Adult Care Home Corrective Action Report (CAR)

Facility Name: The Landings of Oak Island
Address: 2910 Pine Plantation Parkway, Oak Island NC 28461
II. Date(s) of Visit(s): 01/15/25, 01/16/25, 01/29/25, 02/07/25, 02/21/25

County: Brunswick
License Number: HAL-010-013
Purpose of Visit(s): Complaint Investigation

Exit/Report Date: 03/10/25

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0901 Rule/Statutory Reference: 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan, and current symptoms. Level of Non-Compliance: Type A1Violation Findings: This rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with each resident's assessed needs and current symptoms for 1 of 5 sampled residents (Resident #1) who had a known history of physically aggressive behaviors resulting in physical attacks on other Special Care Unit (SCU) residents. The findings are: Review of the facility's current Special Care Unit Safety Measures for Aggressive Behaviors and Supervision of Behaviors policies (not dated) revealed: -Behavior management began prior to admission by learning as much as possible about the prospective resident and	☐ POC Accepted _____ *DSS Initials*	

identifying at-risk behaviors.
-Aggressive behavior was defined as behavior that was forceful, hostile, or attacking and could be with the intention to cause physical harm.
-Assaultive behavior was defined as behavior characterized by aggression, that could present with physical violence.
-Prior to admission, designated staff were to interview the appropriate persons and obtain the proper records to learn as much as possible about the prospective resident and to identify at-risk behaviors.
-Residents were to be evaluated when each new behavior occurred, and a behavioral intervention plan was to be implemented which was to include increased supervision.
-Additional interventions could include redirection, recognizing escalating behaviors, maintaining safety, a mental health referral, or a room change.
-Any behavior that escalated to a threat to the resident or others required immediate intervention to assure safety.
-Behaviors that required involuntary commitment were to be initiated with local authorities.
-If deemed necessary, the required steps for issuing a notice of immediate discharge were to be followed.

1.Review of Resident #1's current FL-2 dated 12/06/24 revealed:
-Diagnoses included dementia, hypertension, asthma, prostate cancer, and foot pain.
-The resident's recommended level of care was SCU.

Review of Resident #1's Resident Register revealed an admission date of 12/04/24.

Review of Resident #1's current Assessment and Care Plan dated 12/09/24 revealed:
-The resident was ambulatory.
-The resident was dependent for toileting, bathing, dressing, and personal hygiene.
-The resident was injurious to himself and others.
-The resident was receiving mental health services and behavioral health medications.

Attempted review of Resident #1's SCU preadmission assessment revealed:
-On 11/13/24 a preadmission assessment was conducted for Resident #1.
-The preassessment scores indicated the resident required

limited assistance with all personal care tasks, did not have a cognitive impairment, was not combative, and was not injurious to others.

Review of Resident #1's electronic progress notes for December 2024 through January 2025 revealed:
-On 12/04/24 at 2:09pm there was an entry, Resident #1 was admitted from home.
-On 12/05/24 at 5:58pm there was an entry, Resident #1's family member requested a change in the resident medications; a new order was given for Trazodone (given to treat anxiety and sleep disorders) 50mg 2 tablets to be given at bedtime and Quetiapine (used to treat mental health disorders) 50mg twice daily for three days.
-On 12/08/24 at 10:27am there was an entry, Resident #1 punched a staff member in the jaw and punched a second staff member in the back.
-On 12/08/24 at 8:15pm there was an entry, Resident #1 was being physically abusive toward staff and was being sent to the Emergency Department (ED) due to behaviors; the Primary Care Provider (PCP) was notified that the resident continued to exhibit behaviors; the resident returned from the ED with no new orders.
-On 12/10/24 at 7:35am there was an entry by the PCP, Resident #1 had multiple episodes of behavioral issues since being admitted on 12/04/24 and his symptoms worsened at night; new orders were given for Lorazepam (used to treat anxiety and sleep problems) 1mg as needed up to three times daily for 10 days and Quetiapine 25mg twice daily.
-On 12/18/24 at 8:32pm there was an entry, Resident #1 was sent to the ED to be evaluated due to choking a staff member and hitting a second staff member; the resident returned from the ED with no new orders.
-On 12/20/24 at 7:54am there was an entry by the PCP, it was reported to her while she was at the facility that Resident #1 had just tried to choke a staff member while the staff was attempting to shower him; the PCP examined Resident #1, whom she documented as having severe dementia and being non-verbal, and he was not displaying any signs of aggression during the exam; there had been two recent ED visits due to agitation and aggression and the PCP did not think it was appropriate to send the Resident #1 out to the ED at that time since he was scheduled to see psychiatry that afternoon; a new order was given for Depakote Sprinkles (used to treat mental and mood conditions) 125mg every morning.
-On 12/20/24 at 2:18pm there was an entry, Resident #1

slammed a staff against a wall and proceeded to choke her; Law Enforcement (LE) was called.
-On 12/21/24 at 2:14pm there was an entry, Resident #1 was aggressive that day including trying to hit a staff member twice, and going into other residents' rooms throughout the day and going through their belongings; he did not follow attempted redirection by staff.
-On 12/24/24 at 10:01pm there was an entry, the PCP was notified that Resident #1 was refusing all medications.
-On 12/24/24 at 10:06pm there was an entry, the PCP was notified Resident #1 hit a resident and a staff member, and LE was called.
-On 12/27/24 at 7:05am there was an entry, the Special Care Unit Coordinator (SCUC) contacted the PCP and recommended hospice services for Resident #1; the PCP provided a hospice referral order; the diagnosis given with the order was worsening dementia with associated behavioral disturbances.
-On 01/01/25 at 11:20pm there was an entry, Resident #1 tried to hit a staff member and then chased staff members down the hallway trying to hit them when they attempted to redirect him out of a resident's room; an as-needed (PRN) medication was given for agitation.
-On 01/03/25 at 3:03pm there was an entry, Resident #1 twisted a shirt and wrapped it around a staff member's neck; LE and hospice were notified.
-On 01/03/25 at 4:43pm there was an entry, a new order was given to increase Quetiapine from 25mg to 50mg twice daily
-On 01/04/25 at 2:11pm there was an entry, Resident #1 grabbed a dirty brief, threw it at a staff member, and tried to punch the staff with a closed fist.
-On 01/04/25 at 4:29pm there was an entry, Resident #1 was found sitting at the nurse's station when a staff member attempted to redirect him; he began punching the staff member, grabbed her by putting his hands around her neck, and pushed her against the wall; the staff member turned her back to the resident and he began punching her in her back and the back of her head; LE and hospice were notified and the resident was sent to the ED for behavioral disturbances.
-On 01/06/25 at 6:43pm there was an entry, new orders were given to discontinue Quetiapine 50mg twice daily and to begin Quetiapine 100mg twice daily.
-On 01/07/25 at 8:00am and 7:59pm there was an entry, a dose of PRN Lorazepam was given for behavioral issues.
-On 01/08/25 at 9:34pm there was an entry, Resident #1 was hitting and scratching staff members and hitting a window.
-On 01/09/25 at 10:53am there was an entry, a dose of PRN

Lorazepam was given for behavioral issues.
-On 01/12/25 at 8:32pm there was an entry, Resident #1 was found in another resident's room, when a staff member attempted to redirect the resident, he picked up multiple colored art pencils and stabbed her in the face; LE was called, and hospice was notified; an evening dose of PRN Lorazepam was given.
-On 01/13/25 at 3:12pm there was an entry, Resident #1 was cooperating with two staff members changing his pants, and he suddenly slapped one of the staff members across the top of her head; an evening dose of PRN Lorazepam was given.
-On 01/13/25 at 3:39pm there was an entry, Resident #1 was in another resident's room and hit a staff member in the head when she attempted to redirect him.
-On 01/15/25 at 9:45pm there was an entry, the hospice nurse was on site and Resident #1 was Quetiapine and a one-time dose of Lorazepam .5mg topical applied to the wrist after he refused his oral dose.
-On 01/16/25 at 10:05am there was an entry, recorded as a late entry, that on 01/15/25 after a resident-to-resident incident involving Resident #1, it was determined that the resident needed alternative placement and was being admitted to the hospice care center.

