in to work at about 5:00am to get a resident ready for surgery at 6:00am.
-When she walked into the SCU she heard Resident #2 yelling "stop" and she went to see what the yelling was about.
-She saw Resident #2 kicking and hitting Staff F as Staff F was trying to put Resident #2's pants on.
-She saw Staff F being very aggressive by using her hands to push back Resident #2 as Resident #2 was hitting her while trying to get Resident #2's pants on.
-She asked Staff F if she needed help and as Staff F stood up and said yes, Staff F kicked Resident #2 in the legs and slapped Resident #2 on the shoulder, arm and then hand.
-Resident #2 screamed out in pain.

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-Staff F was very frustrated and mad with Resident #2.
-She reported the incident to the MA shift supervisor after she dressed Resident #2 and followed up with the same MA shift supervisor when she returned to work the next day.
-She spoke to the facility Manager a few days later and gave her verbal statement and then she was instructed to give her verbal statement to the facility Manager for a report.

Telephone interview with Staff F on 12/17/24 at 11:53am revealed:
-Resident #2 was aggressive when she tried to dress or change clothing or briefs.
-On 10/25/24, Resident #2 started kicking her in the face multiple times and she attempted to dress Resident #2.
-Resident #2 hit her several times and as a reflex reaction she kicked at Resident #2 but did not make contact and she slapped Resident #2's hand and said, "no, that's not nice".
-Staff B came in to get Resident #2 dressed after the incident.
-The Administrator called her into the office and asked her about the incident and she was written up for the slap to Resident #2 and was warned not to do that again or she would be fired.
-She was not suspended and continued to work through the investigation.

Telephone interview with the day shift MA supervisor on 12/17/24 at 12:10pm revealed:
-On 10/25/24, a PCA informed her of the incident she witnessed when Staff F kicked and hit Resident #2 while Staff F was trying to get Resident #2 dressed.
-She reported the incident to the SCC.
-The Administrator would be responsible for the investigation and any paperwork that was to be

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completed.

Interview with the facility Manager on 12/18/24 at 10:30am revealed:
-The Administrator instructed her to speak to the PCA and Staff F, and then on 10/29/24 she complete the 24 hour report and sent it to HCPR.
-On 10/29/24, she spoke to the PCA and was told on 10/25/24, when she arrived at work at 6:00am, she heard Resident #2 yelling, so she went to Resident #2's room.
-When the PCA arrived at Resident #2's room she saw Staff F tried to put Resident #2's pants on when Resident #2 kicked Staff F and Staff F kicked Resident #2, the Resident #2 swung at Resident #2 and Staff F smacked Resident #2 on the shoulder.
-When she talked to Staff F, she was told she kicked at Resident #2, but did not actually kick Resident #2 and then Staff F smacked Resident #2's hand.
-She did not feel there was no injury or harm.
-She did give Staff F a disciplinary action write up on 11/21/24 stating Staff F kicked and smacked Resident #2 and if Staff F ever touched a resident again in an inappropriate way Staff F would be terminated.
-The Administrator told her there was an incident last year where the PCA witnessed the incident but later found out that the PCA did not and from that the PCA lost creditability in this incident.

Interview with the Administrator on 12/16/24 at 1:20pm revealed:
-She was notified by a MA shift supervisor around the last week of October 2024 about a staff member who laid hands on a resident.
-At that time she did not know the name of the staff or the resident.
-She instructed the Manager of the facility to

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complete a 24 hour report which was the initial investigation.
-She spoke to a PCA who witnessed the alleged abuse and was told Staff F, kicked and hit Resident #2.
-The Staff F told her that Resident #2 kicked her in the face and hit her and as an instinct the Staff F kicked at and hit at Resident #2 but did not make physical contact.
-It took several days to figure out and Staff F was not suspended and continued to work.
-Staff F was written up for abuse on a resident and would be terminated if the abuse ever happened again.
-The policy was to terminate staff if they displayed any kind of physical abuse towards a resident.
-She did not terminate Staff F because she thought Staff B lost creditability over something from last year.

