Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Wellington House Assisted Living
Address: 850 Majestic Court, Gastonia NC 28054
County: Gaston
License Number: HAL-036-031

II. Date(s) of Visit(s): 1/27/25, 1/28/25, 1/29/25, 2/4/25, 2/14/25, and 3/20/25
Purpose of Visit(s): Complaint Investigation

Exit/Report Date: 3/20/25

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 CAR. 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, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *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 .0909 Resident Rights	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: 10A NCAC 13F .0909 Resident Rights An Adult Care Home shall assure that rights of all Residents are guaranteed under G.S. 131D-21, Declaration of Residents Rights are maintained and may be exercised without hindrance.		
Level of Non-Compliance: Type A1 Violation		
Based on record reviews, interviews and observations, the facility failed to ensure 3 of 5 sampled Residents (#1, #2, & #3) were free from physical abuse by facility staff when a staff member was observed by other staff hitting a resident with a shower head and hairbrush (#1), and five other staff were observed throwing ice at residents (#1, #2, & #3). Review of the facility's Resident Abuse and Neglect Policy dated September 2021 revealed: -Community management will direct staff to assure the immediate safety of the resident.		

-The Department's Vice President of Operations will be notified immediately, and all required reporting will be complete as required, not limited to local law enforcement and the Department of Social Services. -The community will complete the Health Care Personnel Registry, (HCPR) 24-hour report and begin an immediate investigation. -Complete the Health Care Personnel Registry report within 24 hours of discovery or knowledge of abuse.		
-Community management begins the investigation to substantiate unsubstantiated allegations for reporting on the HCPR five-day reporting report. -Complete and submit the five-day working report either substantiated or unsubstantiated. -If allegations are substantiated the employee will receive disciplinary action, not including termination. -Community management will follow up with the primary care physician for resident needs regarding abuse if required to include, but not limited additional care aftercare, or supportive services needed. 1. Review of Resident #1's current FL-2 dated 09/06/24 revealed: -Diagnoses included dementia without behaviors, urinary and bowel incontinence, pediculosis (a condition in which tiny insects infest the scalp), type 2 diabetes, hypertension (elevated blood pressure), and hyperlipidemia (elevated lipids). -Recommended level of care was Special Care Unit. Review of Resident #1's care plan dated 01/19/25 revealed: -She had a history of resisting care. -She was injurious to self and others. -She was currently receiving medication(s) for mental illness/behaviors. -She was receiving mental health services. -She required limited assistance with toileting, bathing, dressing, and grooming/personal hygiene. -She was independent with ambulation/locomotion and transferring. Observation of Resident #1 on 01/28/25 at 10:30am revealed: -The resident had a bruise across her forehead from temple to temple that, light blue, and purple in color. -The resident had dark bruising on her left eye lid and around her left eye. -The resident had light red colored bruising on both cheekbones.		

-The resident had purple bruising on both hands, wrist, and forearm. Review of Resident #1's progress note dated 01/27/25 revealed: -Communication with the primary care physician (PCP) was documented at 2:22pm. -The Special Care Coordinator (SCC) informed the PCP Resident #1 needed to be sent to the Emergency Department (ED) due to altered mental status and discoloration of her skin. -There was no documentation of the bruising on her face, forearms, wrist, cheek, eyes, or hands. Based on observations, record reviews and interviews it was determined Resident #1 was not interviewable. Review of the local county police 911 communications report dated 01/27/25 revealed: -The call came in at 2:14pm to dispatch that Resident #1 had altered mental status. -Resident #1 was not responding normally. -Resident #1 was breathing normally. -Resident #1 arrived at the hospital at 2:48pm. Interview with a local paramedic on 01/30/25 at 10:00am revealed: -He responded to a call at the facility on 01/27/25 for a report of a resident with altered mental status and discoloration of skin. -Staff met him and the other paramedics at the door when they arrived on 01/27/25 -Resident #1 did not have any symptoms of altered mental status when Emergency Medical Services (EMS) arrived at the facility on 01/27/25. -Resident #1's forehead, nose, and eyes had a discoloration. -Resident #1's left eye was black. -Resident #1 had bruising to her nose and forehead were two distinct stages of healing. -On Resident #1's forehead from one temple to the other side of the temple was bruised. -Resident #1's nose was bruised and there was no blood. -He asked the Special Care Coordinator (SCC) what happened to Resident #1 she said nothing happened. -The SCC told him Resident #1 had altered mental status and discoloration of her skin. -The SCC reported the resident had not fallen. -The staff did not tell him there was an allegation that Resident #1 was physically assaulted.		

-The facility staff gave minimal information and rushed EMS out the door. -Resident #1's paperwork was handed to EMS quickly and no staff could answer any questions regarding how Resident #1 sustained the bruises. -The Staff were extremely nervous when he asked them about the resident's bruises. -The SCC could not tell how there was a change in resident's mental status.		
-While transporting Resident #1 to the hospital, he heard a notification over the police and EMS scanner requesting the police at the facility for an alleged assault on a resident. -He reported an allegation of physical assault to the hospital staff. Review of Resident #1's hospital discharge summary dated 01/27/25 revealed: -The reason for the visit other. -The diagnosis was dementia. -The resident exam included: computed tomography (CT) scan of the head without contrast. -The resident was discharged from the ED back to the facility on the same day (1/27/25). Review of Resident #1's hospital records dated 01/27/25 revealed: -The Resident was seen for altered mental status. -There was no report of trauma, and the specifically denied having any falls. -A CT scan without contrast showed no acute intracranial findings. Interview with Resident #1's guardian on 01/27/25 at 3:40pm revealed: -The facility called her and left a voicemail for a return call today (01/27/25). -She called the facility and was made aware Resident #1 was involved in an alleged assault. -She was told Resident #1 was being sent to the ED. Interview with Resident #1's guardian on 01/30/25 at 11:30am revealed: -The Administrator left a voicemail on 01/27/25 at 2:06 pm saying Resident #1 was sent to the ED. -The Administrator emailed her at 2:18pm and said Resident #1 was being sent to the ED for altered mental status. -The guardian called the facility at 3:45pm and spoke with the Administrator.		