Review of Resident #1's Increased Supervision Logs for December 2024 and January 2025 revealed:
-On 12/08/24 through 12/11/24 there were entries the resident was placed under increased supervision to once every hour.
-On 12/22/24 through 12/24/24 there were entries the resident was placed under increased to twice a day.
-On 01/04/05 there were entries the resident was placed under increased supervision to once two hours.
-On 01/05/25 through 01/08/25 there were entries the resident was placed under increased supervision to once every hour.
-On 01/13/25 through 01/15/25 there were entries the resident was placed under increased supervision to once every shift.

Review of Resident #1's emergency department (ED) visit report dated 12/08/24 revealed:
-The chief complaint for Resident #1 was documented as dementia with aggressive behaviors.
-Resident #1 was returned to the facility with no new orders.

Attempted review of Resident #1's ED visit report for 12/18/24 revealed the report was not available for review.

Review of Resident #1's ED visit report dated 01/04/25 revealed:
-The chief complaint for Resident #1 was documented psychological problems and dementia with aggressive behaviors.
-Resident #1 was returned to the facility with no new orders.

Review of Resident #1's Incident and Behavioral Intervention reports for December 2024 and January 2025 revealed:
-On 12/08/24 at 10:17am there was documentation, Resident #1 was sent out to the ED for a psychiatric evaluation due to being a "physical threat to others" which included punching a Certified Nursing Assistant (CNA) in the face during care; the planned interventions were to increase supervision to every hour and to redirect the resident.
-On 12/08/24 at 5:55pm there was documentation, Resident #1 was sent out to the ED for a psychiatric evaluation due to the resident being a "physical threat to others" which included pushing an aide against a wall; the planned intervention was to redirect the resident.
-On 12/18/25 at 8:00pm there was documentation, Resident #1 was sent to the ED for "being a physical threat to others" which included combative behaviors; the planned intervention was to increase supervision to every hour, to redirect the resident, and to relocate the resident from room 509 for closer supervision.
-On 12/20/24 at 1:55pm there was documentation, Resident #1 was seen at the facility by the PCP due to "aggressive behavior with physical contact towards staff" which included grabbing a staff member's wrist and neck and pushing the staff against a wall; the planned intervention was to redirect the resident and to follow up with the PCP and the psychiatric provider.
-On 01/03/25 at 2:30pm there was documentation, Resident #1 was a "physical threat toward others" which included rolling a t-shirt and putting it around a staff member's neck that day at 2:30pm and grabbing another staff member by the neck at 2:45pm; the planned interventions were to increase supervision to every hour, to redirect the resident, a medication adjustment, and consultation with hospice.
-On 01/04/25 at 3:30pm there was documentation, Resident #1 was a "physical threat to others" which included assault on

a staff member by pulling her hair and grabbing her throat; the planned interventions were to increase supervision to every hour, to redirect the resident, and to work with hospice to find placement at a higher level of care.
-On 01/12/25 at 6:25pm there was documentation Resident #1 had "increased anger and frustration" which included staffing a staff member in the face with pencils after she attempted multiple times to redirect him from another resident's room; the planned interventions were relocation for closer supervision and notification to hospice.
-On 01/15/25 at 7:48pm there was documentation, Resident #1 "grabbed another resident, yanked her to the ground, and dug his fingernails into her; the planned intervention was relocation for closer observation and redirection.

Review of Resident #1's hospice provider notes for January 2025 revealed:
-On 01/01/25 at 9:08pm there was documentation Resident #1 was admitted to hospice services after having a functional and cognitive decline and increased behavioral disturbance.
-On 01/03/25 at 12:01am there was late entry documentation that on 01/02/25 the hospice Social Worker assessed the resident where he was located when she arrived, in another resident's bed asleep.
-On 01/12/25 at 9:19am that was late entry documentation that on 01/11/25 the hospice nurse responded to a call to the facility due to Resident #1 having an unwitnessed fall in another resident's room.
-On 01/13/25 at 10:25pm there was documentation of the hospice team's discussion about Resident #1 with the facility administrative staff; the outcome of the meeting was that hospice was informed that Resident #1's behavior was the result of staff inappropriately redirecting the resident and staff were going to receive additional education.
-On 01/16/25 at 12:13am there was documentation a notice was received from the SCUC and RCD on 01/15/25 regarding Resident #1 having aggressive behaviors where he pulled Resident #2 out of bed and attacked her; per the facility policy, law enforcement was called; an on-call hospice nurse arrived at the facility and along with the SCUC, found Resident #1 sitting in his shower with his clothes on; the on-call hospice nurse spoke with the Executive Director by

telephone and he requested Resident #1 move to the hospice care center for symptom management of restlessness and agitation, with plan for the resident to return once behaviors were managed; a call was received after the hospice nurse left the facility alerting her that a DSS representative was in the building due to LE filing a complaint and asking that Resident #1 be transferred first thing on the morning of 01/16/25.

Telephone interview with the manager of Resident #1's hospice provider agency on 02/28/25 at 10:45am revealed:
-She was the owner/manager of the hospice agency and was also a Registered Nurse (RN).
-Typically, hospice only referred SCU residents for psychiatric services if the resident had a history of serious mental health conditions because a diagnosis of dementia limited what a psychiatric provider could do.
-For a SCU resident with dementia, medication management was key in trying to regulate behaviors, and the hospice PCP was experienced and capable of managing the medications for Resident #1.
-It was not recommended for a resident with dementia to have the hospice PCP managing their behavioral health medications as well as a psychiatric provider.
-If Resident #1 was referred to a psychiatric provider outside of hospice, the provider would have likely deferred to the hospice PCP for managing Resident #1's behavioral health needs.
-Hospice services were considered supplemental care for Resident #1.
-She did not know what actions the facility had taken to ensure Resident #1 was adequately supervised, but it was the facility's responsibility to determine the level of supervision the resident required and to provide the supervision.
-If the level of supervision Resident #1 required was more than what the facility could provide, hospice had been available for consultation and would have helped facilitate a move if needed.
-The first request hospice received asking for assistance with identifying alternative placement for Resident #1, was on the evening of 01/15/25, after he attacked a female resident; he was moved to a hospice care center the next day.
-Resident #1 had behaviors before 01/15/25 that involved

physical attacks.
-The facility notified hospice when the resident had physical outbursts; sometimes the resident was sent to the ED for behaviors and/or had a medication adjustment, but his behaviors did persist and were frequent.

Review of Resident #1's Psychiatry Progress notes for December 2024 and January 2025 revealed:
-On 12/22/24 at 5:58pm there was an entry for an initial telehealth psychiatry consultation at which time the resident's medications were adjusted for diagnoses of dementia with behavioral disturbance and adjustment disorder.
-On 12/27/25 there was an entry that stated a reduction in the adult's current behavioral health medication regimen was not recommended due to the likelihood that it would risk decompensation; the adult was referred to hospice.
-On 01/09/25 at 1:02pm there was an entry the adult was anxious, agitated, and had combative behaviors including choking staff; psychiatric provider consulted with hospice and the decision was made to defer to the hospice PCP's current medication orders and continue with the same regimen.