2. Review of Resident #3's current FL2 dated 08/23/24 revealed:
-Diagnoses included dementia, hearing loss, arthritis, morbid obesity, hypertension and general debility.
-Resident #3's level of care was SCU.
-The resident was semi-ambulatory.

Review of Resident #3's Resident Register revealed an admission date of 11/30/17.

Review of Resident #3's care plan dated 08/23/24 revealed:
-She had wandering behaviors and was always disoriented.
-She had significant memory loss and required direction.
-She required limited assistance with ambulation/locomotion.
-She required extensive assistance with bathing,

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D 338	Continued From page 12 grooming and personal hygiene. Review of Resident #3's charting note dated 11/27/24 at 8:00pm revealed: -The Administrator documented Resident #3 came out of a male resident's room, in her wheelchair. -Resident #3 was not wearing a brief or pants and wearing a top and a blanket over her lap. -Resident #3 was not able to state what was going on. -There was potential for sexual interaction. -She would consider moving Resident #3 to a different room. Review of Resident #3's 30-minute Wellness Checks revealed: -The every 30-minutes wellness checks was initiated on 12/02/24 at 4:30pm. -There was no documentation the 30-minute wellness checks were completed from, 11/27/24 at 8:00pm to 12/02/24 at 4:30pm. -There was no documentation the 30-minute wellness checks were completed from 10:30am to 3:00pm on 12/04/24. -There was no documentation the 30-minute wellness checks were completed from 6:00am to 7:00am on 12/05/24. -There was no documentation the 30-minute wellness checks were completed from 12:00am to 7:00am on 12/06/24. -There was no documentation the 30-minute wellness checks were completed from 2:00pm to 3:00pm on 12/07/24. -There was no documentation the 30-minute wellness checks were completed from 12:00am to 12/11/24 at 9:42am on 12/08/24. -There was no documentation the 30-minute wellness checks were completed from 10:42am to 12/12/24 9:26am on 12/11/24.	D 338		

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-There was no documentation the 30-minute wellness checks were completed from 11:22am to 3:15pm on 12/12/24.
-There was no documentation the 30-minute wellness checks were completed from 8:15pm to 12/23/24 at 3:00pm on 12/12/24.
-There was no more documentation of the 30-minute wellness checks available after 12/13/24 at 7:30pm.

Interview with Resident #3's PCP on 12/17/24 at 8:07am revealed:
-On 12/26/24 between 2:00pm and 5:00pm, a MA notified him of the sexual interaction between Resident #3 and Resident #4 on 11/27/24.
-Resident #3's PCP last saw her on 12/03/24 and there were no concerns reported by the facility staff.
-Resident #3 was not orientated to person and could not consent to that type of interaction.

Refer to interview with the Special Care Coordinator (SCC) on 12/16/24 at 12:28pm.

Refer to interview with a MA on 12/16/24 at 4:06pm.

Refer to telephone interview with a PCA on 12/17/24 at 4:13pm.

Refer to interview with the Administrator on 12/16/24 at 1:20pm.

3. Review of Resident #4's current FL2 dated 09/03/24 revealed:
-Diagnoses included Alzheimer's dementia, hypertension, and osteoarthritis.
-Resident #4's level of care was SCU.
-The resident was ambulatory.

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Review of Resident #4's Resident Register revealed an admission date of 11/07/22.

Review of Resident #4's care plan dated 08/29/24 revealed:
-He had wandering behaviors and was always disoriented.
-He had significant memory loss and required direction.
-He required limited assistance with grooming and personal hygiene.
-He was totally dependent with bathing,

Review of Resident #4's charting note dated 11/27/24 at 8:00pm revealed:
-The Administrator documented Resident #3 walked out of resident's room, naked.
-Resident #4 was not able to state what was going on.
-There was potential for sexual interaction.