-The Administrator said Resident #1 was involved in a situation involving staff. -It was alleged Resident #1 was abused. -The Administrator told her she could not give out the alleged abuser's name. -The Administrator did not give the police the alleged abuser's name or any other information. -The Administrator could not give out information to anyone until she got clarification from the facility's corporate office. -The Administrator called EMS at 2:13pm on 01/27/25. -The facility gave her a picture of a bruise on Resident #1's left hip about the size of a cantaloupe. Review of Staff A's, PCA personnel file revealed: -Her date of hire was 01/23/25. -There was documentation and an initial HCPR check was completed on 01/23/25 with no findings. -There was documentation that a criminal background check was completed on 01/21/25. -There was no documentation a HCPR report was completed related to alleged abuse of Resident #1. Review of Staff B's PCA personnel file revealed: -Her date of hire was 11/18/22. -There was documentation and an initial HCPR check was completed on 11/15/22 with no findings. -There was documentation a criminal background check was completed on 11/16/22. -There was no documentation a HCPR report was completed related to alleged abuse of Resident #1. Review of Staff C's, PCA, personnel file revealed: -Her date of hire was 12/10/24. -There was documentation and an initial HCPR check was completed on 12/04/24 with no findings. -There was documentation a criminal background check was completed on 12/05/24. -There was no documentation a HCPR report was completed related to alleged abuse of Resident #1. Review of Staff D's, PCA, personnel file revealed: -Her date of hire was 08/09/24. -There was documentation an initial HCPR check was completed on 08/06/24 with no findings. -There was documentation a criminal background check was completed on 08/06/24. -There was no documentation a HCPR report was completed related to alleged abuse of Resident #1.		

Review of Staff E's, PCA, personnel file revealed: -Her date of hire was 05/29/24. -There was documentation that an initial HCPR check was completed on 06/28/24 with no findings. -There was documentation that a criminal background check was completed on 05/23/24. -There was no documentation a HCPR report was completed related to alleged abuse of Resident #1.		
Review of Staff F's, MA, personnel file revealed: -Her date of hire was 08/12/24. -There was documentation that an initial HCPR check was completed on 08/08/24 with no findings. -There was documentation a criminal background check was completed on 08/06/24. -There was no documentation a HCPR report was completed related to alleged abuse of Resident #1. Review of facility Observation Detail List Report dated 01/25/25 revealed: -Resident #1 had bruising on her forehead and eye. -Resident #1 had redness on her neck. Review of Resident #1's Observation Detail List Report dated 01/27/25 revealed: -Resident #1 had bruising on forehead, left eye, nasal bridge, bilateral wrist, left lateral thigh, bilateral upper extremities, and bilateral digit. -Resident #1 had discoloration seen forehead and eye. -Resident #1 had a bump above left eye on forehead. -The observation report was completed by the SCC on 01/27/25 at 3:40pm. Telephone interview with Resident #1's Primary Care Provider (PCP) on 02/27/25 at 9:05am revealed: -He saw Resident #1 on 01/29/25 for a follow up visit to the ED on 01/27/25. -He told the facility to be sure to contact the responsible person. -Resident #1 was very cooperative during medical assessment. -Resident #1 had some superficial bruises on her face. -Resident #1 had no broken skin and no other signs of trauma. -His order was to treat the bruises with cold packs. -The bruising on her left temple was resolving. -The bruising on left eye and both arms could be from anything. -The condition mentally and physically it could have come from anything.		

-He ordered for her to be put on a 30-minute watch. Interview with Staff A, PCA on 01/28/25 at 12:00pm revealed: -On the morning of 01/25/25 Resident #1 was a little combative in the shower. -She saw Staff E pour shampoo on Resident #1's head. -Staff E took the shower head and hit Resident #1 in the head. -There were 3 staff (Staff B, Staff C, and Staff E) in the shower during the abuse taking place.		
-After getting Resident #1 dressed, Staff E brushed resident's hair, took the brush, and hit Resident #1 in the head five times. -Resident #1 had a large bruise on her hip when getting her dressed. -She was scheduled to be on shift with "these people" (Staff B, Staff C, and Staff E) that weekend. -She told the Business Office Manager (BOM) about the incident on 01/27/25 at 9:30am. Interview with Staff B, PCA on 01/28/25 at 12:32pm revealed: -On 01/25/25 she saw Staff E hitting Resident #1 in the head with a shower head and spray water in her face while other staff watched. -Staff C walked in on the assault and did nothing. -On the morning of 01/28/25 she went to report the assault, but SCC was in meetings her entire shift. -She came to report the abuse that occurred on 01/27/25 but the SCC and Administrator were too busy to stop and talk. -She and another MA worked the entire shift on the morning of 01/28/25 and never had a chance to tell management about the abuse. -She was trained on reporting abuse, neglect, and exploitation when she was hired. Interview with Staff C on 01/29/25 at 11:38am revealed: -On 1/25/2025, at 12:00pm Staff A, Staff B, and Staff E in the shower room. -She heard the resident yell stop through the doors while sitting in television room with residents. -When she opened the door, she saw a Staff E hitting Resident #1 in the head with the showerhead. -She walked out and shut the door. -She did not tell anyone because she was afraid of Staff E. -Staff E threatened her on Friday 01/24/25 that she would shoot up her house. -The weekend of 01/25/27 was the first time she saw Resident #1 face bruised.		

Interview with Staff E on 01/30/2025 at 12:07pm revealed: -When she came in on Friday 01/25/25 morning, she told Staff F, Resident #1 had a black eye. -On 1/25/25 she washed Resident #1's hair. -The showerhead fell off but did not hit Resident #1 in the head. -She never hit Resident #1 or anybody. -She did not know anything about the bruises. -She worked there for eight months.		
-The Administrator met with her on 01/27/25 about allegations of abuse to Resident #1. Review of the 24-hour HCPR Initial Allegation Report dated 01/27/25 revealed: -Incident date was 01/25/25. -The date the facility became aware of the incident was on 01/27/25. -There was no time documented when the facility became aware of the incident. -A physical therapist reported findings bruising on Resident #1 on 01/27/25. -There was an interview with a Staff A, Personal Care Aide (PCA) that she observed Staff E, causing physical harm to Resident #1 while providing personal care on 01/25/25. -Resident #1 sustained bruises to her face. -There was no documentation of how the residents were protected from further harm by Staff E that Staff A, B, and C staff witnessed on 01/25/25 until 01/27/25. Interview with a police officer that arrived on site on 02/10/25 at 9:50am revealed: -She initially went out to the facility on 01/27/25 at that time the Administrator reported Resident #1 had been physically assaulted but per the facility's corporate office the Administrator was not to share any named staff or residents that assaulted Resident #1. -She gave the Administrator an incident report number and told her she would be back. -She returned to the facility on 01/31/25 to gather information for her investigation. -The Administrator still did not want to give her the information needed to complete her report. -She told the Administrator she needed staff's statements not any of the resident's health care personal information. -She told the Administrator the information could be subpoenaed. -The Administrator gave her staff's statements.		

