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	HAL093010	A. BUILDING: _____ B. WING _____	C 07/08/2025

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D 000	Initial Comments The Adult Care Licensure Section and the Warren County Department of Social Services conducted a complaint investigation on 06/06/25; 06/09/25-06/11/25; 07/02/25 and 07/08/25 with an exit via telephone conference on 07/08/25. The complaint investigation was initiated on 05/13/25 by the Warren County Department of Social Services.	D 000		
D 080	10A NCAC 13F .0306 (a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (6) have a supply available in the facility at all times of bath soap, clean towels, washcloths, sheets, pillowcases, blankets, and additional covers such as a bedspread, comforter, or quilt for each resident to use; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure the residents had soap and paper towels available for use at all times. The findings are: 1. Observation of resident rooms in the Special Care Unit (SCU) on 06/06/25 between 12:45pm-1:02pm revealed:	D 080	An initial audit of paper towels, soap, dispensers will be completed by Director/Administrator. Additional supplies will be ordered from manufacter by Administrator/Director/Designess. Supplies will be installed as they arrive. An inservice will be completed with all staff regarding the proper use of dispensers. Ongoing weekly audits will be completed by Housekeeping Manager/Director/Administrator/Designee to ensure proper dispensing of supplies. The vendor representative will come quarterly to ensure dispensers are in place and working properly. Facility will maintain back up supply of dispensers.	7/25/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lyndsey Cheek, RN | TITLE: Clinical Director | (X6) DATE: 7/21/2025

Received on 08/04/25

Reviewed and Acknowledged Janet Thornburg 08/14/25

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D 080	Continued From page 1 -Room #1 did not have paper towels in the bathroom; three residents resided in the room. -Room #2 did not have paper towels in the bathroom; three residents resided in the room. -Rooms #4 and #5 shared a bathroom, and did not have paper towels; two residents resided in each room. -Room #6 did not have paper towels in the bathroom; two residents resided in the room. Observation of resident rooms in the SCU on 06/09/25 between 7:54am-8:30am revealed: -Room #1 did not have paper towels or hand towels in the bathroom; three residents resided in the room. -Rooms #4 and #5 shared a bathroom, and did not have paper towels or hand towels in the bathroom; two residents resided in each room. -Room #6 did not have paper towels; two residents resided in the room. -Rooms #7 and #8 shared a bathroom, and did not have paper towels or hand towels in the bathroom; two residents resided in each room. Interview with a resident, who resided in room #4, on 06/10/25 at 7:54am revealed: -She ran out of paper towels. -She did not know who to ask for paper towels. Interview with a resident, who resided in room #6, on 06/10/25 at 7:58am revealed: -If there was a towel in the bathroom she dried her hands on it, but if not, she used her dress. -She did not know who to ask for paper towels. Interview with a resident, who resided in room #7, on 06/09/25 at 8:12am revealed: -He did not always have paper towels in his bathroom. -He did not know where to get paper towels if he	D 080		

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ran out.
-He used his pants to dry his hands when he washed them.
-He had not thought about asking anyone for paper towels.

Interview with a resident, who resided in room #8, on 06/09/25 at 8:14am revealed:
-He did not know if he had paper towels in his bathroom or not.
-Sometimes there were paper towels and sometimes there were not.

Based on observations and interviews, the residents who resided in room #1 were not interviewable.

Based on observations and interviews, the residents who resided in room #2 were not interviewable.

Based on observations and interviews, the two residents who resided in room #5 were not interviewable.

2. Observation of resident rooms in the Assisted Living (AL) on 06/06/25 between 1:20pm-1:32pm revealed:
-Room #5 did not have any paper towels in the bathroom; three residents resided in the room.
-Room #6 did not have any paper towels in the bathroom; two resident resided in the room.
-Room #9 did not have any paper towels in the bathroom; two residents resided in the room.
-Room #33 and #34 did not have any paper towels in the bathroom; two residents resided in each room.

Interview with a resident, who resided in room #34, on 06/09/25 at 1:32pm revealed:

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-He did not have any paper towels in his room.
-He needed paper towels to dry his hands after washing them with water.
-He dried his hands on his pants.

Interview with a resident, who resided in room #5, on 06/09/25 at 8:15am revealed:
-They did not have paper towels in the bathroom.
-He went to the shower room and washed his hands.

Interview with a housekeeper on 06/11/25 at 7:57am revealed:
-There were 3 rolls of paper towels in the special care unit (SCU) storage room.
-He did not know when the next shipment of paper towels were to be delivered.
-No one had asked him for paper towels.
-He would place a roll of paper towels in the bathroom if a roll was needed.

Interview with a second housekeeper on 06/11/25 at 8:07am revealed:
-The Administrator ordered supplies every week, including paper towels.
-The paper towels should be delivered tomorrow, 06/12/25.

Interview with the Housekeeping Supervisor on 06/11/25 at 11:19am revealed:
-The housekeepers should check the bathrooms each day and ensure each bathroom had paper towels.
-She should be notified if there were no paper towels in the bathrooms and if more paper towels needed to be ordered.
-The Administrator ordered the paper towels; she did not know how often.

Interview with a representative for the facility's

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contracted supply company on 06/11/25 at 12:25pm revealed there was an order for rolled paper towels placed today, 06/11/25.

Interview with the SCU Coordinator (SCC) on 06/11/25 at 10:23am revealed:
-Housekeeping staff made sure the bathrooms were stocked with paper towels.
-Housekeeping staff made rounds in the afternoon to ensure paper towels were in each bathroom.
-She did not know there were bathrooms that did not have paper towels.

3. Observation of resident rooms in the Special Care Unit (SCU) on 06/06/25 between 12:45pm and 1:02pm revealed:
-Room #1 had an empty soap dispenser; three residents resided in the room.
-Room #4 and #5 shared a bathroom, and did not have any soap in the bathroom; two residents resided in each room.
-Room #6 did not have any soap in the bathroom; two residents resided in the room.

Observation of resident rooms in the SCU on 06/09/25 between 7:54am-8:30am revealed:
-Rooms #4 and #5, shared a bathroom, and did not have soap in the bathroom; two residents resided in each room.
-The first room on the left in the SCU did not have soap in the bathroom; two residents resided in the room.