Review of Resident #4's 30-minute Wellness Checks revealed:
-The every 30-minutes wellness checks was initiated on 12/02/24 at 5:00pm.
-There was no documentation the 30-minute wellness checks were completed from 11/27/24 at 8:00pm to 12/02/24 at 5:00pm.
-There was no documentation the 30-minute wellness checks were completed from 10:00am to 3:00pm on 12/02/24 .
-There was no documentation the 30-minute wellness checks were completed from 6:00am to 7:00am on 12/05/24.
-There was no documentation the 30-minute wellness checks were completed from 12/05/24 at 10:00pm to 12/06/24 at 7:00am.
-There was no documentation the 30-minute wellness checks were completed from 12/06/24 at 3:00pm to 12/07/24 at 7:00am.

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-There was no documentation the 30-minute wellness checks were completed from 2:00pm to 3:00pm on 12/07/24.
-There was no documentation the 30-minute wellness checks were completed from 8:00pm to 12/02/24 at 5:00pm on 11/27/24.
-There was no documentation the 30-minute wellness checks were completed from 12/08/24 at 12:00am to 12/09/24 at 7:00am.
-There was no documentation the 30-minute wellness checks were completed from 2:30pm to 7:30pm on 12/09/24.
-There was no documentation the 30-minute wellness checks were completed from 12/11/24 at 12:00am to 7:00am and from 3:00pm to 11:00pm.
-There was no documentation the 30-minute wellness checks were completed from 11:30pm to 12/13/24 at 3:00pm on 12/12/24.
-There was no documentation the 30-minute wellness checks were completed from 7:30am to 7:00pm on 12/14/24.
-There was no more documentation of the 30-minute wellness checks available after 12/14/24 at 11:30pm.

Telephone interview with Resident #4's PCP on 12/17/24 at 3:43pm revealed:
-He was not made aware of the possible sexual incident which included Resident #4 on 11/27/24.
-His concern was that in order to really know what happened, would have been to have Resident #3 and Resident #4 see a medical provider in order to determine if the substance described in the incidence was really semen.
-If he knew about the alleged incident, he would have completed a sexually transmitted disease (STD) test and monitored Resident #4 for and signs or symptoms of an STD.
-He would also have ordered the staff to increase

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monitoring Resident #4 to decrease another sexual encounter because Resident #4 was not capable of giving consent, it was an action.

Refer to interview with the Special Care Coordinator (SCC) on 12/16/24 at 12:28pm.

Refer to interview with a MA on 12/16/24 at 4:06pm.

Refer to telephone interview with a PCA on 12/17/24 at 4:13pm.

Refer to interview with the Administrator on 12/16/24 at 1:20pm.

Interview with the Special Care Coordinator (SCC) on 12/16/24 at 12:28pm revealed:
-On 11/28/24, she reviewed all the SCU resident's charting notes and that was how she was made aware of an incident where Resident #3 was found coming out of Resident #4's room in her wheelchair with no brief or pants on, only a top and a blanket.
-She and the day shift MA supervisor discussed moving Resident #3 to another room that was not directly across from Resident #4.
-Resident #3 was moved on 11/19/24 to another room, away from Resident #4.
-She did not know what was done immediately after the incident in 11/27/24.
-On 11/27/24 or 11/28/24, there was no increased supervision just to keep an eye out on where Resident #3 was as the staff walked down the hall.
-She did not contact the provider about the incident.
-The Administrator was responsible for notification to whoever needed to be notified.

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-She questioned the MA on duty at the time of the incident and was told that when the MA went into Resident #4's room, she slipped on a substance on the floor which the MA's understanding was semen.
-Other than that information, that MA knows the other details and she did not investigate any further.
-The only way to determine if there was actually a sexual encounter would have been to send Resident #3 out but that was the Administrators' call.