-The Administrator told her that Staff E and Staff F were terminated. -The Administrator told her Staff E abused Resident #1 and Staff F was throwing ice at Resident #1. -She interviewed Staff A, Staff B, and Staff C and Staff A and Staff C cooperated. -Staff told her Resident #1 was hit with a showerhead in the head. -They told her about an incident where staff were throwing ice at residents, but she could not prove who took part in the incident. Interview with the BOM on 01/27/25 at 4:31pm revealed: -Staff A came to her on 01/27/25 at 9:45am with allegations of abuse. -Staff A told her Staff B, Staff E, and Staff F were throwing ice at the residents. -Staff A told her Staff E was hitting Resident #1 in the head with shower head. -Staff A told her Staff C walked into the spa during the assault when she heard Resident#1 was yelling "stop!" -She took Staff A to the Administrator's office to report the incident. Interview with Resident #1's Physical Therapist (PT) on 02/27/25 at 2:50pm revealed: -She saw Resident #1 for therapy on Monday, 01/27/25. -She noted no new bruising on 1/25/25 visit. -She noted old healing bruises to the left side of the head. -She told the Administrator on Monday 01/27/25 there were new bruises she was obligated to report it. -Resident #1 was fine on 01/25/25, but not on 01/27/25. -The resident said she felt like she was beaten. -She investigated the computer matrix system to see if there were any falls, and there were not any. -She looked at skin assessments for the week and saw no bruising matching what she saw on 01/27/25. -She asked all staff on shift what happened to Resident #1's face and arms. -One staff said she ran into a wall; she could not remember which staff. -She told staff this new bruising could not be from running into a wall or a fall. -On Monday, 01/27/25 she conducted her own investigation. -She reported the bruising to the SCC. -Resident #1 was walking unsteady and had discoloration of skin. -Resident #1 better and her bruises were healing on 1/27/25.		

-She reported the bruising before 11:00am to the SCC and the Administrator. Interview with the SCC on 01/27/25 at 4:43pm revealed: -Staff A came into the Administrator's office and reported she saw abuse happening over the weekend. -Staff A did not report the abuse because she was scared. -Staff A said Staff E threatened to shoot up her house and her family therefore she was afraid to report the abuse.		
-She saw bruising on Resident #1's eye, thigh, wrist, and forearm when completing an assessment on 01/27/25. -Resident #1 was walking unsteady and had discoloration of skin. -She called the PCP and informed him the Resident #1 was unsteady and had discoloration to the skin. -She did not inform the PCP of the allegations of abuse. -She sent Resident #1 to the ED around 2:00pm. -She did not report the alleged abuse to the PCP because she was not allowed to give information on assault until corporate gave the approval to disclose the information. -Staff E and Staff F were suspended. Interview with the SCC on 01/28/25 at 11:45am revealed: -She was made aware of the abuse allegation at 10:00am on 1/27/25 the same time as the Administrator. -The BOM brought Staff A to the Administrator's office on 01/27/25 to repot the abuse. -She sent Resident #1 out to the ED for altered mental status. -She did not inform EMS of alleged abuse. -She was waiting on clearance from corporate. -She told EMS Resident #1 had an altered state and discoloration of her skin. -She did not tell the doctor or EMS about the alleged abuse. -She was not allowed to discuss any information until corporate gave permission. -She did not send Resident #1 to the ED to get examined for abuse. -The facility did not take pictures of the bruising. Interview with the Administrator on 01/27/25 at 5:00pm revealed: -She was made aware on the allegation of abuse to Resident #1 by Staff E on the morning of 01/27/25. -She did not remember the time. -Staff A reported she was in training with Staff B and Staff E. -Staff A reported Staff E hit Resident #1 in the head with the shower head and sprayed water in her face. -She suspended Staff E and Staff F on 01/27/25 due to the allegations of abuse.		

-She did not have an incident report, progress notes, or HCPR report completed at this time. -Staff A told the BOM of the allegations on 01/27/25. -The BOM brought Staff A to the Administrator's office. -She completed a body assessment of the Resident #1. -She saw bruising on Resident #1's face. -She called the guardian and reported Resident #1 was being sent to the ED for possible abuse. -The SCC called the doctor around 1:45pm. -She and the SCC called the police to make a report around 3:00pm. -She did not tell the PCP or EMS about the alleged abuse. -She stated she could not give the Adult Home Specialist (AHS) any documents related to staff's written interviews until she received approval from the corporate office. -The AHS never received the requested documents from the Administrator. Interview with the Administrator on 01/28/25 at 10:45am revealed: -The BOM brought Staff A to her office around 10:00am on 01/27/25. -The BOM stated Staff A came into her office around 9:45am to report allegations. -Staff A told her what happened and what she witnessed 01/25/25. -After Staff A provided her statement on the morning of January 27, 2025, the Administrator sent her to BOM's office to document her statement. -She assessed the bruising on Resident #1. -Staff C reported the incident shortly after seeing Staff A in the office on the morning of 01/27/25. -She did a HCPR Investigation report (24 hour/5 day) for Staff E and Staff F and submitted it to the Regional Vice President of Operations on 01/27/25 for review. -She faxed the initial HCPR report to HCPR on 01/28/25 but could not find the confirmation page. -The facility would not give out names or information until their investigation was completed. -Staff A told her, Staff B, and Staff C were in the shower area as this alleged abuse occurred -Staff C told her she stuck her head in to see what was going on and witnessed Staff E hitting Resident #1 in the head with the shower head. -Staff C told her She did not report the abuse because she was afraid of Staff E due to Staff E threatening her earlier in the week.		

-The doctor was called by RCC to get permission to send Resident #1 to the ED. -The doctor was not informed of Resident #1's alleged abused because she had to wait on getting approval from the corporate office. -The facility called the EMS at 2:13pm on 01/27/25. -Resident #1 was sent out for altered mental status and skin discoloration, not abuse, as corporate approval was needed to disclose any possibility of abuse.		
Refer to interview with the Administrator on 02/04/25 at 2:30pm. 2. Review of Resident #2's current FL-2 dated 07/19/24 revealed: -Diagnoses included Alzheimer's disease with late onset, unspecified urinary incontinence, and unspecified chronic kidney. -Recommended level of care was Special Care Unit. Based on observations, record reviews, and interviews it was determined Resident #2 was not interviewable. Review of Resident #3's current FL-2 dated 12/09/24 revealed: -Diagnoses included advanced dementia, metabolic encephalopathy (a problem in the brain), failure to thrive, hypokalemia (low Potassium), hypophosphatemia (low level of phosphate in your blood), and acute kidney injury. -Recommended level of care was Special Care Unit. Based on observations, record reviews and interviews it was determined Resident #3 was not interviewable. Interview with Staff A, PCA on 1/28/25 at 12:00pm revealed: -On 01/26/25 she saw Staff D and Staff E throw Cookie snacks at Resident #1 and Resident #2. -She saw 3 staff (Staff B, Staff C, and Staff D) throwing ice at Resident #1, Resident #2, and Resident #3. -She was trained in reporting abuse. -She did not report staff throwing ice to any management because she was afraid of the other staff who threatened her. -She did not intervene because she was afraid of Staff E because Staff E threatened to harm her if she did or if she told management. -Staff A said Staff E threatened to shoot up her house and her family therefore she was afraid to report the abuse Interview with Staff B, PCA on 01/28/25 at 12:32pm revealed:		