Review of local Law Enforcement (LE) officers' electronic dispatch and response reports for Resident #1 for December 2024 through January 2024 revealed:
-On 12/08/24 at 6:28pm LE officers were dispatched to the facility due to Resident #1 being violent and they assisted EMS with strapping the resident down to a gurney to be transported to the ED.
-On 12/18/24 at 7:29pm LE officers were dispatched to the facility due to Resident #1 grabbing a staff member by her neck and pushing her against a wall after she attempted to redirect him from another resident's room; the resident was transported to the ED for evaluation.
-On 12/20/24 at 10:28am LE officers were dispatched to the facility due to Resident #1 becoming violent with an episode of assault by strangulation of a staff member; the resident had grabbed the staff member's wrist and throat and pushed her against a wall.
-On 12/24/24 at 8:26pm LE officers were dispatched to the facility due to Resident #1 punching a staff member in the jaw.
-On 01/03/25 at 3:09pm LE officers were dispatched to the facility due to Resident #1 becoming violent with a second

episode of assault by strangulation; the resident grabbed a staff member by her right wrist with one hand and grabbed her throat and applied pressure to choke her with his other hand; there were red marks on the staff member's neck and face; after the facility visit the officer contacted the county district attorney's office to inquire about what could be done related to Resident #1's violent behaviors in the facility and was informed since the resident had a diagnosis of dementia, it was the responsibility of the facility to find a resolution.
-On 01/03/25 at 3:09pm LE officers were dispatched to the facility due to Resident #1 becoming violent with a third episode of assault by strangulation; the resident twisted a shirt, wrapped it around a staff member's neck, clinched it tight, and began choking her; the staff member was able to pull the shirt away from her neck to stop the restriction of airflow and pulled down and away from the resident before running out of the room.
-On 01/04/25 at 4:49pm LE officers were dispatched to the facility due to Resident #1 assaulting two staff members.
-On 01/04/25 at 6:21pm LE officers were dispatched to the facility due to Resident #1 assaulting another resident and staff; an officer rode with Emergency Management Services (EMS) to transport the resident to the ED due to his violent behaviors.
-On 01/12/25 at 6:41pm LE officers were dispatched to the facility due to Resident #1 stabbing a staff member in her face with pencils; the officer contacted the local magistrate's office to inquire about what could be done related to Resident #1's violent behaviors in the facility; a representative from the magistrate's office recommended the facility pursue an involuntary commitment (IVC) order.
-On 01/15/25 at 7:51pm LE officers were dispatched to the facility due to Resident #1 chasing staff down the hallway and subsequently entering another resident's room, grabbing her by her arms, pulled her out of bed, and attempted to drag her out of her bedroom; the investigating officers found Resident #1 sitting alone and unsupervised in a hallway in a chair; an officer requested another officer supervise Resident #1 so he could conduct the investigation; staff informed officers Resident #1 had gone into several residents rooms and was ransacking them; staff informed officers they did not feel safe and management was not doing anything about the situation; the investigating officer informed staff he was filing a complaint with the local Department of Social Services (DSS) due to his concerns that the residents behaviors had continued to escalate and he did not see any indication anything was

being done to protect the residents.

Telephone interview with a LE officer on 01/16/25 at 4:40pm revealed:
-LE officers had responded to the facility ten times in the past twenty days related to Resident #1's violent behaviors.
-There had been an escalation in Resident #1's behaviors, and he did not see an indication the facility was doing anything to protect the residents.
-Resident #1 had enough cognitive ability to know how to twist a shirt to use as a strangulation weapon and to turn pencils around to the sharp side before he stabbed a staff member in the face.
-On 01/12/25 he was dispatched to the facility after Resident #1 stabbed a staff member in the face with pencils, and when he arrived Resident #1 was walking in the dayroom with other residents and still holding pencils in his hand; staff told him they were afraid of the resident and knew they needed to take the pencils away from him but did not want to go up and touch him; the officer asked staff what was the plan to protect the other residents and the staff did not have an answer.
-He was so concerned, he communicated with the local district attorney's office and the magistrate's office to inquire about what needed to be done, but it was clear the responsibility fell on the facility to address the matter since Resident #1 had a diagnosis of dementia.
-He informed staff members they could pursue an IVC order.
-Staff informed him they were frustrated because every time they notified management of their concerns about Resident #1's behaviors, management would just say the resident would be fine and they would take care of it, but nothing was done.
-He told staff he did not understand why Resident #1 was placed at the very end of the hall out of sight of the staff.
-Responding LE officers who did not see an indication anything was being done to address the situation.
-When he responded to the facility on 01/15/25 about Resident #1 attacking another resident, staff members told him they were concerned about resident safety; before leaving the facility he spoke by telephone to a facility manager whose name he did not remember and informed her he did not think

anything had been done to protect the residents and it was at the point that he was going to have to report it to Department of Social Services; she responded by saying they could not do much due to liability reasons; he told her he did not know what that meant and what he wanted to know was what was going to be done to address the situation; she said they would figure something out, but he was not satisfied with that answer and told her he would be filing a complaint with DSS.

Interview with a third shift Medication Aide (MA) on 01/15/25 at 11:00pm revealed:
-The MA was the third shift manager in charge.
-The MA was very familiar with Resident #1's behaviors which included violent attacks against staff and residents that had begun as soon as he was admitted to the facility in early December 2024.
-Resident #1's behaviors had continued to escalate.
-Staff had repeatedly called LE due to Resident #1's violent outbursts.
-It was a facility policy that LE be called for assaultive episodes even for residents with dementia, so LE could take a report.
-Several staff members had expressed concerns about Resident #1's violent behaviors to leadership staff and were informed they would make arrangements for staff to get additional dementia training to help them manage his behaviors better.
-The leadership staff included the SCUC, the Resident Care Director (RCD), and the Executive Director.
-She was concerned about the safety of other residents because Resident #1 was often found in other resident's rooms, but it was impossible to have eyes on him at all times.
-Earlier that evening, staff members heard a SCU resident screaming in her bedroom and calling out in Spanish, her native language; staff entered the resident's room and saw that Resident #1 had pulled the resident out of her bed and he was shaking her and pulling on her; staff had
to pull Resident #1 off of her; when LE officers responded to the incident, they told her they were going to file a complaint with DSS because Resident #1's behaviors had continued to escalate and nothing had been done; she notified the SCUC who notified the Executive Director that a complaint was being filed by LE; after that, the Executive Director contacted

Resident #1's hospice provider since staff could not get through to them, and it was decided that someone from his hospice provider agency was coming to assess him tomorrow (01/16/25) to determine if he would be appropriate to go to the hospice care center for a while until they could get his behavioral health medications adjusted; after that the SCUC and a hospice nurse came to the facility to check on Resident #1 and he was given a medication to help induce sleep.
-The hospice physician served as Resident #1's PCP.
-As far as she knew, Resident #1 was in his room sleeping.
-There had been many other incidents of violence involving Resident #1.
-Resident #1 had pushed another resident down to the floor; she could not remember who the resident was, but the resident was not injured.
-Resident #1 put his hands on his suitemate more than one time which included a time when his suitemate was found on the floor in his room with Resident #1 standing over him.
-She heard Resident #1 hit another resident a few weeks ago but she did not remember who.
-Resident #1 had choked multiple staff members.
-Responses to Resident #1's behaviors included being placed on increased supervision after an incident; other interventions included keeping his PCP informed, behavioral health services, a hospice referral, sending Resident #1 to the ED and calling law enforcement.
-The level of increased supervision was usually determined by the SCUC or the RCD and was typically increased to every hour for up to three days after the behavior.
-Based on the number of assaults involving Resident #1, "obviously the amount of supervision being provided had not been enough."
-Resident #1's bedroom was the last room at the end of the SCU, room 509, which had been assigned to him since he was admitted in December 2024.
-She did not know of any discussions about moving Resident #1 closer to the front of the SCU, but it was probably a good idea since staff could not see what Resident #1 was doing without walking to the end of the L-shaped hallway.
-Resident #1 had not been assigned a one-on-one worker to ensure the safety of the other residents; she did not know why.