Interview with a MA on 12/16/24 at 4:06pm revealed:
-On 11/27/24 around 7:00pm, a PCA informed her that she found Resident #3 leaving Resident #4's room in her wheelchair.
-She told her that Resident #3 was without pants and a brief, and did have a top on and a blanket around her upper body.
-She instructed the PCA to take Resident #3 back to her room and get her dressed.
-She also instructed the PCA to check Resident #3 for any signs of redness or bleeding.
-She went to Resident #4's room, and she slipped on a slippery substance on the floor near his bed.
-She described the substance as wet, slippery, slightly sticky, gelled, and she believed it to smell like "semen".
-She questioned both Resident #3 and #4, both were not able to say what had happened.
-She notified the Administrator about the incident and was also responsible for notification to the family, PCP's, and documentation related to this incident.
-She was not sure of the policy for this type of incident.
-She did not move Resident #3 or #4.
-She did not implement any increased

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D 338	Continued From page 18 supervision because it was at the end of her shift. Telephone interview with a PCA on 12/17/24 at 4:13pm revealed: -On 11/27/24, she worked in the SCU. -She was completing last rounds around 6:00pm and 7:00pm. -On 11/27/24, Resident #3 resided in room #146, which was next door to Resident #4's room. -She and another PCA went into Resident #3's room, took both residents to the bathroom, and got them ready for bed. -She put a new brief, sweat pants and a top on Resident #3 and placed Resident #3 in the bed. -She and the other PCA exited Resident #3's room and went diagonally across the hall to room #145 which was directly across from Resident #4's room. -They were in room #145 for about 20 minutes. -Around 7:00pm, when she and the other PCA exited room #145, she saw Resident #3 roll out of Resident #4's room in her wheelchair, which was across the hall, room #144. -Resident #3 was not wearing a brief or pants. -Resident #3 was wearing a top and had a blanket around her shoulders. -When she looked in Resident #4's room, Resident #4 was in there but not Resident #4's roommate. -Resident #4 walked out of his room behind Resident #3 and she noticed Resident #4 did not have on shoes which was very unusual for Resident #4. -She took Resident #3 to her room and put Resident #3 in her bed. -She did not see Resident #3's pants anywhere. -She went and reported what she saw to the MA on duty. -She then went into Resident #4's room and provided care for Resident #4's roommate	D 338		

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because Resident #3 had not gone back to his room
-After getting Resident #4's roommate ready for bed, Resident #3 walked into the room and would not allow them to get him ready for bed but let them put him in bed.
-About the same time as Resident #3 walked into the room the MA brought medication in for Resident #3 and slipped on something in the floor.
-When she and the MA looked at the floor there was a clearish/whitish gel on the floor.
-The MA instructed her to go check Resident #3 for any signs of bleeding, bruising or redness to Resident #3's vaginal area.
-When she looked at Resident #3's vaginal area she saw what she believed to be the same clearish/whitish "glob", about a tablespoonful coming out of Resident #3's vagina.
-She called for the MA to come and look.
-She and the MA asked Resident #3 about what happened and was she in any kind of pain and Resident #3 just talked about other things not related to the questions.
-Resident #3 looked sacred to her because her eyes were wide open, and she was looking around the room to see who was there and flinched when she touched Resident #3's legs and when she cleaned up Resident #3's vaginal area.
-The MA reported it to the Administrator.
-Resident #3 was not moved that day but a day or two later.
-There was no increased supervision put in place until later because she did fill out every 30-minute safety checks.
-She was not sure when except was was in December 2024.