-Staff A, Staff C, Staff D, Staff E, and Staff F were in the television room on 01/26/25. -Resident #1 got combative, kicking another resident, and the resident was acting out. -Staff A filled a cup with ice and began throwing pieces of ice at Resident #1, Resident #2, and Resident #3. -Staff A hit Resident #1 in the eye with ice. -No one intervened to stop the incident and some of the staff laughed during the incident.		
-She told the housekeeper who she thought was a manager on duty. -The housekeeper told her; she was no longer in a management position. -All the managers were at home asleep; so, she did not report it. Interview with Staff C on 01/29/25 at 11:38am revealed: -On 01/26/25, snacks were being handed out in the television room by Staff A, Staff C, and Staff D. -She never saw any bruises on Resident #1 on 01/25/25. -When she came in on Saturday 01/26/25 Resident #1 had bruises and a black eye. -She asked where the bruises came from. -Staff E told her Resident #1 fell and ran into a wall. -All staff involved did not say anything to anybody involved. -This weekend was the first time she saw Resident #1's face bruised. -She had been working at the facility for two months. -Resident #1 kept asking people not to lock her in the bathroom. -She signed a statement on reporting abuse when she was Interview with Staff D on 01/29/25 at 11:58am revealed: - On Sunday 01/26/25 at 10:00am around snack time all staff were in the television room. -Staff E started throwing the cookie snacks and ice at Resident #1 and Resident #2. -This lasted about eight or ten minutes. -Staff E was still throwing ice when he came back five minutes later. -He told Staff E to stop it, but she continued for about 15 minutes. -He came back, and all the cookie snacks were gone. -He thought she was playing when Staff E was throwing ice, and Staff E did not hit anyone. -He thinks ice hit the wall. -He did not know if it was directed at the residents, but it was in their direction.		

-He never saw it as being abusive to any of these residents. -He did not report it to anyone. -He was trained on resident rights but did not think it was abuse. Interview with Staff E on 01/30/2025 at 12:07pm revealed: -She saw Staff A and Staff D throwing ice at the residents, and she told Staff F about them throwing ice. -She saw Staff A hit Resident #1 in the eye with ice and caused a black eye. -That was why Resident #1's eye was black. -The Administrator met with her on 01/27/25 about allegations of abuse to Resident #1. -She was trained to report abuse. -She said, "I am shy and was scared to step up and tell management". Interview with Staff F, MA on 02/10/25 at 8:40am revealed: -Around snack time on 01/25/25 all staff were sitting in the television room with the resident's watching television. -Staff A had a cup full of ice. -During snack time, she saw Staff A, Staff C, and Staff D throwing ice and cookie snacks at the residents. -Staff A threw a big block of ice hitting, Resident #1 in the head. -No one said anything; they just watched. -She said that was enough and told Staff A to stop. -She did not tell the appointed manager for the shift about the ice and cookie snack being thrown at residents. -She was outside on the phone. -Staff members were mean to the residents since she started in August 2024. -She saw a staff push and pull a resident. -She did not remember who the resident or staff were. -She was trained to report any abuse. -It was a busy day, so she did not get to tell the manager. Interview with the housekeeper on 01/28/25 at 12:47pm revealed: -Staff B came and said staff were throwing ice at residents, but not sure who. -She let Staff B know she was no longer a manager. -She followed up with the management on Monday (1/27/25). -She said she did not report staff throwing ice because she told Staff B, she was not a manager and she needed to contact a manager, it was not her responsibility.		

Interview with the Administrator on 01/28/25 at 10:45am revealed: -Staff A told her Staff E and Staff F were throwing chunks of ice on Sunday 01/26/25 in the living room area. -Staff E and Staff F were suspended as of 01/27/25. -Staff A told her Resident #2 had ice thrown at her. -Staff A told her she did not remember seeing any bruising on Resident #2.		
Refer to interview with the Administrator on 02/04/25 at 2:30pm. Interview with Administrator on 02/4/25 at 2:30pm revealed: -She did not have confirmation of sending the initial 24/5 or investigation report to HCPR. -Staff A and Staff C reported the alleged abuse on the morning on 1/27/25. -She did not submit all six staff to HCPR who knew about the abuse. -She did not suspend Staff A and C while the investigation was going on because they reported the abuse on 1/27/25. -No staff reported the abuse immediately, and did not report the abuse of the three residents for four days. -She received a call on 02/3/25 from the Healthcare Personnel Registry (HCPR). -The Department Health Service Regulation wanted to confirm information for everyone who knew about the abuse was submitted to the HCPR. -She submitted a new HCPR 24 hours report on 02/04/25 around 3:30pm and added four more staff (Staff A, Staff B, Staff C, and Staff D). -The staff who knew of the alleged physical abuse were Staff A, Staff B, Staff C, Staff D. -The Staff who were throwing ice was Staff D and Staff F. -The Administrator confirmed on 1/27/25 AHS discussed all who had knowledge of the alleged abuse, had to be reported to the HCPR. The facility failed to protect Resident #1, who has a diagnosis of dementia and requires staff assistance for activities of daily living from physical abuse by Staff E who was observed by Staff A, B, C, D, and F Resident #1 in the head with a showerhead and a hairbrush. Additionally, five other staff (Staff A, Staff B, Staff C, Staff D, and Staff F) were seen throwing food and ice at Resident #1, #2, and #3. The facility neglected to report this abuse to the Administrator for four days leaving all residents vulnerable to further mistreatment. This situation constitutes a Type A1 violation.		

The facility provided a plan of Protection in accordance with G.S. 131D-21 on 02/4/25 was received for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 19, 2025.		
Rule/Statute Number: 10A NCAC 13F .1205 Health Care Personnel Registry	☐ POC Accepted _____ *DSS Initials*	
Rule/Statutory Reference: 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting rules 10A NCAC 13F .0130 .0101 and .0102. The reporting of healthcare personnel as defined in G.S. 131E-256(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appears to be related to any act listed in subdivision (a) (1) of this section. Facilities must have evidence that all alleged acts are investigated and must make every effort to protect the residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.		
Level of Non-Compliance: TYPE A2 VIOLATION		
Findings: Based on observation, interviews, and record reviews the facility failed to complete a Health Care Personnel Registry (HCPR) report within 24 hours of knowledge that 6 staff members (Staff A, B, C, D, E, and F) physically abused Residents (#1, #2, and #3). 1. Review of Resident #1's current FL-2 dated 09/06/24 revealed: -Diagnoses included dementia without behaviors, urinary and bowel incontinence, pediculosis (a condition in which tiny insects infest the scalp), type 2 diabetes, hypertension (elevated blood pressure), and hyperlipidemia (elevated lipids). -Recommended level of care was Special Care Unit. Review of Resident #1's care plan dated 01/19/25 revealed: -She had a history of resisting care.		