Telephone interview with the Executive Director on 01/15/25 at 11:31pm revealed:
-After the incident earlier that evening when Resident #1 attacked a female SCU resident staff called LE.
-He did not think the other SCU resident was injured.
-One of the responding officers informed staff he was filing a complaint with DSS because he did not think the facility was doing enough to address Resident #1's behaviors.
-Staff reported this to him after LE left the facility and informed him they were having issues reaching Resident #1's hospice provider; he started trying to reach the hospice provider by telephone; after about 10 unsuccessful tries to make contact with hospice, he called his Regional Director of Operations (RDO) and informed her a responding officer was filing a complaint with DSS and that he nor the staff had been able to make contact with the hospice provider that evening.
-The RDO told him to keep trying until he reached hospice, to tell them to send a nurse immediately to check on Resident #1; the RDO also informed the Executive Director that Resident #1 "was going to have to go somewhere" until his medications could be adjusted.
-He finally reached hospice, a nurse was dispatched to the facility to check on Resident #1, and it was decided he would go tomorrow, 01/16/25 to the hospice care center long enough to have his medications adjusted.
-He had planned to take Resident #1 back after his medications were adjusted but he was not sure if he would now.
-Resident #1's behaviors started a couple of weeks after he was admitted but there had been "very few incidents".
-Before tonight, there was one incident with a staff member during which Resident #1 pushed her and maybe grabbed at her throat, and maybe a couple of incidents involving other residents, but he did not remember the details.
-The hospice physician was Resident #1's PCP.
-For behavioral incidents involving Resident #1, staff were to call hospice and LE so LE could take a report.
-When Resident #1's behaviors started, he was referred to hospice and to a mental health provider.
-The RCD was working on getting more dementia care training for staff.
-Since hospice served as Resident #1's PCP, they were solely responsible for determining if Resident #1 needed to be sent

out for any reason.
-He did not have any concerns that Resident #1 was a safety risk to other residents.
-He did not have any concerns about Resident #1's room being at the end of the SCU hallway.
-There had not been any discussion about moving Resident #1 closer to the front of the SCU for increased supervision because he did not think he had any semi-private male rooms, only private.
-In hindsight, he guessed Resident #1 could have been moved to a private room closer to the front of the SCU, at least until his behaviors were addressed.
-Resident #1 had not been assigned a one-on-one worker after any of the behavioral incidents, but he was placed on increased supervision, meaning staff increased the frequency of checking on the resident for the assigned period of time.
-He could not say the increased supervision was not working because he did not think there had been many incidents involving Resident #1.

Observation of the SCU on 01/15/25 at 11:35pm revealed:
-The third-shift Personal Care Aides (PCAs) were standing at the front of the SCU in and around the dayroom.
-The path to Resident #1's room, was to go to the end of the main SCU hallway, turn right, and go to the end of that hallway.
-There was not a camera system or mirrors enabling staff to be able to see activity down the hallways.
-There were twenty-one resident's bedrooms between where the staff were located and Resident #1's room.

Observation of Resident #1 on 01/15/25 at 11:45pm revealed:
-The doorway that led to Resident #1's suite was closed.
-The suite included room 509A, Resident #1's bedroom on the left, and on the right in 509B was Resident #1's suitemate, Resident #3.
-Both residents were lying in bed with their eyes closed.
-There were no staff on the hallway.

Observation of a female SCU resident on 01/16/25 at 12:01am revealed:
-The female resident was pacing in and out of her room speaking loudly and quickly in an anxious tone and showing

staff members her arms.
-She spoke in Spanish, so it was not known what she was saying.
-She was pointing to faint but still visible red marks on both her arms.

Interview with a third shift PCA on 01/16/25 at 12:10am revealed:
-Resident #1 attacked a female resident in her room earlier that evening, and it was completely unprovoked.
-Resident #1 entered the female resident's room where she was in bed; he pulled her out of bed onto the floor.
-Staff heard the female resident yelling and ran to the room and pulled Resident #1 off the resident and out of the room.
-Staff were afraid to work with Resident #1 because he was so unpredictable and violent.
-When she worked with him, she was always very cautious and explained things to him to try to put him at ease.
-He would seem to be just fine and then he would suddenly attack.
-Recently when she was helping him with his shoes, she gave him a shirt to hold to occupy his hands; he twisted the shirt tightly and suddenly wrapped the shirt around the back of her neck, crossed it over the front of her neck, and began choking her with it; she dropped down to the floor to get out of his grip.
-The resident had attacked several residents and staff.
-Staff had expressed their concerns that he was going to seriously injure a resident.
-Staff had been told they just needed additional dementia training, but she did not think this was the issue since staff already had dementia training.
-Staff had been instructed not to send Resident #1 out for behaviors since he was under hospice care.
-Behavioral interventions included increased supervision after each behavioral episode, to notify hospice, and LE.
-Resident #1 had been in room 509 at the end of the SCU hall since he was admitted.
-It probably would be easier to supervise him if he was closer to the front of the SCU but as far as she knew there were not any plans to move the resident to a different room.

Interview with a 2nd third shift PCA on 01/16/25 at 12:16am

revealed:
-Staff were afraid to work with Resident #1 because he had hurt so many people.
-Thankfully the female resident did not have more severe injuries after being attacked by Resident #1 that evening because he was very strong and violent.
-Resident #1 was placed on a status of increased supervision after each behavioral episode.
-Increased supervision meant that staff were supposed to check on Resident #1 more frequently, usually either every 30 minutes or every hour.
-The standard time for increased supervision was three days but if an incident occurred during the 3 days period, the increased supervision time would be extended by the SCUC or the RCD, and they would decide how much additional time should be added.
-Some staff provided increased supervision for Resident #1 but others probably just tried to stay away from him because they were afraid of him.
-She thought he was a danger to other residents.
-There had been incidents involving Resident #1 and other residents, but she did not remember the details because there had been so much going on with Resident #1's behaviors that it was hard to keep up.
-Resident #1 pulled his suitemate out of his bed one night a couple of weeks earlier and his suitemate was found on the floor with Resident #1 standing over the top of
him.
-Resident #1's suitemate was not severely injured, but she was pretty sure Resident #1 was sent to the hospital for evaluation after this happened.

Interview with a 3rd third shift PCA on 01/16/25 at 12:20am revealed:
-Resident #1 had recently chased her down the hall, picked up a wooden basket and tried to hit her.
-The resident was tall, strong, and very large hands that could really injure someone.
-The resident had choked several staff members.
-During the incident earlier that evening involving a female resident, she heard the resident yelling and when she ran into her room, Resident #1 had drug the female resident out of her

bed, his hands were gripping her arms, and he was shaking her violently back and forth and jerking her around; she and another PCA had to unlatch Resident #1's fingers from the other residents
arms and removed him from her room.
-Resident #1 dug his fingernails into the female resident's arms and though the skin was not broken, she had red marks on her arms from Resident #1 squeezing her arms.
-The female resident had been extremely upset and seemed traumatized since the incident.
-She was thankful the female resident was a resident that could call for help because not all the SCU could have called out for help like she did.
-There had been incidents with other residents, but she did not remember which residents except recently she heard he had pulled his suitemate out of his bed onto the floor.

Review of Resident #1's suitemates Accident/Incident reports for December 2024 to January 2025 revealed:
-On 01/04/25 at 6:04pm the suitemate had a "fall with injury"; he was found on the floor in his room bleeding from his nose and indicating hip pain.
-A hospice nurse evaluated the resident, determined he did not need to be sent to the ED, and treated his injuries with first aid.
-No further details were given.

Confidential interview with a staff member revealed:
-On 01/04/25 Resident #1 either pushed his suitemate to the floor or pulled him out of his bed onto the floor.
-When staff entered the room, the suitemate was on the floor bleeding from his nose with Resident #1 standing over him.
-Initially, the suitemate indicated his hip area was hurting.
-The suitemate was evaluated by a hospice nurse and did not need further treatment.
-There was a wide belief among staff that the facility was keeping Resident #1 because the census was so low, and they could not afford to discharge the resident.
-After each of Resident #1 behavioral incidents, he was placed under increased supervision.
-Increased supervision usually meant "laying eyes on" Resident #1 at least every hour.
-The increased supervision that was being provided was not

effective.
-Due to how unpredictable Resident #1 could be, he really needed someone watching him at all times, but it needed to be someone strong enough that he could not injure them.
-Staff were afraid to get near the resident and redirection was mostly ineffective for him.

Telephone interview with a first-shift PCA on 01/29/25 at 8:30am revealed:
-There was an incident when she heard Resident #1's suitemate yelling out, and when she went into the room, the suitemate was on the floor in his bedroom bleeding from his nose, and Resident #1 was standing over him punching him; the suitemate was likely in bed when he was attacked; EMS and a hospice nurse responded and when EMS moved the suitemate from the floor he started yelling that his hip was hurting him; after further assessment by EMS and the hospice nurse, they did not recommend that he be sent to the ED but treated his bloody nose; it was not recommended that Resident #1 be sent out to the ED for a behavioral evaluation and he was sent to the ED that evening.