Interview with a resident, who resided in room #4, on 06/10/25 at 7:54am revealed:
-She ran out of soap.
-She did not know who to ask for soap.

Interview with a resident who resided in the first

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room on the left in the SCU, on 06/09/25 at 8:21am revealed:
-He did not have soap in his bathroom.
-He washed his hands with "just water".

Based on observations and interviews, the residents who resided in room #1 were not interviewable.

Based on observations and interviews, the two residents who resided in room #5 were not interviewable.

4. Observation of resident rooms in the Assisted Living (AL) on 06/06/25 between 1:20pm-1:32pm revealed:
-Room #5 did not have any soap in the bathroom; three residents resided in the room.
-Room #9 did not have any soap in the bathroom; two residents resided in the room.
-Room #33 and #34 did not have any soap in the bathroom; two residents resided in each room.

Interview with a resident, who resided in room #34, on 06/06/25 at 1:32pm revealed:
-He did not have any soap in his room.
-He needed soap to wash his hands and to take a bath.

Interview with a resident, who resided in room #5, on 06/09/25 at 8:15am revealed:
-They did not have any soap in the bathroom.
-He went to the shower room and washed his hands.

Interview with a housekeeper on 06/11/25 at 7:57am revealed:
-The soap dispensers were not the correct dispensers to hold the bags of soap that were ordered.

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-The soap in the bags had been placed at the sinks in the bathroom, but not in the dispenser.
-The residents could pump the soap out of the bags.
-There was not enough soap to place in each bathroom.
-He did not know when the next shipment of soap was due to arrive.

Interview with a second housekeeper on 06/11/25 at 8:07am revealed:
-The Administrator ordered supplies every week, including soap.
-New hand soap dispensers had been ordered for the residents' bathrooms.
-He thought the new hand dispensers were ordered after the survey on 04/29/25.

Interview with the Housekeeping Supervisor on 06/11/25 at 11:19am revealed:
-The housekeepers should check the bathrooms each day and ensure each bathroom had soap.
-She knew the containers of soap did not fit in the current soap dispensers for two weeks when she became the Housekeeping Supervisor.
-She ordered the correct dispensers for the current containers of soap a week ago.
-There were 20 soap dispensers delivered today, 06/11/25, and 15 more dispensers would be delivered tomorrow, 06/12/25.
-There were 2 cases of containers of soap delivered today, 06/11/25, and she was expecting 7 more cases of soap tomorrow, 06/12/25.
-The containers of soap were placed at the sink of the each bathroom until the dispensers arrived and were installed.
-The residents could use the soap without it being in the dispenser; the pump was attached to the bag of soap.

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D 080	Continued From page 7 Interview with a representative for the facility's contracted supply company on 06/11/25 at 12:25pm revealed: -There were 20 soap dispensers ordered on 06/10/25 and delivered to the facility today, 06/11/25. -There was no order for soap, and no soap was delivered today. -There was no order scheduled for delivery tomorrow, 06/11/25. -The facility ordered 2 cases of soap in December 2024; each case contained 6 bags of soap. Interview with the SCU Coordinator (SCC) on 06/11/25 at 10:23am revealed: -Housekeeping staff made sure the bathrooms were stocked with soap. -Housekeeping staff made rounds in the afternoon to ensure soap was in each bathroom. -She did not know there were bathrooms that did not have soap. -She had boxes of soap in her office; because the containers of soap would disappear when it was stored in the supply storage room. _____ The facility failed to ensure residents had a supply of soap and paper towels, at all times, resulting in the residents not having soap to bathe or wash their hands after toileting and having to dry their hands off on their clothing. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on 06/11/25. THE CORRECTION DATE FOR THIS TYPE B	D 080		

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D 080	Continued From page 8 VIOLATION SHALL NOT EXCEED AUGUST 22, 2025.	D 080		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 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. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision according to the residents' assessed needs for 2 of 5 sampled residents (#1, #7) related to a resident (#1) who resided in the special care unit (SCU) and was sexually assaulted by another resident and a resident who resided in the Assisted Living (AL) who eloped from the facility and was found outside sitting on the ground (#7). The findings are: 1. Review of Resident #7's current FL-2 dated 05/24/24 revealed: -Diagnosis included dementia. -She was ambulatory. -The orientation section was blank.	D 270	2 hour rounds will be completed on all residents in AL and SCU. Staff completed 15 min checks for the first 72 hours following incident. Staff will be inserviced on SCU and AL staffing and need to be present on the floor the entire shift. Supervisors will complete ongoing/offgoing rounds with each other to report/monitor for any changes. Supervisors will audit 2 hour rounds Monday-Friday.	8/5/2025

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Review of Resident #7's care plan dated 02/05/25 revealed:
-The care plan was not signed by the Primary Care Provider (PCP).
-There were no performance codes documented for activities of daily living (ADL).
-She was oriented, but forgetful.
-She was ambulatory.

Review of Resident #7's ADL log dated 05/15/25 revealed:
-Resident #7 had safety checks every 2 hours.
-There was documentation that Resident #7 was checked on and was safe every two hours from 12:00am to 12:00pm.

Review of video footage from the facility's surveillance camera obtained on 07/02/25 and 07/08/25 revealed:
-The surveillance camera was on the outside of the facility facing the exit door of the dining room.
-The video footage was dated 05/15/25 at 4:23am; it was noted to be dark outside the facility.
-There was a stoop outside the back door that had 5 steps leading to the ground.
-At 4:23am, Resident #7 was observed standing on the stoop outside the dining hall exit door; she was holding the door open with one hand looking around.
-At 4:24am, she went back inside the facility; the door shut behind her but was slightly ajar.
-There was no video footage from 4:24am-4:27am.
-At 4:28am, Resident #7 was observed standing at the dining hall exit door, outside of the facility, with her pants around her thighs.
-At 4:30am, Resident #7 was twisting the door handle.
-At 4:32am, Resident #7's pants were around her