-She was injurious to self and others. -She was currently receiving medication(s) for mental illness/behaviors. -She was receiving mental health services. -She required limited assistance with toileting, bathing, dressing, and grooming/personal hygiene. -She was independent with ambulation/locomotion and transferring.		
Observation of Resident #1 on 01/28/25 at 10:30am revealed: -The resident had a bruise across her forehead from temple to temple that, light blue, and purple in color. -The resident had dark bruising on her left eye lid and around her left eye. -The resident had light red colored bruising on both cheekbones. -The resident had purple bruising on both hands, wrist, and forearm. Review of Resident #1's progress note dated 01/27/25 revealed: -Communication with the primary care physician (PCP) was documented at 2:22pm. -The Special Care Coordinator (SCC) informed the PCP Resident #1 needed to be sent to the Emergency Department (ED) due to altered mental status and discoloration of her skin. -There was no documentation of the bruising on her face, forearms, wrist, cheek, eyes, or hands. Based on observations, record reviews and interviews it was determined Resident #1 was not interviewable. Review of the local county police 911 communications report dated 01/27/25 revealed: -The call came in at 2:14pm to dispatch that Resident #1 had altered mental status. -Resident #1 was not responding normally. -Resident #1 was breathing normally. -Resident #1 arrived at the hospital at 2:48pm. Interview with a local paramedic on 01/30/25 at 10:00am revealed: -He responded to a call at the facility on 01/27/25 for a report of a resident with altered mental status and discoloration of skin. -Staff met him and the other paramedics at the door when they arrived on 01/27/25		

-Resident #1 did not have any symptoms of altered mental status when Emergency Medical Services (EMS) arrived at the facility on 01/27/25. -Resident #1's forehead, nose, and eyes had a discoloration. -Resident #1's left eye was black. -Resident #1 had bruising to her nose and forehead were two distinct stages of healing. -On Resident #1's forehead from one temple to the other side of the temple was bruised. -Resident #1's nose was bruised and there was no blood. -He asked the Special Care Coordinator (SCC) what happened to Resident #1 she said nothing happened. -The SCC told him Resident #1 had altered mental status and discoloration of her skin. -The SCC reported the resident had not fallen. -The staff did not tell him there was an allegation that Resident #1 was physically assaulted. -The facility staff gave minimal information and rushed EMS out the door. -Resident #1's paperwork was handed to EMS quickly and no staff could answer any questions regarding how Resident #1 sustained the bruises. -The Staff were extremely nervous when he asked them about the resident's bruises. -The SCC could not tell how there was a change in resident's mental status. -While transporting Resident #1 to the hospital, he heard a notification over the police and EMS scanner requesting the police at the facility for an alleged assault on a resident. -He reported an allegation of physical assault to the hospital staff. Review of Resident #1's hospital discharge summary dated 01/27/25 revealed: -The reason for the visit other. -The diagnosis was dementia. -The resident exam included: computed tomography (CT) scan of the head without contrast. -The resident was discharged from the ED back to the facility on the same day (1/27/25). Review of Resident #1's hospital records dated 01/27/25 revealed: -The Resident was seen for altered mental status. -There was no report of trauma, and the specifically denied having any falls. -A CT scan without contrast showed no acute intracranial findings.		

Interview with Resident #1's guardian on 01/27/25 at 3:40pm revealed: -The facility called her and left a voicemail for a return call today (01/27/25). -She called the facility and was made aware Resident #1 was involved in an alleged assault. -She was told Resident #1 was being sent to the ED. Interview with Resident #1's guardian on 01/30/25 at 11:30am revealed: -The Administrator left a voicemail on 01/27/25 at 2:06 pm saying Resident #1 was sent to the ED. -The Administrator emailed her at 2:18pm and said Resident #1 was being sent to the ED for altered mental status. -The guardian called the facility at 3:45pm and spoke with the Administrator. -The Administrator said Resident #1 was involved in a situation involving staff. -It was alleged Resident #1 was abused. -The Administrator told her she could not give out the alleged abuser's name. -The Administrator did not give the police the alleged abuser's name or any other information. -The Administrator could not give out information to anyone until she got clarification from the facility's corporate office. -The Administrator called EMS at 2:13pm on 01/27/25. -The facility gave her a picture of a bruise on Resident #1's left hip about the size of a cantaloupe. Review of Staff A's, PCA personnel file revealed: -Her date of hire was 01/23/25. -There was documentation and an initial HCPR check was completed on 01/23/25 with no findings. -There was documentation that a criminal background check was completed on 01/21/25. -There was no documentation a HCPR report was completed related to alleged abuse of Resident #1. Review of Staff B's PCA personnel file revealed: -Her date of hire was 11/18/22. -There was documentation and an initial HCPR check was completed on 11/15/22 with no findings. -There was documentation a criminal background check was completed on 11/16/22. -There was no documentation a HCPR report was completed related to alleged abuse of Resident #1. Review of Staff C's, PCA, personnel file revealed:		

-Her date of hire was 12/10/24. -There was documentation and an initial HCPR check was completed on 12/04/24 with no findings. -There was documentation a criminal background check was completed on 12/05/24. -There was no documentation a HCPR report was completed related to alleged abuse of Resident #1. Review of Staff D's, PCA, personnel file revealed: -Her date of hire was 08/09/24. -There was documentation an initial HCPR check was completed on 08/06/24 with no findings. -There was documentation a criminal background check was completed on 08/06/24. -There was no documentation a HCPR report was completed related to alleged abuse of Resident #1. Review of Staff E's, PCA, personnel file revealed: -Her date of hire was 05/29/24. -There was documentation that an initial HCPR check was completed on 06/28/24 with no findings. -There was documentation that a criminal background check was completed on 05/23/24. -There was no documentation a HCPR report was completed related to alleged abuse of Resident #1. Review of Staff F's, MA, personnel file revealed: -Her date of hire was 08/12/24. -There was documentation that an initial HCPR check was completed on 08/08/24 with no findings. -There was documentation a criminal background check was completed on 08/06/24. -There was no documentation a HCPR report was completed related to alleged abuse of Resident #1. Review of facility Observation Detail List Report dated 01/25/25 revealed: -Resident #1 had bruising on her forehead and eye. -Resident #1 had redness on her neck. Review of Resident #1's Observation Detail List Report dated 01/27/25 revealed: -Resident #1 had bruising on forehead, left eye, nasal bridge, bilateral wrist, left lateral thigh, bilateral upper extremities, and bilateral digit. -Resident #1 had discoloration seen forehead and eye. -Resident #1 had a bump above left eye on forehead.		