Telephone interview with the RCC on 01/16/25 at 1:06pm revealed:
-On 01/04/25 she was informed Resident #1 pulled his suitemate out of bed and onto the floor.
-A hospice nurse evaluated the suitemate and did not recommend further intervention.
-After the incident, Resident #1 was sent to the ED for evaluation but was not admitted.
-Resident #1 returned to the facility and was placed back in room 509 and was placed on increased supervision, so that meant staff were checking on him every thirty minutes.
-She had not been worried about Resident #1 remaining in room 509 with his suitemate because she "had a hard time believing" Resident #1 actually pulled his suitemate out of bed.

Telephone interview with the Executive Director on 01/16/25 12:59pm revealed:
-Resident #1 left the facility that morning, 01/16/25 at

8:45am and was transported to the hospice care center.
-Regarding Resident #1's behaviors, there had been "one or maybe two incidents" where staff had been changing the resident, and he had "reached his arm straight out and put his hands at their throat, but not in a forceful way."
-Resident #1 had never choked a staff member.
-He did not believe Resident #1 twisted a shirt and put it around a staff member's neck, and this conversation was the first time he heard anything about that.
-"Yes, there might have been" a couple of incidents between Resident #1 and other residents before last night's incident with the female resident.
-He was pretty sure Resident #1 had pushed one resident and grabbed another one, but he did not remember who.
-"Yes, there had been an incident with his suitemate" where he went into the room and "rolled him out of bed."
-He questioned if the staff were approaching Resident #1 appropriately and he had instructed the SCUC to gather some information to provide dementia care training in addition to the standard SCU dementia care training.
-Interventions for Resident #1 included increased supervision, which meant the staff were to lay eyes on Resident #1 every 30 minutes for the assigned timeline.
-The standard timeline for increased supervision was typically three days past the last behavior.
-When Resident #1's behaviors first started, he was referred for mental health and hospice services, they tried different staff working with him to see if perhaps some were more effective than others, and when possible, one of the male PCAs would shower the resident.
-If asked if he was concerned if Resident #1 was going to injure another resident, the answer would be "It was not to that point" and he just "did not think we were there."
-Since the first-day Resident #1 was admitted, there had been a few select staff that had been trying to get him discharged and saying the facility was not doing enough about his behaviors.
-LE had responded to the facility several times about Resident #1, so if they were so concerned, he did not understand why last night, 01/15/25, was the first time they said were going to file a complaint with DSS was last night.
-Resident #1 had not been moved from the end of the hallway closer to the main area of the SCU because there was not

another semi-private room, only private.
-He guessed in hindsight they could have moved the resident to a private room or assigned a staff member to him for one-on-one supervision if needed.
-The reason they had not gotten to Resident #1's "final strike" was because they were "kind of following the same model" they did with another resident who was in the facility last year and was having behavioral issues, but that resident was finally discharged on the "day he attacked me."

Review of Resident #1's Notice of Discharge dated 01/16/25 revealed:
-Notice of an immediate discharge was issued effective 01/16/25.
-The given reason for the discharge was documented as the safety of the resident or others at the facility was endangered.

Telephone interview with first shift PCA on 01/29/25 at 8:30am revealed:
-Resident #1's violent outburst began as soon as he was admitted.
-At first, he was just attacking staff but then he began attacking residents as well.
-The worst incident she had with Resident #1 was when she found him sitting inside the nurse's station; she called him by name and inquired if he would like to go with her; at first, the resident just looked at her and she told him it was time to get ready to eat lunch; he shook his head yes and she put her hand out for him to stand up and take her hand; he stood up, 'suddenly snapped', punched her in the jaw and grabbed her by the throat; he was holding her throat with one hand and punching her with the other hand; she turned herself around to try to get his hands off her throat and he pulled her hair straight up over her head and began beating her with his fist in the back of her head and back; she began screaming for help and he stopped punching her when another staff entered the room and started yelling and crying and telling him to stop; she had a hard time moving her jaw after the incident; he was sent to the hospital but quickly returned.
-There was another incident when Resident #1 punched her, but she was able to get away from him.
-She notified her the SCUC the RCD, and the Executive

Director when the incidents occurred.
-Staff that worked with Resident #1 were concerned about the safety of the residents.
-Resident #1 would often go into other residents' rooms and he would get mad when the resident assigned to the room came in.
-Staff tried to redirect the resident out of other residents' rooms so he would not hurt the residents.
-Resident #1 had been in room 509A since his admission and she did not know of any plans to move him to an area where he could be more closely supervised.
-She did not know why the resident had not been moved from the end of the SCU hallway when his behaviors began, but it was true that it was much more challenging to closely supervise him in that location.
-He was placed on increased supervision after his behavioral outbursts, which meant staff were supposed to check on him at the assigned intervals, usually every hour.

Telephone interview with first shift PCA on 01/29/25 at 10:43am revealed:
-She had been a PCA for ten years, had her certified nursing assistant (CNA) certification, and understood that SCU residents need time to get acclimated to their environment.
-The way residents with dementia were approached by staff was very important.
-The first time she attempted to give Resident #1 a shower, right after he was admitted, she and another PCA were both assisting him.
-She was careful to make eye contact with him and explained to him each step of the process as she helped him.
-Resident #1 suddenly, out of the blue, punched her in the jaw and punched the other PCA in her back.
-During a second incident, she walked with Resident #1 hand in hand into the bathing room and asked if it was ok if she assisted him with undressing; at first, he was cooperative but suddenly flipped like a light switch and grabbed both of her wrists; she told him he was hurting her and if he did not want to take a bath it was fine, but to please let go of her wrist; he let go of her wrist and grabbed her by her throat and threw her against a wall; he had one hand wrapped around her neck and she was trying to prevent him from getting his other hand around her neck because he was a large strong man and could

have easily broken her neck; she was able to break away.
-Resident #1 began assaulting staff and residents as soon as he was admitted in December 2024.
-She was so concerned Resident #1 was going to seriously injure someone that she expressed her concerns to the leadership staff several times.
-She followed the chain of command when speaking about her concerns about Resident #1, but when she did not see any being done, she went directly to the Executive Director on 01/15/25 during the day shift and asked him "What are we doing about this situation and what if he puts his hand around a resident's throat like he did mine?"
-She was trying not to overstep and to be respectful when speaking about her concerns with the Executive Director but was frustrated and the conversation became a bit heated; she asked him what he was doing to ensure the safety of the residents and the Executive Director just said he was handling it; when she pressed to ask what that meant because this was what he had been telling staff for weeks, he said it was above her pay grade to be asking that kind of questions.
-Resident #1 attacked a female resident in her room that night.
-There had already been two or three incidents involving Resident #1 "putting his hands on other residents" but since she was not there when it happened, she was not the person to give details.
-Resident #1 was placed on increased supervision after each behavioral incident but there was only so much staff could do.
-As far as she knew there were not any plans to move him to a location where he could be more closely supervised and no plans for the resident to have one-on-one supervision.

Telephone interview with first shift PCA on 01/29/25 at 11:11am revealed she had requested to remain scheduled only on the Assisted Living (AL) side because she was pregnant and would have been concerned about the safety of her unborn child if she had to work with Resident #1.

Telephone interview with first shift MA on 01/29/25 at 11:17am revealed:
-Resident #1's behaviors were extremely unpredictable, and he would be fine one second and then "suddenly snap."
-Resident #1 often wandered into other resident's room and

one evening just before dinner time she found him sitting in another resident's bedroom in her recliner while the resident was out of her room; she attempted to redirect Resident #1 by asking if he would like to go to his room to sit in his recliner; he did not respond so she stepped out of the room and came back a couple more times to try to persuade him to come out of the other resident's room; the third time that she entered the room to ask if he wanted to go to his room, he grabbed a handful of pencils from the other resident's art set, turned all the pencils around in his hand to where the pointed tips were pointing out and came toward her, swinging the sharp pencils at her head; she was trying to get out of the way, but he did make contact with the side of her face with the pointed edges of the pencils.
-Resident #1 had attacked other residents.
-Interventions that were put into place related to Resident #1's behaviors included increased supervision, meaning staff were to ensure they checked on him at increased intervals of either 30 minutes or an hour.
-To her knowledge, there was not any discussion about moving Resident #1 to an area of the SCU where he could be more closely supervised.
-Resident #1 really needed one one-on-one supervision.
-She had been very concerned about the safety of the residents.
-She and other staff had expressed their concerns to management.
-Staff were "on edge" every day at work worrying about what Resident #1 was going to do.
-Whenever he got near a resident or staff, it was frightening thinking that he could suddenly attack or come up behind someone who could not defend themselves and choke them.
-Resident #1 was very unpredictable and so strong.