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ankles, and she twisted the doorknob.
-At 4:38am, Resident #7 was knocking on the exit door.
-At 4:37am, Resident #7 was knocking on the exit door of the facility while standing on the stoop with her pants down around her ankles.
-At 4:38am, Resident #7 was knocking on the exit door.
-From 4:41am to 4:43am, Resident #7 was knocking on the exit door.
-At 4:44am, Resident #7 was knocking on a window air conditioning unit to the right of the exit door.
-At 4:45am, Resident #7 was hitting her hand repeatedly on the wooden rail.
-At 4:46am, Resident #7 was trying to pull her pants up with one hand while holding onto the wooden rail with her other hand.
-At 4:48am, Resident #7's pants had not been pulled up.
-At 5:19am, Resident #7 was hitting the window air conditioning unit with her hand.
-At 5:28am, Resident #7 was standing at the top of the stoop; her pants were pulled up.
-It was noted to still be dark outside the facility.
-There was no video footage from 8:14am-9:42am.
-At 9:42am, Resident #7 was standing at the top of the stoop.
-It was noted to be light outside the facility.
-At 9:55am, Resident #7 was observed holding onto the handrails on the right side and slowly moving down the steps.
-At 10:08am, Resident #7 was observed standing at the bottom of the steps holding onto the handrail.
-At 10:40am, Resident #7 was observed on the left side of the bottom step; she was reaching behind her, trying to hold onto the railing.
-The exit door to the dining room was opened,

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and a contracted construction worker was working on the door handle at the top of the steps and within sight of Resident #7.
-There was no video footage from 10:42am-10:43am.
-At 10:43am, Resident #7 was lying on the ground beside the bottom of the steps.
-There was no video footage to show how Resident #7 ended up on the ground.
-At 10:59am, the contracted construction worker was working on the door handle, and Resident #7 was still lying on the ground at the bottom of the steps within sight of the door.
-At 11:02am, the contracted construction worker continued to work on the door handle.
-Resident #7 appeared to try to sit up but was unable to and laid back down.
-At 11:07am, the contracted construction worker looked at Resident #7 and returned inside the facility.
-At 11:14am, the Administrator, the Dietary Manager (DM), and the contracted construction worker exited the facility and observed Resident #7 lying on the ground.
-At 11:15am, the DM was standing over Resident #7, the Administrator and the contracted construction worker were standing at the top of the stoop, and the video footage ended.
-There was no video footage after 11:15am.

Review of Resident #7's incident report dated 05/15/25 revealed:
-The incident report was completed on 05/15/25 between 10:00am and 11:00am.
-The description of the incident was a contracted construction worker was working on the back door of the dining room and notified the DM that Resident #7 was outside.
-The Administrator was immediately notified and paged for the Resident Care Coordinator (RCC),

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to come to the back of the facility.
-The RCC, who was a Registered Nurse (RN) found Resident #7 lying at the bottom of the steps, with her upper body on the last step and her lower body on the ground.
-Resident #7 was fully clothed, but her clothes were wet and muddy because of the rain during the night.
-A physical assessment was performed on Resident #7 with no injuries noted.
-Resident #7 denied having pain.
-Resident #7 was assisted off the ground after several attempts.
-Resident #7 was taken inside and immediately received a shower by the personal care aide (PCA).
-No apparent injuries were noted to Resident #7 when a full body assessment was completed during the shower.
-Resident #7 was dressed and walked to her room with assistance from the staff.
-Resident #7 asked to go to bed.
-No further action required at that time.
-Staff would continue to closely monitor Resident #7 for any new complaints related to the incident.

Review of Resident #7's progress notes revealed:
-There was no documentation of the incident dated 05/15/25.
-There was no documentation that the Mental Health Provider (MHP) was notified of the incident.

Review of Resident #7's MHP triage note dated 05/15/25 revealed:
-The chief complaint was Resident #7 continued to refuse her medications.
-There was an order to discontinue all scheduled medications.
-There was no documentation that the MHP was

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notified of Resident #7 being found outside.

Interview with Resident #7's roommate on 06/11/25 at 11:26am revealed:
-About 2 weeks ago, she woke up at 4:00am and Resident #7 was not in her bed.
-She stayed awake until 5:00am, then she got up and got dressed; Resident #7 was not in her bed.
-She usually got up at 5:00am each morning and Resident #7 would be in her bed.
-Resident #7's bed was not messed up like she had slept in it that night.
-She did not know if Resident #7 was at breakfast that morning.

Interview with a PCA on 06/11/25 at 8:17am revealed:
-She worked third shift and was working the morning of 05/15/25.
-She made rounds every two hours.
-Resident #7 was in her bed all night.
-At 6:00am, she started getting residents up and dressed for breakfast.
-She got Resident #7 up and got her dressed for breakfast which was served between 7:00am-7:15am.
-She did not make Resident #7's bed; first shift made the beds.
-She heard about Resident #7 being outside.
-She got Resident #7 up that morning, but she did not come out of her room and did not come to breakfast.

Interview with a PCA on 06/10/25 at 2:12pm revealed:
-She was the only PCA on the AL the morning of 05/15/25.
-She was told Resident #7 had gotten out of the facility through the back door.
-She did not see Resident #7 at breakfast.

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-On her second rounds of the resident, she noticed Resident #7's bed was made and had not been slept in all night.
-She asked the Activity Director (AD) if Resident #7 was out of the facility while she assisted another resident.
-The AD was checking to see if Resident #7 was out of the facility.
-Resident #7 was found out back on the steps and the Administrator and the RCC were bringing her back into the facility while she finished helping another resident.
-The DM, who was also a PCA, assisted her with Resident #7's shower.
-She was not soiled of urine or bowels.
-Her pants were dirty from where she had been down on the ground.