-The observation report was completed by the SCC on 01/27/25 at 3:40pm. Interview with Staff A, PCA on 01/28/25 at 12:00pm revealed: -On the morning of 01/25/25 Resident #1 was a little combative in the shower. -She saw Staff E pour shampoo on Resident #1's head. -Staff E took the shower head and hit Resident #1 in the head. -There were 3 staff (Staff B, Staff C, and Staff E) in the shower during the abuse taking place. -After getting Resident #1 dressed, Staff E brushed resident's hair, took the brush, and hit Resident #1 in the head five times. -Resident #1 had a large bruise on her hip when getting her dressed. -She was scheduled to be on shift with "these people" (Staff B, Staff C, and Staff E) that weekend. -She told the Business Office Manager (BOM) about the incident on 01/27/25 at 9:30am. Interview with Staff B, PCA on 01/28/25 at 12:32pm revealed: -On 01/25/25 she saw Staff E hitting Resident #1 in the head with a shower head and spray water in her face while other staff watched. -Staff C walked in on the assault and did nothing. -On the morning of 01/28/25 she went to report the assault, but SCC was in meetings her entire shift. -She came to report the abuse that occurred on 01/27/25 but the SCC and Administrator were too busy to stop and talk. -She and another MA worked the entire shift on the morning of 01/28/25 and never had a chance to tell management about the abuse. -She was trained on reporting abuse, neglect, and exploitation when she was hired. Interview with Staff C on 01/29/25 at 11:38am revealed: -On 1/25/2025, at 12:00pm Staff A, Staff B, and Staff E in the shower room. -She heard the resident yell stop through the doors while sitting in television room with residents. -When she opened the door, she saw a Staff E hitting Resident #1 in the head with the showerhead. -She walked out and shut the door. -She did not tell anyone because she was afraid of Staff E. -Staff E threatened her on Friday 01/24/25 that she would shoot up her house. -The weekend of 01/25/27 was the first time she saw Resident #1 face bruised.		

Interview with Staff E on 01/30/2025 at 12:07pm revealed: -When she came in on Friday 01/25/25 morning, she told Staff F, Resident #1 had a black eye. -On 1/25/25 she washed Resident #1's hair. -The showerhead fell off but did not hit Resident #1 in the head. -She never hit Resident #1 or anybody. -She did not know anything about the bruises. -She worked there for eight months.		
-The Administrator met with her on 01/27/25 about allegations of abuse to Resident #1. Review of the 24-hour HCPR Initial Allegation Report dated 01/27/25 revealed: -Incident date was 01/25/25. -The date the facility became aware of the incident was on 01/27/25. -There was no time documented when the facility became aware of the incident. -A physical therapist reported findings bruising on Resident #1 on 01/27/25. -There was an interview with a Staff A, Personal Care Aide (PCA) that she observed Staff E, causing physical harm to Resident #1 while providing personal care on 01/25/25. -Resident #1 sustained bruises to her face. -There was no documentation of how the residents were protected from further harm by Staff E that Staff A, B, and C staff witnessed on 01/25/25 until 01/27/25. Interview with a police officer that arrived on site on 02/10/25 at 9:50am revealed: -She initially went out to the facility on 01/27/25 at that time the Administrator reported Resident #1 had been physically assaulted but per the facility's corporate office the Administrator was not to share any named staff or residents that assaulted Resident #1. -She gave the Administrator an incident report number and told her she would be back. -She returned to the facility on 01/31/25 to gather information for her investigation. -The Administrator still did not want to give her the information needed to complete her report. -She told the Administrator she needed staffs' statements not any of the residents' health care personal information. -She told the Administrator the information could be subpoenaed. -The Administrator gave her staffs' statements.		

-The Administrator told her that Staff E and Staff F were terminated. -The Administrator told her Staff E abused Resident #1 and Staff F was throwing ice at Resident #1. -She interviewed Staff A, Staff B, and Staff C and Staff A and Staff C cooperated. -Staff told her Resident #1 was hit with a showerhead in the head. -They told her about an incident where staff were throwing ice at residents, but she could not prove who took part in the incident. Interview with the BOM on 01/27/25 at 4:31pm revealed: -Staff A came to her on 01/27/25 at 9:45am with allegations of abuse. -Staff A told her Staff B, Staff E, and Staff F were throwing ice at the residents. -Staff A told her Staff E was hitting Resident #1 in the head with shower head. -Staff A told her Staff C walked into the spa during the assault when she heard Resident#1 was yelling "stop!" -She took Staff A to the Administrator's office to report the incident. Interview with Resident #1's Physical Therapist (PT) on 02/27/25 at 2:50pm revealed: -She saw Resident #1 for therapy on Monday, 01/27/25. -She noted no new bruising on 1/25/25 visit. -She noted old healing bruises to the left side of the head. -She told the Administrator on Monday 01/27/25 there were new bruises she was obligated to report it. -Resident #1 was fine on 01/25/25, but not on 01/27/25. -The resident said she felt like she was beaten. -She investigated the computer matrix system to see if there were any falls, and there were not any. -She looked at skin assessments for the week and saw no bruising matching what she saw on 01/27/25. -She asked all staff on shift what happened to Resident #1's face and arms. -One staff said she ran into a wall; she could not remember which staff. -She told staff this new bruising could not be from running into a wall or a fall. -On Monday, 01/27/25 she conducted her own investigation. -She reported the bruising to the SCC. -Resident #1 was walking unsteady and had discoloration of skin.		

-Resident #1 better and her bruises were healing on 1/27/25. -She reported the bruising before 11:00am to the SCC and the Administrator. Interview with the SCC on 01/27/25 at 4:43pm revealed: -Staff A came into the Administrator's office and reported she saw abuse happening over the weekend. -Staff A did not report the abuse because she was scared. -Staff A said Staff E threatened to shoot up her house and her family therefore she was afraid to report the abuse. -She saw bruising on Resident #1's eye, thigh, wrist, and forearm when completing an assessment on 01/27/25. -Resident #1 was walking unsteady and had discoloration of skin. -She called the PCP and informed him the Resident #1 was unsteady and had discoloration to the skin. -She did not inform the PCP of the allegations of abuse. -She sent Resident #1 to the ED around 2:00pm. -She did not report the alleged abuse to the PCP because she was not allowed to give information on assault until corporate gave the approval to disclose the information. -Staff E and Staff F were suspended. Interview with the SCC on 01/28/25 at 11:45am revealed: -She was made aware of the abuse allegation at 10:00am on 1/27/25 the same time as the Administrator. -The BOM brought Staff A to the Administrator's office on 01/27/25 to repot the abuse. -She sent Resident #1 out to the ED for altered mental status. -She did not inform EMS of alleged abuse. -She was waiting on clearance from corporate. -She told EMS Resident #1 had an altered state and discoloration of her skin. -She did not tell the doctor or EMS about the alleged abuse. -She was not allowed to discuss any information until corporate gave permission. -She did not send Resident #1 to the ED to get examined for abuse. -The facility did not take pictures of the bruising. Interview with the Administrator on 01/27/25 at 5:00pm revealed: -She was made aware on the allegation of abuse to Resident #1 by Staff E on the morning of 01/27/25. -She did not remember the time. -Staff A reported she was in training with Staff B and Staff E. -Staff A reported Staff E hit Resident #1 in the head with the shower head and sprayed water in her face.		