Interview with the Administrator on 12/16/24 at

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D 338	Continued From page 20 1:20pm revealed: -On 11/27/24, a MA called her and informed her that Resident #3 was seen coming out of Resident #4's room in her wheelchair without a brief and pants on. -Resident #3 was wearing a top and had a blanket over her lap. -Resident #3's room was across from Resident #4's room in the SCU before Resident #3 was moved and she did not know to which room. -She completed a charting note about the incident. -In the charting note she documented that the incident was a potential "sexual interaction". -The MA believed it to be a sexual interaction because the MA found a clearish substance on the floor that was sticky around the edges and slightly gelled and according to the MA smelled like semen. -The MA also reported that there were no signs of bruising or bleeding on Resident #3's vaginal area. -She instructed the MA to keep an eye out on Resident #3 every 30 minutes, and make sure Resident #3 did not wander into any of the other rooms except her own. -She did not call Resident #3's PCP because she believed that it was not that "intense" of a issue. -The MA did step in something slippery in Resident #4's room which increased the possibility of it being a sexual interaction. -The policy on sexual interactions in the SCU was that there were residents who were boyfriend and girlfriend and intimate and the staff do not encourage it or discourage it. -Resident #3 does have a boyfriend in the SCU and that was the roommate of Resident #4 and because of her dementia, it was possible that Resident #3 was not capable of determining who her boyfriend was at the time.	D 338		

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D 338	Continued From page 21 Attempted telephone interview with Resident #3's Responsible Person on 12/17/24 at 2:00pm was unsuccessful. _____ The facility failed to protect the residents from physical harm and neglect when Resident #2 in the SCU was physically assaulted by Staff F allowing Staff F to continue to work 17 shifts while the investigation into the assault was active, and when staff neglected to protect residents in the Special Care Unit from sexual advances from other SCU residents. This failure resulted in serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/16/24 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 16, 2024.	D 338		
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: Based on interviews and record reviews, the facility failed to complete a Health Care	D 438		

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D 438	Continued From page 22 Personnel Registry (HCPR) report within 24 hours of knowledge of an allegation of physical abuse of a resident and a 5 day investigative report for 1 of 1 staff (Staff F). The findings are: Review of Resident #2's current FL2 dated 07/01/24 revealed: -Diagnoses included dementia with behavioral disturbances, abnormal weight loss, chronic kidney disease, and a wedge compression fracture (a type of spinal fracture). -Resident #2's level of care was SCU. -The resident was semi-ambulatory. Review of Resident #2's Resident Register revealed an admission date of 06/27/23. Review of the facility's Initial Allegation Report revealed: -On 10/25/24 at 8:00am the facility became aware of the incident. -The allegation details were documented as the witness arrived at work at 6:00am, heard Resident #2 yelling and she went to Resident #2's room. -The witness saw Staff F trying to put Resident #2's pants on. -Resident #2 got angry and kicked Staff F, in turn Staff F kicked Resident #2 back. -At that point another personal care aide (PCA) told Staff F she would finish helping Resident #2. -As Staff F was leaving, Resident #2 swung at Staff F and then Staff F smacked Resident #2 on the shoulder. -There was documentation of no physical or mental harm. -The notifications to another agency were left blank.	D 438		

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D 438	Continued From page 23 -The facility Manager prepared the report. Review of the facility's Investigation Report revealed: -The employee information section was left blank. -The Allegation/Incident type was documented as Resident Abuse. -The allegations details were documented as an update after speaking to Staff F and getting a different story than what was reported, it was unclear what actually happened. -There was no fax conformation sheet attached. Telephone interview with a representative from the HCPR on 12/17/24 at 9:52am revealed: -The Initial 24 hour report was received at their office on 10/31/24 at 1:07pm for an incident that happened on 10/25/24. -The facility staff were required to submit a 24 hour and 5 day report to the HCPR for allegations against Staff F involving alleged physical abuse. Telephone interview with a PCA on 12/17/24 at 8:32am revealed: -On 10/25/24, she came in to work at about 5:00am to get a resident ready for surgery at 6:00am. -When she walked into the SCU she heard Resident #2 yelling "stop" and she went to see what the yelling was about. -She saw Resident #2 fighting Staff F by kicking and hitting Staff F as Staff F was trying to put Resident #2's pants on. -She saw Staff F being very aggressive by using her hands to push back Resident #2 as Resident #2 was hitting her while trying to get Resident #2's pants on. -She asked Staff F if she needed help and as Staff F stood up and said yes, Staff F kicked Resident #2 in the legs and slapped Resident #2	D 438		

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on the shoulder, arm and then hand.
-Resident #2 screamed out in pain.
-Staff F was very frustrated and mad with Resident #2.
-She reported the incident to the MA supervisor after she dressed Resident #2 and followed up with the same MA shift supervisor when she returned to work the next day.
-She spoke to the facility Manager a few days later and gave her statement and then she was instructed to give her verbal statement to the facility Manager for a report.