Interview with the DM on 06/10/25 at 2:25pm revealed:
-She was cleaning the dining room after breakfast on 05/15/25, when the contracted construction worker came in the dining room and said there was a lady lying out back on the ground by the steps.
-She also worked as a PCA, so she approached Resident #7 to attempt to get her to come inside the facility.
-She got the Administrator and the RCC and told them Resident #7 was outside and lying on the ground.
-Resident #7's pants were soiled with urine which could be seen through her pants.
-Resident #7's clothes were dirty and muddy and she appeared cold and scared.
-She and a PCA showered Resident #7; during the shower Resident #7 was noted to have dried stool on her.
-No one interviewed her about what happened; she did not know if an incident report was

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D 270	Continued From page 15 completed or not. Interview with Resident #7's MHP on 06/11/25 at 11:06am revealed: -Resident #7 was always in her bed when she saw her. -Resident #7 did not speak with her; she attempted to use a language translator application to assist with communication but she was unsuccessful. -The staff did not tell her Resident #7 got out of the facility on 05/15/25 until that morning, 06/11/25, when she arrived at the facility. -The staff should have notified her that Resident #7 was found outside. -It was unacceptable that Resident #7 was outside of the facility; she could have been injured. -The staff should be making rounds at least every hour; if the staff did not see Resident #7, they should have looked for her. Interview with the Special Care Coordinator (SCC) on 06/11/25 at 10:23am revealed: -She heard a couple of days after the incident there was an electronic recording of Resident #7 being outside the back of the facility. -She was not able to access the electronic recording; she heard that a previous employee accessed the electronic recording and sent it to a representative at the local Department of Social Services (DSS). -She did not know how long Resident #7 was outside. -She returned from picking up lunch around 11:30am on 05/15/25, and was met at the door by the RCC stating Resident #7 was found outside. Interview with the RCC on 06/10/25 at 2:46pm revealed:	D 270		

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D 270	Continued From page 16 -She saw the DM running to the Administrator's office on 05/15/25. -The Administrator paged for all AL staff to report to the back of the dining room. -When she arrived, she saw Resident #7 lying on the ground with the upper part of her back lying on the bottom steps. -She was told a contracted construction worker saw her; he notified the DM who notified the Administrator. -She assessed her, and no injuries were identified. -It had rained the night before and Resident #7's back and backside were wet from the moisture on the ground. -Resident #7 was assisted up and she ambulated into the building. -The PCA gave her a shower and put her to bed. -Resident #7 was muddy and dirty, but her clothing was not soiled with urine or stool. -The PCA stated that when she got Resident #7 in the shower, she had dry stool on her buttocks. -Resident #7 did not smell as if she was soiled. -She did not know of any other time Resident #7 had gotten out of the facility. Interview with the Administrator on 06/10/25 at 4:07pm revealed: -The contracted construction worker came and got her and the RCC and told them there was a resident outside in the backyard. -The DM came out also. -Resident #7 was at the bottom of the steps, lying with her back on the steps. -The front of Resident #7's clothing was clean; she did not see the back side of her clothing. -She had feces on the side of her pants; there was no sign of urinary incontinence and no odor. -There was feces beside the steps where Resident #1 had a bowel movement.	D 270		

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D 270	Continued From page 17 -The RCC assessed Resident #7; there were no injuries noted. -The PCA showered Resident #7. -Resident #7 did not want to come back into the facility; she stated sun, sun. -It was between 9:30am to 10:00am when Resident #7 was brought into the facility. -She did not know how long Resident #7 had been outside. -The contracted construction worker was working on the alarm on the back door; he left the door propped open. -She did not know Resident #7 was not at breakfast. -If she was not at breakfast, the staff should have stopped and looked for Resident #7. -She did not know there was only one PCA on the floor that morning; the facility should have been fully staffed. Telephone interview with the Owner on 06/11/25 at 3:44pm revealed: -She was informed Resident #7 was found outside of the facility on 05/15/25. -A contracted construction worker was working on the alarms for the back door of the dining room and left the back door open. -Resident #7 went outside when the door was left open. -The contracted construction worker saw Resident #7 outside and reported it to the staff. -She had not seen an electronic recording of Resident #7 being outside. -She did not know an electronic recording of Resident #7 being outside existed. -She did not know the electronic recording showed Resident #7 outside from 4:28am to 10:45am on 05/15/25. -She was concerned that something could happen to Resident #7; she could get hurt.	D 270		

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D 270	Continued From page 18 Attempted interview with the contracted construction worker on 06/09/25 at 4:47pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable. 2. Review of the census log revealed the census in the SCU on 06/03/25 was 15. Review of Resident #1's current FL-2 dated 02/11/25 revealed: -Diagnoses included dementia, major neurocognitive disorder, hyperlipidemia, and pre-diabetes. -She was constantly disoriented. -She was ambulatory and wandered. Review of Resident #1's care plan dated 02/04/25 revealed: -Her diagnoses included major neurocognitive disorder, insomnia, seizure disorder, and dementia. -She was ambulatory. -She was always disoriented. -She had significant memory loss; she had to be directed. Observation of the SCU on 06/06/25 from 12:34pm-12:39pm revealed: -At 12:34pm, 10 residents were sitting in the television room. -There were no staff in the television room. -There was a personal care aide (PCA) in the hallway. -There was a second PCA who exited the SCU. -Resident #1 was in another female resident's room, sitting on the bed with her pants and her	D 270		

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adult incontinence brief pulled down to her ankles.
-The PCA was notified, and she entered the room to assist the resident.
-There were no other staff members present in the SCU.
-At 12:39pm, the second PCA returned to the SCU.

Observation of the SCU on 06/06/25 from 1:04pm-1:08pm revealed:
-There was one PCA in the SCU.
-A housekeeper was mopping the floors.
-Resident #1 was walking in the hallway.
-Resident #1 picked up the wet floor sign and continued walking down the hallway.
-When Resident #1 got to the exit door of the SCU, she dropped the sign, and it made a loud noise.
-Resident #1 could not be seen from the television room where the PCA was supervising the residents.
-The PCA did not come down the hallway to investigate the loud noise made when Resident #1 dropped the sign.
-Resident #1 continued to walk in the hallway, going in and out of other residents' rooms.
-At 1:08pm, the second PCA returned to the SCU.

Review of Resident #1's incident/accident report dated 06/03/25 revealed:
-The incident report was completed on 06/03/25 at 6:30pm.
-The description of the incident was a male resident was on top of Resident #1 with their clothes off.
-The question, do they need to be sent out for treatment, was checked no.
-There was no signature of the staff who completed this report.