-She suspended Staff E and Staff F on 01/27/25 due to the allegations of abuse. -She did not have an incident report, progress notes, or HCPR report completed at this time. -Staff A told the BOM of the allegations on 01/27/25. -The BOM brought Staff A to the Administrator's office. -She completed a body assessment of the Resident #1. -She saw bruising on Resident #1's face. -She called the guardian and reported Resident #1 was being sent to the ED for possible abuse. -The SCC called the doctor around 1:45pm. -She and the SCC called the police to make a report around 3:00pm. -She did not tell the PCP or EMS about the alleged abuse. -She stated she could not give the Adult Home Specialist (AHS) any documents related to staff's written interviews until she received approval from the corporate office. -The AHS never received the requested documents from the Administrator. Interview with the Administrator on 01/28/25 at 10:45am revealed: -The BOM brought Staff A to her office around 10:00am on 01/27/25. -The BOM stated Staff A came into her office around 9:45am to report allegations. -Staff A told her what happened and what she witnessed 01/25/25. -After Staff A provided her statement on the morning of January 27, 2025, the Administrator sent her to BOM's office to document her statement. -She assessed the bruising on Resident #1. -Staff C reported the incident shortly after seeing Staff A in the office on the morning of 01/27/25. -She did a HCPR Investigation report (24 hour/5 day) for Staff E and Staff F and submitted it to the Regional Vice President of Operations on 01/27/25 for review. -She faxed the initial HCPR report to HCPR on 01/28/25 but could not find the confirmation page. -The facility would not give out names or information until their investigation was completed. -Staff A told her, Staff B, and Staff C were in the shower area as this alleged abuse occurred. -Staff C told her she stuck her head in to see what was going on and witnessed Staff E hitting Resident #1 in the head with the shower head.		

-Staff C told her She did not report the abuse because she was afraid of Staff E due to Staff E threatening her earlier in the week. -The doctor was called by RCC to get permission to send Resident #1 to the ED. -The doctor was not informed of Resident #1's alleged abused because she had to wait on getting approval from the corporate office. -The facility called the EMS at 2:13pm on 01/27/25.		
-Resident #1 was sent out for altered mental status and skin discoloration, not abuse, as corporate approval was needed to disclose any possibility of abuse. Refer to interview with the Administrator on 02/04/25 at 2:30pm. 2. Review of Resident #2's current FL-2 dated 07/19/24 revealed: -Diagnoses included Alzheimer's disease with late onset, unspecified urinary incontinence, and unspecified chronic kidney. -Recommended level of care was Special Care Unit. Based on observations, record reviews, and interviews it was determined Resident #2 was not interviewable. Review of Resident #3's current FL-2 dated 12/09/24 revealed: -Diagnoses included advanced dementia, metabolic encephalopathy (a problem in the brain), failure to thrive, hypokalemia (low Potassium), hypophosphatemia (low level of phosphate in your blood), and acute kidney injury. -Recommended level of care was Special Care Unit. Based on observations, record reviews and interviews it was determined Resident #3 was not interviewable. Interview with Staff A, PCA on 1/28/25 at 12:00pm revealed: -On 01/26/25 she saw Staff D and Staff E throw Cookie snacks at Resident #1 and Resident #2. -She saw 3 staff (Staff B, Staff C, and Staff D) throwing ice at Resident #1, #2, and #3. -She was trained in reporting abuse. -She did not report staff throwing ice to any management because she was afraid of the other staff who threatened her. -She did not intervene because she was afraid of Staff E because Staff E threatened to harm her if she did or if she told management.		

-Staff A said Staff E threatened to shoot up her house and her family therefore she was afraid to report the abuse Interview with Staff B, PCA on 01/28/25 at 12:32pm revealed: -Staff A, Staff C, Staff D, Staff E, and Staff F were in the television room on 01/26/25. -Resident #1 got combative, kicking another resident, and the resident was acting out. -Staff A filled a cup with ice and began throwing pieces of ice at Resident #1, Resident #2, and Resident #3. -Staff A hit Resident #1 in the eye with ice. -No one intervened to stop the incident and some of the staff laughed during the incident. -She told the housekeeper who she thought was a manager on duty. -The housekeeper told her; she was no longer in a management position. -All the managers were at home asleep; so, she did not report it. Interview with Staff C on 01/29/25 at 11:38am revealed: -On 01/26/25, snacks were being handed out in the television room by Staff A, Staff C, and Staff D. -She never saw any bruises on Resident #1 on 01/25/25. -When she came in on Saturday 01/26/25 Resident #1 had bruises and a black eye. -She asked where the bruises came from. -Staff E told her Resident #1 fell and ran into a wall. -All staff involved did not say anything to anybody involved. -This weekend was the first time she saw Resident #1's face bruised. -She had been working at the facility for two months. -Resident #1 kept asking people not to lock her in the bathroom. -She signed a statement on reporting abuse when she was Interview with Staff D on 01/29/25 at 11:58am revealed: - On Sunday 01/26/25 at 10:00am around snack time all staff were in the television room. -Staff E started throwing the cookie snacks and ice at Resident #1 and Resident #2. -This lasted about eight or ten minutes. -Staff E was still throwing ice when he came back five minutes later. -He told Staff E to stop it, but she continued for about 15 minutes. -He came back, and all the cookie snacks were gone.		