Telephone interview with Staff F on 12/17/24 at 11:53am revealed:
-Resident #2 was aggressive when she tried to dress or change clothing or briefs.
-On 10/25/24, Resident #2 started kicking her in the face multiple times and she attempted to dress Resident #2.
-Resident #2 even hit her several times and as a reflex reaction she kicked at Resident #2 but did not make contact and she slapped Resident #2's hand and said, "no, that's not nice".
-Staff B came in to get Resident #2 dressed after the incident.

Interview with the facility Manager on 12/18/24 at 10:30am revealed:
-The Administrator instructed her to speak to a PCA and Staff F.
-On 10/29/24, she spoke to the PCA and was told on 10/25/24, when she arrived at work at 6:00am, she heard Resident #2 yelling, so she went to Resident #2's room.
-When the PCA arrived at Resident #2's room she saw Staff F tried to put Resident #2's pants on when Resident #2 kicked Staff F and Staff F kicked Resident #2, the Resident #2 sung at Resident #2 and Staff F smacked Resident #2 on

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D 438	Continued From page 25 the shoulder. -When she talked to Staff F, she was told she kicked "at" Resident #2, but did not actually kick Resident #2 and then Staff F smacked Resident #2's hand. -She did not know she was to submit the report to HCPR within 24 hours because she thought she was to finish the investigation first so she waited to to send the report to HCPR. Interview with the Administrator on 12/16/24 at 1:20pm revealed: -She was notified by a MA shift supervisor around the last week of October 2024 about a staff member who laid hands on a resident. -She spoke to the, a PCA who witnessed the alleged abuse and was told that a second PCA, Staff F, kicked and hit Resident #2. -The Staff F told her that Resident #2 kicked her in the face and hit her and as an instinct the Staff F kicked at and hit at Resident #2 but did not make physical contact. -She thought she was to finish the investigation first and then report it to the HCPR.	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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW MANOR CARE CENTER	150 CRISP STREET FRANKLIN, NC 28734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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This Rule is not met as evidenced by:
Based on interview and record reviews, the facility failed to immediately notify the county Department of Social Services (DSS) and local law enforcement about potential abuse of 1 of 1 sampled residents (#2) who was smacked by Staff F and notification to DSS for 2 of 2 sampled residents (#3 and #4) who were Special Care Unit (SCU) residents involved in a potential sexual interaction.

The findings are:

1. Review of Resident #2's current FL2 dated 07/01/24 revealed:
-Diagnoses included dementia with behavioral disturbances, abnormal weight loss, chronic kidney disease, and a wedge compression fracture (a type of spinal fracture).
-Resident #2's level of care was SCU.
-The resident was semi-ambulatory.

Review of Resident #2's Resident Register revealed an admission date of 06/27/23.

Review of the facility's Initial Allegation Report revealed:
-The incident occurred on 10/25/24.
-On 10/25/24 at 8:00am the facility became aware of the incident.
-The allegation details were documented as the witness arrived at work at 6:00am, heard Resident #2 yelling and she went to Resident #2's room.
-The witness saw Staff F trying to put Resident #2's pants on.