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D 270	Continued From page 20 -The Administrator signed the report on 06/04/25. Review of Resident #1's progress notes dated 06/03/25 revealed: -The Administrator received a call from a facility staff member that a PCA had walked in on a male resident having sex with Resident #1. -The residents were separated, and the Administrator told the PCA to keep a close eye on the residents. Review of the service note sheet from Resident #1's court-appointed guardianship dated 06/03/25 at 9:18pm revealed: -The on-call guardian specialist received a telephone call from the facility's Administrator. -The Administrator provided information that Resident #1 was located in the bedroom of a male resident and was engaging in sexual activity. -She indicated the encounter appeared to be consensual; there was no indication of coercion or force by the male resident and Resident #1 was not traumatized by the encounter. -The Administrator informed the guardian that Resident #1 was redirected to her bedroom without incident and staff would perform bed checks every 15 minutes. -The Administrator wanted to inform the guardian, and she stated that she would complete an incident report and would also notify the facility's PCP. Interview with a PCA on 06/09/25 at 3:16pm revealed: -She worked the evening shift in the SCU on 06/03/25. -She was the only PCA in the SCU when the incident between Resident #1 and a male resident occurred; the other PCA and the MA had	D 270		

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left the floor.
-Resident #1 was in the television (TV) room, when she went into another resident's room to provide incontinence care.
-She heard a female voice yelling no, no, stop, stop; she recognized the voice as Resident #1.
-She opened the male resident's bedroom door and saw Resident #1 bent over the back of a chair and the male resident was behind Resident #1, both of their pants were down, and the male resident had penetrated Resident #1.
-She told the male resident to stop and the male resident replied no because they were having sex.
-She told the male resident that Resident #1 was saying stop and he replied it did not matter; Resident #1 was his.
-The male resident stepped away from Resident #1 and she removed Resident #1 from the male resident's room.
-She called for the medication aide (MA) on the AL side to come to the SCU, the AL MA told the SCU MA what happened, and the SCU MA called the Administrator.
-The Administrator called and asked her to write a report about the incident and what she saw.
-She told the SCU MA that she heard Resident #1 say no, no, stop, stop.
-She told the Administrator that the male resident sexually assaulted Resident #1.

Interview with the MA on 06/10/25 at 5:11pm revealed:
-She was the MA on second shift in the AL on 06/03/25.
-She could hear loud noise coming from the SCU.
-She was administering medications in the AL when the SCU PCA came out of the SCU hysterical and stated, "I am the only one back here" and stated she needed help.

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-She asked the SCU PCA why she was by herself in the SCU and the PCA told her another PCA was gone for 45 minutes.
-The PCA had separated them.
-The male resident was "off"; something seemed wrong with him.
-He was aggressive and he looked like he wanted to grab the staff.
-The staff tried to keep him in his bedroom, but he came out the door, and charged at the PCA aggressively, pinning her up against the door and hit her in the face.
-There was supposed to be three people in the SCU, but the MA and the other PCA had left the floor, leaving only one PCA in the SCU.

Interview with a second PCA on 06/10/25 at 5:34pm revealed:
-She was on her lunch break when the PCA, who found the male resident assaulting Resident #1, ran out to the AL to get someone.
-When she got to the SCU, the male resident was in his room; she did not see Resident #1.
-The MA said to close the male resident's bedroom door; the MA thought it may calm him down by being in his room.
-She and another PCA went to his room to close his door, to try and keep him calm.
-The male resident opened the door and ran toward them, pinned the other PCA up against his bedroom door and punched her in the face; this happened around 10:00pm.
-Someone called 911 after the PCA was hit in the face.
-When she asked the male resident what happened, he said yeah, he [expletive] her.
-When Emergency Medical Services (EMS) arrived, they questioned the male resident and he did not remember what happened.
-No one in management had asked her what

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happened or asked her to write a statement.

Interview with another SCU MA on 06/09/25 at 2:53pm and 4:16pm revealed:
-She was working in the SCU on 06/03/25 when the incident occurred between Resident #1 and the male resident, but she was not in the SCU at the time the incident occurred.
-She had stepped outside of the facility to get something out of her car.
-Two PCAs were working with her in the SCU the night the incident occurred.
-The AL MA came outside and told her she was needed in the SCU.
-Upon return to the SCU, the PCA told her Resident #1 was in the male resident's room.
-Resident #1 went in and out of other residents' rooms.
-"We were told we have to let her walk; we could not restrain her."
-The other PCA took more than a 15-minute break and that was when the incident occurred.
-The PCA told her she heard someone hollering stop, and saw the male resident, who did not have clothes on and was on top of Resident #1.
-She did not know if Resident #1 had clothes on or not.
-She was told Resident #1 was hypersexual.
-She was not aware of any other incidents with Resident #1 and sexual activity since she started working at the facility 5 months ago.
-Two named staff members told her to call law enforcement.
-When she called the Administrator to report the incident, she told her the PCA reported the male resident was trying to sexually assault Resident #1.
-The Administrator told her not to call law enforcement until she talked to Resident #1's guardian to see how the guardian wanted to

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handle the situation.
-The Administrator called her back and told her she had heard from the guardian and the guardian said Resident #1 had a history of this behavior and they did not want to press charges against the male resident.
-Resident #1 was not oriented and would not be able to decide to have sex.
-When EMS entered the facility for another resident, the EMS personnel were told about the incident with Resident #1 and that was how law enforcement got involved.

Interview with a third MA on 06/09/25 at 10:39am revealed:
-She did not work the evening of the incident between Resident #1 and a male resident.
-It was reported to her that the male resident had tried to get Resident #1 in his room one time prior to the incident on 06/03/25.
-Resident #1 needed assistance with everything.
-Resident #1 was not aware of her surroundings.
-She did not think Resident #1 was capable of making the decision to have sex.

Interview with the Mental Health Provider (MHP) on 06/11/25 at 10:53am revealed:
-The facility did not notify her regarding the incident dated 06/03/25 between Resident #1 and a male resident.
-Last night she was preparing for the facility visit today, when she read about the incident in Resident #1's notes.
-The SCC told her that morning that Resident #1 was found having sex with a male resident.
-That was not good; the staff should be monitoring the residents because it was a memory care unit.
-The SCC did not say whether the incident was consensual or not, but the residents had

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dementia and required supervision and needed redirecting.
-Resident #1's cognition was not great and it had declined; she could not make decisions for herself.
-Resident #1 should be checked on every 15 minutes or be within an eye's view of staff at all times.
-There was one previous incident months ago, where Resident #1 was found in a male resident's room with her pants down but there was no penetration.
-She told staff to monitor Resident #1 closely because of her cognitive decline.
-Resident #1 did not know what she was doing.