Telephone interview with the Resident #1's responsible party on 02/19/25 at 10:00am revealed:
-She took Resident #1 to the facility on 11/13/24 for his preassessment.
-She was caretaker for the resident at home prior to his admission.
-She was pretty sure she and Resident #1 met with the Special Care Unit Coordinator (SCUC) and the Resident Care

Director (RCD) for completion of the preassessment.
-She did not remember if she was asked questions related to Resident #1's behaviors at home, but if staff asked her about this, she was honest with them.
-There were times at home when he became aggressive and would fight her when it was time to provide his personal care.
-His dementia process had advanced to the point that she could no longer care for him at home.
-After he was admitted to the facility, based on the information she was given by facility staff and hospice about his behavioral outbursts, it began as soon as he was admitted and continued to escalate during his stay.
-She did not know what the facility did to ensure the resident was properly supervised.
-She did not ask about moving the resident closer to the front of the SCU because it did not occur to her that this might be an option; the facility staff did not suggest it.
-She had another family member in the facility that died on the day she admitted Resident #1, so everything was kind of a blur because so much was happening.
-She was still coping with her grief when Resident #1 was having so many behaviors, so she was reliant on the facility to address Resident #1's needs.
-She appreciated everything the facility had done for both of her loved ones, but she wished the facility had been more proactive concerning Resident #1's behaviors.
-She did not know exactly what was needed for Resident #1 but a lot of money was paid for his care, and it seemed they should have been better prepared to know what to do in situations like this.
-She hoped the facility's experience in caring for Resident #1 behavioral health needs did not go in vain and that some lessons were learned that would help the facility somehow in the future.

Interview with the Executive Director on 01/29/25 at 4:03pm revealed:
-Only one staff member, a CNA, had spoken to him about being concerned about Resident #1 being dangerous.
-It seemed like every time Resident #1 acted out, it was with that same CNA, so "the one" was probably the problem and was probably doing something to set Resident #1 off.
-One day he witnessed that same CNA running out of

Resident #1's room saying Resident #1 was dangerous and tried to choke her, but he did not believe it really happened; the reason he did not believe it was because the PCP was in the building and checked Resident #1's heart rate right after the accusations were made, but his heart rate was normal; he did not think Resident #1 choked a staff member and remained completely calm.
-Staff had "brought this on themselves" because they did not use the correct approach with Resident #1.
-He agreed that the residents who were attacked by Resident #1 did not bring it on themselves.
-Hospice services were an intervention for behaviors, and they were responsible for making decisions about if a resident was going to be sent out following behaviors.
-He was "100% notified" when Resident #1 had behavioral issues and the chain of command went from staff to the supervisor, to the SCUC, to the RCD, to him.
-If there was an incident after hours, he was usually informed in a group text thread.
-On the night of 01/15/25 the SCUC called him directly after law enforcement responded to Resident #1 attacking another resident.
-He thought she notified him directly because LE said they were filing a complaint with DSS.

Telephone interview with Resident #1's hospice PCP on 02/12/25 at 1:50pm revealed:
-It was her responsibility to treat Resident #1's symptoms to the best of her ability, but it was the responsibility of the facility to determine if a resident posed a risk to other residents or what level of supervision he required.
-Resident #1 was having violent episodes before hospice services starting.
-On the last night Resident #1 was at the facility, after he attacked a female resident, she was informed by a staff member that LE was filing a complaint with DSS because they had responded to the facility ten times in reference to Resident #1's behaviors and did not think the facility was addressing the situation, and that was the first time she was aware there had been that many incidents since his admission.
-It seemed the facility was trying to blame hospice for the situation with Resident #1, they were responsible for providing the necessary supervision and determining if

Resident #1 was an appropriate fit for their facility.
-The facility should have been doing more to address Resident #1's situation, and at the very least the resident could have been moved closer to where staff could keep a closer eye on him.
-This dementia disease process could sometimes take a violent turn during the end of life.
-If Resident #1 had been involuntarily committed after his first few violent attacks, he probably would have been released from the hospital to the hospice care center to live out his remaining days, because this was often the case in situations like this.
-She was attempting to regulate Resident #1's behaviors with medications, but it was challenging because he did not adjust to being admitted to the facility from home.
-Resident #1 had multiple episodes of choking and hurting staff as well as attacking and injuring other residents, and this was not the outcome anyone hoped for.
-She knew the resident had attacked at least two other residents.
-Resident #1 was discharged from the facility on 01/16/25 and remained at the hospice care center until his death about a week later.

The facility failed to provide supervision in accordance with Resident #1's assessed needs, care plan, and symptoms, all of which indicated he was injurious to others, to ensure each resident was protected from resident-to-resident attacks. This resulted in a female resident being attacked in her bed, drug across her room, and shaken violently, and Resident #1's suitemate being found on the floor in his room, being punched and sustaining a bloody nose and hip pain. Resident #1 exhibited violent behaviors beginning on 12/08/24 that lasted for the duration of his stay until he was discharged on 01/16/25. The facility's failure to provide supervision to Resident #1 resulted in physical harm to other residents and constitutes a Type A1 violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 received on 02/04/25.

THE CORRECTIVE DATE FOR THIS VIOLATION SHALL NOT EXCEED 04/09/25.

Rule/Statute Number: 10A NCAC 13F .0909

Rule/Statutory Reference: 10A NCAC 13F .0909 Residents 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.
131D-21 Declaration of Residents Rights
(4) To be free of mental and physical abuse, neglect, and exploitation.

Level of Non-Compliance: Type A1 Violation

Findings:
This Rule is not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to protect 2 of 5 sampled residents (Residents #2 and #3) from physical abuse by another Special Care Unit resident who had an extensive number of violent attacks on others.

The findings are:

Review of the facility's Residents Rights policy (not dated) revealed:
-Residents were to be free of mental and physical abuse.
-The Executive Director and staff would assist Residents in exercising their Declaration of Residents' Rights.

1. Review of Resident #2's Resident Register revealed an admission date of 12/27/22.

Review of Resident #2's current FL-2 dated 06/11/24 revealed:
-Diagnoses included essential hypertension, dementia without behavior disturbances, and hyperlipidemia.
-The recommended level of care was Special Care

Unit (SCU).

Review of Resident #2's Assessment and Care Plan dated 12/12/24 revealed:
-The resident was ambulatory.
-The resident required supervision for toileting and limited assistance with bathing, dressing, and personal hygiene.
-The resident felt anxious at times, especially if other residents were talking loudly, but loved to sing and dance to Hispanic music, which helped her to calm down.

Review of Resident #2's Accident/Incident reports for January 2025 revealed:
-On 01/15/25 at 8:00pm Resident #2 was attacked in her room by another resident.
-Resident #2 was "grabbed and pushed" by the other resident.
-No further details were given.

Review of Resident #2's increased supervision log for January 2025 revealed:
-On 01/16/25 through 01/19/25, there were entries for increased supervision to "monitor status" documented one time each shift from 7:00am to 7:00pm and 7:00pm to 7:00am.
-The "special instructions" section indicated a shift note was to be completed every shift for 72-hours.

Review of Resident #2's progress notes for January 2025 revealed:
-On 01/15/25, the evening she was assaulted by a male resident, there was no entry.
-On 01/16/25 there was no entry.
-On 01/17/25 there was an entry that stated, "Follow-up from an assault; no changes."
-On 01/19/25 there was an entry that stated, "Follow-up from an assault; resident very upset about the assault."