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D 453	Continued From page 27 -Resident #2 got angry and kicked Staff F, in turn Staff F kicked Resident #2 back. -At that point the personal care aide (PCA) told Staff F she would finish helping Resident #2. -As Staff F was leaving, Resident #2 swung at Staff F and then Staff F smacked Resident #2 on the shoulder. -There was no documentation on how residents were being protected. -There was documentation of no physical or mental harm. -The notifications to another agency were left blank. -The facility Manager prepared the report. Review of the facility's Investigation Report revealed: -The employee information section was left blank. -The Allegation/Incident type was documented as Resident Abuse. -The Allegation Information section documented and update after speaking to Staff F and getting a different story than what was reported, it was unclear what actually happened. -Staff F was given a written warning and informed that if another incident with a resident ever occurred again, she would be terminated and reported to the HCPR. -The allegations were not substantiated, and the employee was not terminated. Review of Resident #2's record revealed there was no accident/incident report completed and no documentation DSS or local law enforcement was notified. Interview with the local Department of Social Services Adult Home Specialist (AHS) on 12/16/24 at 10:00am revealed there was no reporting of any incidents on 10/25/24.	D 453		

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D 453	Continued From page 28 Interview with the Special Care Coordinator (SCC) on 12/16/24 at 12:28pm revealed: -Around the end of October 2024, the MA supervisor reported to her that an unnamed staff member physically assaulted Resident #2 in the SCU. -She and the MA day shift supervisor reported the information to the Manager of the facility and the Administrator. -They did not have the name of the staff member at that time. -When there was an accusation of resident abuse from staff, it was to be reported to the Administrator and the Administrator would determine what reports would be filed and who would be notified. Interview with the day shift MA supervisor on 12/16/24 at 12:36pm revealed: -Around the end of October 2024, a 3rd party staff informed her that one PCA witnessed a second PCA kick and slap Resident #2. -She informed the SCC and the facility Manager of the allegation. -The facility Manager informed her that she and the Administrator were aware of the allegation and that it was being addressed. -She did not know at the time of the alleged abuse that it was Resident #2 or she would have checked on Resident #2. -She did not notify DSS or local law enforcement because the Administrator was responsible since the incident was reported to her to investigate. Interview with the facility Manager on 12/18/24 at 10:30am revealed: -She did not notify DSS or local law enforcement. -The Administrator was responsible for notification to whoever was to be notified.	D 453		

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D 453	Continued From page 29 Interview with the Administrator on 12/16/24 at 1:20pm revealed: -She was notified by a medication aide (MA) shift supervisor around the last week of October 2024 about a staff member who laid hands on a resident. -At that time she did not know the name of the staff or of the resident. -She instructed the Manager of the facility to complete a 24 hour report which was the initial investigation. -She spoke to a PCA who witnessed an alleged abuse and was told that a se Staff F, kicked and hit Resident #2. -The Staff F told her that Resident #2 kicked her in the face and hit her and as an instinct the Staff F kicked at and hit at Resident #2 but did not make physical contact. -She did not notify Local Law Enforcement or DSS because she did not know she needed to. 2. Review of Resident #3's current FL2 dated 08/23/24 revealed: -Diagnoses included dementia, hearing loss, arthritis, morbid obesity, hypertension and general debility. -Resident #3's level of care was SCU. -The resident was semi-ambulatory. Review of Resident #3's Resident Register revealed an admission date of 11/30/17. Review of Resident #3's charting note dated 11/27/24 at 8:00pm revealed: -The Administrator documented Resident #3 came out of a male resident's room, in her wheelchair. -Resident #3 was not wearing a brief or pants and wearing a top and a blanket over her lap.	D 453		

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-Resident #3 was not able to state what was going on.
-There was potential for sexual interaction.

Review of Resident #3's record revealed there was no accident/incident report completed and no documentation DSS or local law enforcement was notified.

Refer to interview with the Special Care Coordinator (SCC) on 12/16/24 at 12:28pm.

Refer to interview with a MA on 12/16/24 at 4:06pm.

Refer to telephone interview with a PCA on 12/17/24 at 4:13pm.

Refer to interview with the Administrator on 12/16/24 at 1:20pm.

3. Review of Resident #4's current FL2 dated 09/03/24 revealed:
-Diagnoses included Alzheimer's dementia, hypertension, and osteoarthritis.
-Resident #4's level of care was SCU.
-The resident was ambulatory.