Telephone interview with a guardian on 06/09/25 at 8:46am revealed:
-He was the guardian on call on 06/03/25 when a call was received from the Administrator regarding Resident #1 having sex with a male resident.
-He was assured the incident was consensual and was not told it was a sexual assault.
-He asked the Administrator if Resident #1 needed to go to the hospital for a SANE exam (a kit used to gather and preserve physical evidence following an instance or allegation of sexual assault) and the Administrator said no it was consensual.
-He knew the resident resided in the SCU.
-He was not told the PCP wanted Resident #1 to be sent to the hospital to be evaluated.
-He only received one call from the facility staff regarding this incident.
-He told the Administrator to do 15-minute checks on Resident #1 after the incident occurred.
-Unless precautions were put in place, the resident could engage in sexual activity again.

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D 270	Continued From page 26 Telephone interview with the Special Care Coordinator (SCC) on 06/09/25 at 6:41pm revealed: -She received a telephone call from the Administrator about the incident on 06/03/25 involving Resident #1 and a male resident. -She wanted to know who Resident #1's legal guardian was and the Administrator said she would call the guardian and handle it. -She was told to start 15 minutes checks on the male resident on 06/04/25. Interview with the Administrator on 06/09/25 at 11:23am revealed: -She received a telephone call between 6:00pm and 6:10pm on 06/03/25 from the MA on the SCU saying that a male resident was on top of Resident #1 and their clothes were pulled down. -She did not ask the MA any questions about the incident. -She instructed the MA to separate the two residents, do an incident report and she would notify the on-call guardian for Resident #1. -She told the MA to put a chair in front of the male residents room and to watch him, and keep a close eye on Resident #1. -There should be two staff on the SCU at all times; three staff were scheduled and only one should be off the SCU at a time. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. _____ The facility failed to ensure supervision was provided according to the resident's assessed needs, for a resident (#7) who wandered out of the back door of the facility and was outside from 4:23am until after 11:14am. The resident was	D 270		

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D 270	Continued From page 27 found by staff with her clothing soiled with urine, feces, mud, and dirt. The facility's failure resulted in serious neglect to the resident, which constitutes a Type A1 Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 06/30/25. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 7, 2025.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure immediate response and intervention by staff in accordance with the facility's policies and procedures for 1 of 1 sampled resident (#1) who resided in the special care unit (SCU) and was allegedly sexually assaulted.	D 271	All facility policies/procedures are to be followed by all staff. An inservice/training will be held with all staff to review all policies. Administrator/ Director/Designee will complete the training.	8/15/2025

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D 271	Continued From page 28 The findings are: Review of the facility's undated Sexual Assault Prevention and Response Policy revealed: -Sexual assault was defined as any non-consensual sexual contact or behavior, including unwanted touching. -Consent was defined as a clear, voluntary, and informed agreement to participate in sexual activity. -Residents with cognitive impairments may not be able to legally consent. -Resident supervision and privacy protocols must be followed. -The staff must monitor interactions between residents. -Any suspected or confirmed incident must be reported immediately to the Administrator and the Department of Social Services (DSS) as required by law. -The Administrator or designee would coordinate with law enforcement and DSS to conduct a thorough investigation. -The resident would be provided with medical care, emotional support, and a safe environment during and after the investigation. Review of Resident #1's current FL-2 dated 02/11/25 revealed: -Diagnoses included dementia, major neurocognitive disorder, hyperlipidemia, and pre-diabetes. -She was constantly disoriented. -She was ambulatory and wandered. Review of Resident #1's care plan dated 02/04/25 revealed: -Diagnoses included major neurocognitive disorder, insomnia, seizure disorder, and	D 271		

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dementia.
-She was ambulatory.
-She was always disoriented.
-She had significant memory loss; she had to be directed.

Review of Resident #1's incident report dated 06/03/25 revealed:
-The incident report was completed on 06/03/25 at 6:30pm.
-The description of the incident was a male resident was on top of Resident #1 with their clothes off.
-The question of did they need to be sent out for treatment, was checked no.
-There was no signature of the staff who completed this report.
-The Administrator signed the report on 06/04/25.

Review of Resident #1's progress notes dated 06/03/25 revealed:
-The Administrator received a call from the facility staff member that a personal care aide (PCA) had walked in on a male resident having sex with Resident #1.
-The residents were separated, and the Administrator told the PCA to keep a close eye on the residents.
-The Administrator called Resident #1's on-call guardian and informed them of what was communicated to her from the staff.
-The guardian informed the Administrator to contact the primary care provider (PCP) and keep moving.

Review of the service note sheet from Resident #1's court-appointed guardianship program dated 06/03/25 at 9:18pm revealed:
-The on-call guardian specialist received a telephone call from the facility's Administrator.

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-The Administrator provided information that Resident #1 was located in the bedroom of a male resident and was engaging in sexual activity with the male resident.
-She indicated the encounter appeared to be consensual; there was no indication of coercion or force by the male resident and Resident #1 was not traumatized by the encounter.
-The Administrator wanted to inform the guardian, and she stated that she would complete an incident report and would also notify Resident #1's PCP.

Review of the telemedicine thread started at 11:08pm on 06/03/25 revealed:
-The complaint was Resident #1 was found in a male resident's room having sex.
-The guardian was contacted and did not want Resident #1 sent out.
-The reporting person was the Administrator.
-The mental health provider (MHP) responded by asking if Resident #1 was alert and oriented.
-There was no response documented from the Administrator.
-The MHP responded and recommended sending Resident #1 to the emergency department (ED); the guardian's refusal was noted.
-Orders received for laboratory testing include human immunodeficiency virus (HIV), syphilis, hepatitis B and C, chlamydia, and gonorrhea.