-He thought she was playing when Staff E was throwing ice, and Staff E did not hit anyone. -He thinks ice hit the wall. -He did not know if it was directed at the residents, but it was in their direction. -He never saw it as being abusive to any of these residents. -He did not report it to anyone. -He was trained on resident rights but did not think it was abuse.		
Interview with Staff E on 01/30/2025 at 12:07pm revealed: -She saw Staff A and Staff D throwing ice at the residents, and she told Staff F about them throwing ice. -She saw Staff A hit Resident #1 in the eye with ice and caused a black eye. -That was why Resident #1's eye was black. -The Administrator met with her on 01/27/25 about allegations of abuse to Resident #1. -She was trained to report abuse. -She said, "I am shy and was scared to step up and tell management". Interview with Staff F on 02/10/25 at 8:40am revealed: -Around snack time on 01/25/25 all staff were sitting in the television room with the resident's watching television. -Staff A had a cup full of ice. -During snack time, she saw Staff A, Staff C, and Staff D throwing ice and cookie snacks at the residents. -Staff A threw a big block of ice hitting, Resident #1 in the head. -No one said anything; they just watched. -She said that was enough and told Staff A to stop. -She did not tell the appointed manager for the shift about the ice and cookie snack being thrown at residents. -The manager was outside on the phone. -Staff members were mean to the residents since she started in August 2024. -She saw a staff push and pull a resident. -She did not remember who the resident or staff were. -She was trained to report any abuse. -It was a busy day, so she did not get to tell the manager. Interview with the MA Supervisor on 02/9/25 at 2:00pm revealed: -She was the manager on duty on 01/25/25. -She was outside on the telephone.		

-She did not see or hear anything pertaining to any resident abuse. -No one reported abuse to her at any time during the weekend of 01/24/25-01/26/25. -She had no knowledge of the abuse until she returned to work on Monday (01/27/25). Interview with the BOM on 01/27/25 at 4:31pm revealed: -Staff A came to her on 01/27/25 at 9:45am with allegations of abuse. -Staff A told her Staff B, Staff E, and Staff F were throwing ice at the residents. -Staff A told her Staff E was hitting Resident #1 in the head with shower head. -Staff A told her Staff C walked into the spa during the assault when she heard Resident#1 was yelling "stop!" -She took Staff A to the Administrator's office to report the incident. Interview with the SCC on 01/27/25 at 4:43pm revealed: -Staff A came into the Administrator's office and reported she saw abuse happening over the weekend. -Staff A did not report the abuse because she was scared. -Staff A said Staff E threatened to shoot up her house and her family therefore she was afraid to report the abuse. -Staff E and Staff F were suspended. Interview with the Administrator on 01/27/25 at 5:00pm revealed: -She was made aware on the allegation of abuse to Resident #1 by Staff E on the morning of 01/27/25. -She did not remember the time. -Staff A reported she was in training with Staff B and Staff E. -Staff A reported Staff E hit Resident #1 in the head with the shower head and sprayed water in her face. -She suspended Staff E and Staff F on 01/27/25 due to the allegations of abuse. -She did not have an incident report, progress notes, or HCPR report completed at this time. Interview with the Administrator on 01/28/25 at 10:45am revealed: -The BOM brought Staff A to her office around 10:00am on 1/27/25. -The BOM stated Staff A came into her office around 9:45am to report allegations.		

-Staff A told her what happened and what she witnessed 01/25/25. -After Staff A provided her statement on the morning of January 27, 2025, the Administrator sent her to BOM's office to document her statement. -Staff C reported the incident shortly after seeing Staff A in the office on the morning of 1/27/25. -She did a HCPR Investigation report (24/5) for Staff E and Staff F and submitted it to the Regional Vice President of Operations on 1/27/25 for review. -She faxed the initial HCPR report to HCPR on 1/28/25 but could not find the confirmation page. -The facility would not give out names or information until their investigation was completed. -Staff A said other staff were also throwing ice on Sunday 01/26/25 in the living room area. -Staff A told her Staff E and Staff F were throwing chunks of ice. - Staff A told her Staff E and Staff F were suspended as of 01/27/25. -Staff A told her she Resident #2 had ice thrown at her. - Staff A told her she did not remember any bruising on Resident #2. -She assessed the bruising on Resident #1. -Staff A told her, Staff B, and Staff C were in the shower area as this alleged abuse occurred -Staff C told her she stuck her head in to see what was going on and witnessed Staff E hitting Resident #1 in the head with the shower head. -Staff C told her She did not report the abuse because she was afraid of Staff E due to Staff E threatening her earlier in the week. -The doctor was called by RCC to get permission to send Resident #1 to the ED. -The doctor was not informed of Resident #1's alleged abused because she had to wait on getting approval from the corporate office. -The facility called the EMS at 2:13pm on 01/27/25. -Resident #1 was sent out for altered mental status and skin discoloration, not abuse, as corporate approval was needed to disclose any possibility of abuse. Interview with Administrator on 02/04/25 at 2:30pm revealed: -She did not have confirmation of sending the initial 24 hour/5-day investigation report to HCPR. -Staff A and Staff C reported the alleged abuse on the morning on 1/27/25.		

-She did not submit all six staff to HCPR who knew about the abuse. -She did not suspend Staff A and C while the investigation was going on because they reported the abuse on 1/27/25. -No staff reported the abuse immediately. -Staff did not notify anyone for 4 days to report the abuse. -She received a call on 02/3/25 from the Healthcare Personnel Registry (HCPR). -The Department Health Service Regulation wanted to confirm information for everyone who knew about the abuse was submitted to the HCPR. -She submitted a new HCPR 24 hours report on 02/04/25 around 3:30pm and added four more staff (Staff A, Staff B, Staff C, and Staff D). -The staff who knew of the alleged physical abuse were Staff A, Staff B, Staff C, Staff D. -The Staff who were throwing ice was Staff D and Staff F. -The Administrator confirmed on 1/27/25 AHS discussed all who had knowledge of the alleged abuse, had to be reported to the HCPR. Interview with the Administrator on 02/10/25 at 12:30pm revealed: -She was notified of the alleged abuse around 10:00am on 01/27/25. -She completed interviews with staff and two alleged abusers were reported to her during those interviews. -She called her corporate office for guidance. -She sent the report to HCPR on the afternoon of 01/28/25. -Staff E and Staff F were suspended and later terminated. -She thought the facility did not complete an incident report because an initial report was filled out. The facility failed to report Staff A, B, C, and Staff D to the Health Care Personnel Registry after discovering that they witnessed and participated in abusing Residents #1, #2, and #3 by throwing ice. This resulted in residents experiencing significant mental anguish and physical harm, which was not reported to the Administrator immediately. Furthermore, even after the incident was reported to the Administrator, no action was taken to notify the Health Care Personnel Registry about the staff members' involvement. This failure put all residents at substantial risk of physical abuse and serious harm and constitutes a Type A2 violation. A Plan of Protection in accordance with Licensure Rule 10A NCAC 13F .1205 Health Care Personnel Registry on 02/4/2025 was received for this violation.		

Facility Name: Wellington House Assisted Living

THE CORRECTION DATE FOR THE TYPE A2 VIOLATION WILL NOT EXCEED APRIL 19, 2025		

IV. Delivered Via:	Hand delivered	Date:	3/20/25
DSS Signature:	Geni Moore	Return to DSS By:	4/19/25

V. CAR Received by:	Administrator/Designee (print name): Lorraine Hensley	
	Signature: Lorraine Hensley	Date: 3/20/2025
	Title: Executive Director	

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.*			