Review of Resident #4's Resident Register revealed an admission date of 11/07/22.

Review of Resident #4's charting note dated 11/27/24 at 8:00pm revealed:
-The Administrator documented Resident #3 walked out of resident's room, naked.
-Resident #4 was not able to state what was going on.
-There was potential for sexual interaction.

Review of Resident #4's record revealed there

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D 453	Continued From page 31 was no accident/incident report completed and no documentation DSS or local law enforcement was notified. Refer to interview with the Special Care Coordinator (SCC) on 12/16/24 at 12:28pm. Refer to interview with a MA on 12/16/24 at 4:06pm. Refer to telephone interview with a PCA on 12/17/24 at 4:13pm. Refer to interview with the Administrator on 12/16/24 at 1:20pm. _____ Interview with the Special Care Coordinator (SCC) on 12/16/24 at 12:28pm revealed: -On 11/28/24, she reviewed all the SCU resident's charting notes and that was how she was made aware of an incident where Resident #3 was found coming out of Resident #4's room in her wheelchair with no brief or pants on, only a top and a blanket. -She did not know what was done immediately. -The Administrator was responsible for notification to whoever needed to be notified. Interview with a MA on 12/16/24 at 4:06pm revealed: -On 11/27/24 around 7:00pm, a PCA informed her that she found Resident #3 leaving Resident #4's room in her wheelchair. -She told her that Resident #3 was without pants and a brief, and did have a top on and a blanket around her upper body. -She instructed the PCA to take Resident #3 back to her room and get her dressed. -She also instructed the PCA to check Resident	D 453		

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#3 for any signs of redness or bleeding.
-She questioned both Resident #3 and #4, both were not able to say what had happened.
-She notified the Administrator and the Administrator was responsible for notification to DSS and local law enforcement.

Telephone interview with a PCA on 12/17/24 at 4:13pm revealed:
-On 11/27/24, she worked on the SCU.
-She was completing last rounds around 6:00pm to 7:00pm.
-On 11/27/24, Resident #3 resided in room #146, which was next door to Resident #4's room.
-She and another PCA went into Resident #3's room, took both residents to the bathroom, and got them ready for bed.
-She put a new brief, sweat pants and a top on Resident #3 and placed Resident #3 in the bed.
-She and the other PCA exited Resident #3's room and went diagonally across the hall to room #145 which was directly across from Resident #4's room.
-Around 7:00pm, when she and the other PCA exited room #145, she saw Resident #3 roll out of Resident #4's room in her wheelchair, which was across the hall, room #144.
-Resident #3 was not wearing a brief or pants.
-Resident #3 did have a top and had a blanket around her shoulders.
-When she looked in Resident #4's room, Resident #4 was in there but not Resident #4's roommate.
-Resident #4 walked out of his room behind Resident #3 and she noticed Resident #4 did not have on shoes which was very unusual for Resident #4.
-She took Resident #3 to her room and put Resident #3 in her bed.
-She did not see Resident #3's pants anywhere.

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D 453	Continued From page 33 -She went and reported what she saw to the MA on duty. -She did not inform DSS or local law enforcement because the Administrator was supposed to. Interview with the Administrator on 12/16/24 at 1:20pm revealed: -On 11/27/24, a MA called her and informed her that Resident #3 was seen coming out of Resident #4's room in her wheelchair without a brief and pants on. -Resident #3 was wearing a top and had a blanket over her lap. -Resident #3's room was across from Resident #4's room in the SCU before Resident #3 was moved and she did not know to which room. -She completed a charting note about the incident. -In the charting note she documented that the incident was a potential "sexual interaction". -The MA believed it to be a sexual interaction because the MA found a clearish substance on the floor that was sticky around the edges and slightly gelled and according to the MA smelled like semen. -She MA also reported that there were no signs of bruising or bleeding on Resident #3's vaginal area. -She did not know she was to report the incident to DSS or to local law enforcement.	D 453		