Telephone interview with Resident #1's PCP on 06/06/25 at 2:50pm revealed:
-She was not notified of the incident between Resident #1 and the male resident.
-She was concerned that the incident happened "days ago" and the resident was not evaluated by a medical professional/ED physician.
-The resident should have been evaluated.

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Interview with Resident #1's PCP on 06/10/25 at 9:38am revealed:
-She was informed by the Administrator that morning, 06/10/25, of the incident between Resident #1 and a male resident.
-The Administrator stated that had happened before between the two residents and the on-call guardian did not want Resident #1 sent to the ED.
-The Administrator gave her the impression it was consensual.
-She was not informed by the Administrator that Resident #1 was saying no, no, stop, stop during the encounter.
-Had she been told Resident #1 had said no, she would have called 911 and had the incident investigated as a rape.
-If guardianship had been granted for Resident #1, that meant the resident did not have the capacity to make decisions on her own.
-Resident #1 could have had a sexual assault kit done in the facility by the forensic department.

Interview with Resident #1's MHP on 06/11/25 at 10:53am revealed:
-The facility did not notify her regarding the incident dated 06/03/25 between Resident #1 and a male resident.
-Last night she was preparing for the facility visit today, 06/11/25, when she read about the incident in Resident #1's notes.
-The SCU Coordinator (SCC) told her that morning that Resident #1 was found having sex with a male resident.

Interview with the Administrator on 06/10/25 at 4:07pm revealed:
-She thought she was doing the right thing by listening to the guardian and not sending Resident #1 to the ED as requested.
-If a resident had been injured, she would have

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D 271	Continued From page 32 called 911. -She did not know what the facility's policy was for sexual abuse.	D 271		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the health care needs for 4 of 7 sampled residents (#1, #6, #7, and #8) related to a resident who was sexually assaulted and not sent to the hospital immediately for evaluation (#1), two residents whose toenails were long and jagged and were not referred to a podiatrist (#6, #8), and a resident who eloped from the facility with her whereabouts unknown for more than 5 hours and the primary care provider (PCP) was not notified (#7). The findings are: 1. Review of the facility's undated Sexual Assault Prevention and Response Policy revealed: -Sexual assault was defined as any non-consensual sexual contact or behavior, including unwanted touching. -Consent was defined as a clear, voluntary, and informed agreement to participate in sexual activity. -Residents with cognitive impairments might not	D 273	Provider has been made aware of all incidents. Staff are being inservices on using Telemedic to notify provider/on call around the clock. We will implement a communication log of all notifications. RCC/Director/Administrator/Designee will review logs and bring them to daily stand up meetings (M-F) and Manager on Duty will notify on weekends. A podiatry audit will be completed on all residents. Any residents not currently on service will be offered services.	8/5/2025

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be able to legally consent.
-Resident supervision and privacy protocols must be followed.
-The staff must monitor interactions between residents.
-Any suspected or confirmed incident must be reported immediately to the Administrator and the Department of Social Services (DSS) as required by law.
-The Administrator or designee will coordinate with law enforcement and DSS to conduct a thorough investigation.
-The resident will be provided with medical care, emotional support, and a safe environment during and after the investigation.

Review of Resident #1's current FL-2 dated 02/11/25 revealed:
-Diagnoses included dementia, major neurocognitive disorder, hyperlipidemia, and pre-diabetes.
-She was constantly disoriented.
-She was ambulatory and wandered.

Review of Resident #1's care plan dated 02/04/25 revealed:
-Diagnoses included major neurocognitive disorder, insomnia, seizure disorder, and dementia.
-She was ambulatory.
-She was always disoriented.
-She had significant memory loss; she had to be directed.

Review of Resident #1's incident/accident report dated 06/03/25 revealed:
-The incident report was completed on 06/03/25 at 6:30pm.
-The description of the incident was a male resident was on top of Resident #1 with their

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clothes off.
-The question of did the resident need to be sent out for treatment, was checked no.
-There was no signature of the staff who completed this report.
-The Administrator signed the report on 06/04/25.

Review of Resident #1's progress notes dated 06/03/25 revealed:
-The Administrator received a call from a facility staff member that a personal care aide (PCA) had walked in on a male resident having sex with Resident #1.
-The residents were separated, and the Administrator informed the PCA to keep a close eye on the residents.
-The Administrator called Resident #1's on-call guardian and informed them of what was communicated to her from the staff.
-The guardian stated he did not want the resident sent to the emergency department (ED) because this had happened a lot in other facilities and he was sure this would happen again.
-The guardian informed the Administrator to contact the primary care provider (PCP) and keep moving.
-The on-call PCP was contacted by telemed, and orders were received for labs to be drawn.

Review of the service note sheet from Resident #1's court-appointed guardianship program dated 06/03/25 at 9:18pm revealed:
-The on-call guardian specialist received a telephone call from the facility's Administrator.
-The Administrator provided information that Resident #1 was located in the bedroom of a male resident and was engaging in sexual activity.
-She indicated the encounter appeared to be consensual; there was no indication of coercion

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or force by the male resident and Resident #1 was not traumatized by the encounter.
-The Administrator informed the guardian that Resident #1 was redirected to her bedroom without incident and staff would perform bed checks every 15 minutes.
-The Administrator wanted to inform the guardian, and she stated that she would complete an incident report and would also notify the facility's PCP.

Review of the telemedicine thread started at 11:08pm on 06/03/25 revealed:
-The complaint was Resident #1 was found in a male resident's room having sex with the male resident.
-The guardian was contacted and did not want Resident #1 sent out.
-The reporting person was the Administrator.
-The mental health provider (MHP) responded with the question if Resident #1 was alert and oriented.
-There was no response documented from the Administrator.
-The MHP responded and recommended sending Resident #1 to the ED; the guardian's refusal was noted.
-Orders were received for laboratory testing, including human immunodeficiency virus (HIV), syphilis, hepatitis B and C, chlamydia, and gonorrhea.