Review of local Law Enforcement (LE) electronic dispatch and response reports for Resident #2 dated 01/15/25 revealed:
-On 01/15/25 at 7:51pm LE officers were dispatched to the facility due to a male resident ransacking other residents' rooms and subsequently entering Resident #2's room and attacking her.
-The male resident grabbed Resident #2 by her arms, pulled

her out of bed, and attempted to drag her out of her bedroom.

Telephone interview with the Executive Director on 01/15/25 at 11:31pm revealed:
-Staff informed him by telephone that Resident #2 was attacked in her room earlier that evening (01/15/25) by a male resident.
-He did not know what he could have done to ensure Resident #2's safety before the incident, because he did not have any concerns the male resident was a safety risk to other residents, "until tonight's attack" on Resident #2.
-He did not think this was a resident's rights issue since the attack on Resident #2 was the first of its kind by the male resident.
-There had been very few behavioral incidents involving the male resident before Resident #2 was attacked.
-Resident #2 was not injured in the attack.

Interview with a third shift Medication Aide (MA) on 01/15/25 at 11:00pm revealed:
-Earlier that evening (01/15/25), staff members heard Resident #2 screaming in her bedroom and calling out in Spanish, her native language; staff entered the resident's room and saw that a male resident, who had a history of violent outbursts, had pulled Resident #2 out of her bed, and was shaking and pulling on her until staff pulled the male resident off her.
-Resident #2 was usually a happy and friendly resident, but she had been extremely upset since the incident occurred earlier that evening as evidenced by her pacing up and down the halls and showing staff her arms.
-The male resident who attacked Resident #2 had repeated violent episodes involving staff and residents since he was admitted in early December 2024, which had continued to escalate before he attacked Resident #2.

Interview with a third shift Personal Care Aide (PCA) on 01/16/25 at 12:10pm revealed:
-Resident #2 had been attacked in her bedroom earlier that evening by a male resident, and it was completely unprovoked.
-Resident #2 was in her bed when the male resident entered her room and pulled her out of bed onto the floor.
-Staff heard Resident #2 yelling and ran to her room where

they had to pull the male resident off her and out of her room.
-Before that night's attack on Resident #2, staff had expressed concerns in staff meetings that the male resident was going to seriously injure another resident, so the attack on Resident #2 was unfortunate.
-The other male resident had been violent since being admitted in December 2024, she could not think of anything that had been done to ensure the safety of the other residents.

Interview with a 2nd third shift PCA on 01/16/25 at 12:16am revealed the male resident who attacked Resident #2 was very strong and violent.

Interview with a 3rd third shift PCA on 01/16/25 at 12:20am revealed:
-Earlier that evening, she heard Resident #2 yelling and when she ran into her room, a male resident, who had a history of physical attacks, had drug her from her bed, his hands were gripping her arms, and he was shaking her back and forth and jerking on her; she and another PCA had to unlatch the male residents fingers from Resident #2's arms and removed him from her room.
-The male resident dug his fingernails into Resident #2's arms and left red marks on her arms.
-Resident #2 had been extremely upset and seemed traumatized since the incident.

Observation of Resident #2 on 01/16/25 at 12:01am revealed:
-The resident was pacing in and out of her room speaking loudly and quickly in an anxious tone and showing staff members her arms.
-She spoke in Spanish, so it was not known what she was saying.
-Resident #2 was pointing to faint but still visible red marks on both her arms.

Refer to a review of electronic progress notes for a Special Care Unit (SCU) male resident for December 2024 through January 2025.

Refer to a review of a local Law Enforcement (LE) electronic

dispatch and response reports related to a SCU male resident for December 2024 through January 2025.

Refer to an interview with a third-shift Medication Aide (MA) on 01/15/25 at 11:00pm.

Refer to an interview with a third shift Personal Care Aide (PCA) on 01/16/25 at 12:10am.

Refer to an interview with a 2nd third shift PCA on 01/16/25 at 12:10am.

Refer to a telephone interview with a SCU male residents responsible party on 02/19/25 at 10:00am.

Refer to an interview with the Executive Director (ED) on 02/21/25 at 1:00pm.

2. Review of Resident #3's Resident Register revealed an admission date of 12/16/24.

Review of Resident #3's current FL-2 dated 12/18/24 revealed:
-Diagnoses included dementia and hypertension.
-The resident's recommended level of care was Special Care Unit (SCU).

Review of Resident #3's Assessment and Care Plan dated 12/12/24 revealed:
-The resident was ambulatory.
-The resident required extensive assistance for toileting, bathing, dressing, and personal hygiene.

Review of Resident #3's Accident/Incident reports for January 2025 revealed:
-On 01/04/25 at 6:04pm Resident #3 had a "fall with injury"; he was found on the floor in his room bleeding from his nose and indicating hip pain.
-A hospice nurse evaluated the resident, determined he did not need to be sent to the Executive Director, and treated his injuries with first aid.
-Notification included the Executive Director, the hospice

nurse, and the hospice Primary Care Physician (PCP).
-The resident was placed on increased supervision for 72 hours to monitor for bruising, change in mental status or condition, pain, or other injuries related to the fall.
-No further details were given.

Review of Resident #3's increased supervision logs for January 2025 revealed:
-On 01/05/25 through 01/08/25 there were entries for increased supervision to "monitor status for bruising, change in mental status or condition, pain, and other injuries related to fall" documented one time each shift from 7:00am to 7:00pm and 7:00pm to 7:00am.
-The "special instructions" section indicated a shift note was to be completed every shift for 72-hours.

Review of Resident #3's electronic progress notes for January 2025 revealed:
-On 01/05/25 at 10:21am and 10:25am there were entries, documented as late entries, the resident was found on the floor on 01/04/25, was complaining of hip pain, and was being monitored.
-There were no further entries related to the fall.

Interview with a third-shift Medication Aide (MA) on 01/15/25 at 11:00pm revealed:
-Resident #3's suitemate had repeated violent episodes and had put his hands on Resident #3 more than one time.
-There was an incident when Resident #3 was found on the floor in his room with his suitemate standing over him.
-Resident #3 was not safe in the room with his suitemate.
-Resident #3 was currently in his bed in room 509B.
-Resident #3's suitemate, who attacked another resident earlier that evening, was in the other room within the suite, 509A.
-As far as she knew, there had not been any plans to move Resident #3 or his suitemate to a different room.
-As far as she knew, they were alone in the room and no staff were present.

Telephone interview with the Special Care Unit Coordinator (SCUC) on 01/15/25 at 11:15pm revealed:
-Resident #3's suitemate had attacked another resident around

8:00pm that evening.
-She came to the facility after the attack to check on the situation and when she left, the male resident was back in room 509 in bed.
-Resident #3 was in the suite as well.
-She did not have any concerns about Resident #3's safety because the male resident had never bothered Resident #3.
-Resident #3's and his suitemate were in the last room at the end of the L-shaped SCU hall; the suitemate would be placed on increased supervision which meant staff would check on him every hour.

Telephone interview with the Executive Director on 01/15/25 at 11:31pm revealed:
-He had been informed Resident #3's suitemate attacked another resident earlier that evening.
-He was not concerned about Resident #3 being alone in the room with his suitemate.
-Resident #3's suitemate had never posed a safety risk to him.
-Resident #3's suitemate had never put his hands on him.
-In response to concerns expressed during this telephone conversation, he agreed he would assign a one-on-one staff member to stay in the room with Resident #3 and his suitemate that night.

Confidential interview with a staff member revealed:
-When Resident #3 was admitted, he was put into room 509B with a male resident who was having frequent violent outbursts and had multiple incidents of hitting, pushing, and choking others.
-There was no way to ensure the safety of Resident #3 because the resident's suitemate was so unpredictable.
-On 01/04/25 Resident #3's suitemate pulled him out of his bed onto the floor.
-When staff entered the room, Resident #3 was on the floor bleeding from his nose with his suitemate standing over him.
-Initially, Resident #3 indicated his hip area was hurting but upon further evaluation by a hospice nurse and Emergency Medical Services (EMS), further treatment was not recommended.
-Thankfully, Resident #3 was able to yell out for help.
-It was not safe for any resident to be placed in a room with

another resident with a history of violent outbursts.
-Residents' rights training had been conducted for all staff, which included information about residents being free of abuse, but this had not happened for Resident #3 because he was put into the room with an abusive resident and remained there, even after the suitemate attacked him.

Observation of Resident #3 on 01/15/25 at 11:45pm revealed:
-The doorway that led to the two-bedroom suite was closed.
-The suite included bedroom on the right, Resident #3's room, and a bedroom on the left, Resident #3's suitemate's room.
-Resident #3 and his suitemate were in the suite alone and lying in bed with their eyes closed.
-There was no staff in the area.

Telephone interview with a first shift Personal Care Aide (PCA) on 01/29/25 at 8:30am revealed:
-On 01/04/25 there was an incident when she heard Resident #3 yelling out, and when she went into the room, the resident was on the floor in his bedroom bleeding from his nose, and his suitemate was standing over him, punching him.
-Resident #3 was likely in bed when he was attacked by his suitemate.
-EMS and a hospice nurse responded to the facility after Resident #3 was found on the floor, and when EMS moved Resident #3 from the floor, he started yelling that his hip was hurting him.
-After further assessment by EMS and Resident #3's hospice nurse, they did not recommend that he be sent to the ED but treated his bloody nose with first aid.
-Resident #3's suitemate was sent to the ED that night for behaviors.
-There was no way to ensure Resident #3 was safe as long as he remained in the room with his suitemate who was violent and unpredictable.
-Anytime a resident was put in a situation where it jeopardized their safety, it violated their right to be free of abuse.

Telephone interview with the Resident Care Director (RCD) on 01/16/25 at 1:06pm revealed:

-On 01/04/25 she was informed Resident #3's suitemate pulled him out of bed and onto the floor.
-Resident #3's suitemate was sent to the hospital for behaviors after the attack but Resident #3 was not injured.
-Resident #3 and his suitemate had remained together since Resident 3's admission because she did not have any concerns about Resident #3's safety.
-She did not think Resident #3's suitemate actually pulled him out of the bed onto the floor.

Interview with the RCD on 02/21/25 at 3:05pm revealed:
-She did not think staff had an accurate picture regarding Resident #3's suitemate's behaviors prior to his admission; after Resident #3 was admitted and placed in the room, perhaps there was not a good roommate option available for either of them when it was becoming more evident that his suitemate's behaviors were escalating.
-There had been a semi-private room available with one other male resident but the resident in that room was high functioning and would not have been a good roommate option for Resident #3 or his suitemate.

Telephone interview with the Executive Director on 01/16/25/25 at 12:59pm revealed:
-He had not been concerned about the room placement for Resident #3.
-No staff had actually witnessed Resident #3's suitemate lay hands on him.
-There had been one incident when Resident #3 had been "rolled him out of bed" by his suitemate.
-Resident #3 was not injured during the incident.
-He guessed in hindsight they could have moved Resident 3's suitemate to a private room or assigned a staff member to be with him one-on-one if needed to ensure Resident #3's safety.
-He just did not think Resident #3 had been at risk of being hurt by his suitemate.

Interview with the ED on 02/21/25 at 1:00pm revealed if there were staff who said they witnessed Resident #3's suitemate injure him on 01/04/25, this conversation was the first he heard about it, but regardless, he realized there had been "a lot going on" with Resident #3's suitemates behaviors.

Refer to a review of electronic progress notes for a Special Care Unit (SCU) male resident for December 2024 through January 2025.

Refer to a review of a local Law Enforcement (LE) electronic dispatch and response reports related to a male Special Care Unit (SCU) resident for December 2024 through January 2025.

Refer to an interview with a third-shift Medication Aide (MA) on 01/15/25 at 11:00pm.

Refer to an interview with a third shift Personal Care Aide (PCA) on 01/16/25 at 12:10am.

Refer to an interview with a 2nd third shift PCA on 01/16/25 at 12:10am.

Refer to a telephone interview with a SCU male residents responsible party on 02/19/25 at 10:00am.

Refer to an interview with the Executive Director on 02/21/25 at 1:00pm.

Review of electronic progress notes and incident reports for a SCU male resident from December 2024 through January 2025 revealed the male resident who attacked Resident #2 and #3 had twenty-two documented behavioral incidents involving physical attacks on others.

Review of a local LE electronic dispatch and response reports related to a SCU male resident for December 2024 through January 2025 revealed local LE officers responded to the facility ten times related to incidents of physical violence involving the male resident who attacked Resident #2 and #3.

Interview with a third shift MA on 01/15/25 at 11:00pm revealed:
-She was concerned about the safety of the residents because a male resident who was having violent physical episodes was often found in other resident's rooms, but it was impossible to have eyes on him at all times.
-She had thought the situation with the male resident's behaviors could be considered a residents rights issue but staff

had to follow the direction of their superiors.
-It was the responsibility of the facility to protect the residents from abuse by other residents.
-Staff had expressed concerns to leadership staff in staff meetings about the male residents violent behaviors.
-Leadership staff included the Special Care Unit Coordinator, the Resident Care Director, and the Executive Director.
-The only response staff had received was that they were planning to make arrangements to provide additional dementia care training.

Interview with a third shift PCA on 01/16/25 at 12:10am revealed:
-There was a SCU resident who had attacked residents.
-Staff were concerned the male resident was going to seriously injure another resident.
-Staff had notified the supervisors, including the SCUC and the RCD, as well as the ED.
-She did not know what had been done to ensure the safety of the other residents.
-The violent male resident posed a constant risk to other residents.

Interview with a 2nd third shift PCA at 01/16/25 at 12:16am revealed:
-Staff were afraid to work with the SCU male resident because he had already hurt so many people.
-The male resident was a danger to other residents.

Telephone interview with a SCU male resident's responsible party on 02/19/25 at 10:00am revealed:
-During the time the SCU male resident was in the facility, staff kept her informed of his behaviors, including his physically violent attacks on others.
-She understood the facility was responsible for ensuring the safety of all the residents and she did not want anything to happen that violated the rights of the other residents.
-During the time the male resident was in the SCU, she had thought several times that maybe he needed a one-on-one worker, but she did not say anything because she waited to see if the facility suggested this.
-If the facility thought a one-on-one worker was needed to ensure the safety of the other residents, they could have tried

it for a couple of days to see if it was effective, and if it was, they could have called her to say they needed her to hire someone to serve as a full-time one-on-one for him.
-She would have agreed to do that if she had been asked.
-She probably could have found someone in her place of worship who would have been willing to work as his one-on-one worker.

Interview with the Executive Director on 02/21/25 at 1:00pm revealed:
-Even if residents were having violent behaviors, they had rights too.
-One of the big reasons he had not taken more aggressive steps regarding the violent SCU male resident, such as issuing an immediate discharge, was because he was trying not to violate his residents rights.
-It had not occurred to him that this decision might lead to violating the rights of the other residents in the SCU.
-In hindsight, now that he could see the whole picture and knew the volume of attacks on others by the male resident, it probably would have been a good idea to request his responsible party hire a one-on-one worker for him to ensure the safety of the other residents.

Refer to 10A NCAC 13F .0901b Personal Care and Supervision.

The facility failed to keep residents free of physical abuse by a male resident who had repeated incidents of physical violence, resulting in abuse of Resident #2 who was attacked in her bed, drug to the floor, and shaken violently and abuse of Resident #3 was found on the floor in his room being punched, and sustaining a bloody nose and hip pain. The facility's failure to protect the residents resulted in resident to resident abuse and constitutes a Type A1 violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 received on 01/16/25.

THE CORRECTIVE DATE FOR THIS VIOLATION SHALL NOT EXCEED 04/09/25.

Facility Name:

IV. Delivered Via:	Hand Delivered	Date: 03/10/25
DSS Signature:	[signature]	Return to DSS By: 03/31/25

V. CAR Received by:	Administrator/Designee (print name): Kelly Davis	
	Signature: [signature]	Date: 3/10/25
	Title: Director of Resident Care	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:		Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:	
Comments:			

**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*