Review of the local law enforcement investigation report dated 06/03/25 at 9:53pm revealed:
-The law enforcement officer responded to a call at the facility for a male resident in the special care unit (SCU) with an altered mental status who was holding people down and punching them.
-Emergency Medical Services (EMS) were already on the scene speaking with the male

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resident.
-The law enforcement officer spoke with a PCA who stated the male resident sexually assaulted Resident #1 earlier in the evening, around 6:00pm.
-The PCA stated she contacted the Administrator about the sexual assault and was told not to call law enforcement.
-The PCA stated she went to check on the male resident and saw the male resident with his pants down; he had pulled Resident #1's pants down and was penetrating Resident #1.
-The PCA stated Resident #1 was saying stop.
-The PCA advised the male resident that he was not supposed to be doing that and the male resident responded he did not care what she thought.
-The law enforcement officer attempted to interview Resident #1 with a staff member.
-The law enforcement officer asked Resident #1 a few basic questions and Resident #1 would say hey and no.
-The staff member said Resident #1 was always like this and did not say much.
-The law enforcement officer contacted the on-call adult protective services (APS) worker and advised the APS worker of the situation.
-The law enforcement officer was informed by the APS worker that it was a law enforcement issue, but she would take the report.
-EMS advised the law enforcement officer that they had gotten in contact with the Administrator, and the Administrator had spoken to the PCP, and the PCP replied not to call law enforcement because Resident #1 had a history of having sex with other residents.

Review of the local law enforcement officer's supervisor's investigation report dated 06/03/25 at 10:45pm revealed:

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-He spoke with the PCA who witnessed the rape at the facility on the evening of 06/03/25.
-The PCA stated that she heard someone saying no, no, no, from inside a male resident's room.
-The PCA entered the male resident's room and observed Resident #1 bent over the bed with her pants down and the male resident engaged in sex with her.
-The PCA stated she asked the male resident what they were doing, and he replied having sex.
-The PCA stated she told the male resident that was not what that was, and the male resident responded he did not care what she thought.
-The PCA assisted with getting Resident #1's pants pulled up and walked her back to her room.
-When she returned to the television room, where the male resident was sitting, she overheard the male resident tell another female resident she was next [expletive].
-The on-call law enforcement investigator was notified.
-He was informed by the local law enforcement officer that he had notified the on-call Department of Social Services (DSS) APS worker.
-The local law enforcement officer stated he attempted to speak to Resident #1 who was unable to make any statements.
-The local law enforcement officer stated the EMS personnel on scene had made contact with the Administrator who made contact with Resident #1's PCP and was advised not to contact law enforcement due to Resident #1's previous history of hypersexuality.

Telephone interview with the responding local law enforcement officer on 06/11/25 at 5:35pm revealed:
-He received a call related to a resident having mental health issues at the facility.
-He arrived at the facility and was met by a

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medication aide (MA) who told him there had been a sexual assault at the facility.
-He spoke with the PCA who witnessed the alleged sexual assault and was informed that the PCA notified the Administrator of the incident after it occurred and she was instructed by the Administrator not to call the law enforcement.
-He was informed by the PCA the alleged sexual assault occurred 2 hours prior to this call, which was for the mental health crisis and not the alleged sexual assault .

Telephone interview with the law enforcement investigator on 06/11/25 at 1:10pm revealed:
-He believed the incident between Resident #1 and a male resident was handled inappropriately.
-The staff did not call law enforcement and Resident #1 was not sent out for medical treatment.
-The PCA witnessed the sexual intercourse and heard Resident #1 yelling no, no, no, stop, stop.
-The PCA removed Resident #1 from the male resident's room and called the Administrator.
-It was reported to him that the sexual assault was not reported because the Administrator advised the staff not to report it to the local law enforcement.
-On 06/04/25, he went to the facility to speak to the Administrator.
-The Administrator told him the PCP instructed her not to report the incident and to have the male resident removed from the facility today, 06/04/25.
-The Administrator stated the sexual encounter was consensual and that she was not informed that Resident #1 was yelling no, no, stop, stop.

Interview with a SCU PCA on 06/09/25 at 10:25am revealed:
-She was not working when the incident occurred

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between Resident #1 and the male resident.
-She did not think Resident #1 was capable of deciding to have consensual sex because the resident was "completely out of it."
-Resident #1 did not even know when her food was in front of her.
-Resident #1 had to be directed for everything.

Interview with a second SCU PCA on 06/09/25 at 3:16pm revealed:
-She was the only staff member in the SCU when the incident occurred between Resident #1 and the male resident.
-She had seen Resident #1 in the hallway and was going into the television room.
-She took another resident to their room and Resident #1 must have come out of the television room and gone into the male resident's room.
-She heard Resident #1 saying, "No, no, stop, stop".
-When she entered the male resident's room, Resident #1 was leaning over a chair with her pants down, and the male resident was behind her having sex with her.
-She told the male resident to stop and that Resident #1 said "no" and the male resident said it did not matter, she was his.
-She took Resident #1 and left the male resident's room.
-She went to the assisted living (AL) side of the facility and got the MA, who then went and got the SCU MA.
-She told the SCU MA she heard Resident #1 say, "No, no, stop, stop."
-The SCU MA said she was going to call the Administrator.
-The SCU MA told her to "write up" the incident.
-She wrote that Resident #1 was heard saying no, no, stop, stop.
-The Administrator asked her to write up a

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"different statement" and she refused because she had written one statement and the Administrator did not like what she had written.

Interview with a third SCU PCA on 06/10/25 at 5:45pm revealed:
-She heard the male resident say he [expletive] Resident #1.
-She saw the male resident punch the other SCU PCA in the face.
-When EMS arrived, the male resident did not know what happened.
-She went on break around 7:30pm and thought the incident happened then.
-EMS was called around 9:00pm.
-Nobody had interviewed her about the incident, and no one had asked her to write a statement about the sexual assault.

Interview with a SCU MA on 06/09/25 at 10:39am revealed:
-She had heard about the incident between Resident #1 and the male resident.
-Resident #1 needed assistance with everything.
-Resident #1 did not know what was going on.
-If someone asked Resident #1 if she wanted to have sex, she would not even understand the question.

Interview with another SCU MA on 06/09/25 at 2:53pm and 4:16pm revealed:
-She was working in the SCU on 06/03/25 when the incident occurred between Resident #1 and the male resident, but she was not in the SCU at the time the incident occurred.
-She had stepped outside of the facility to get something out of her car.
-Two PCAs were working with her in the SCU the night the incident occurred.
-The AL MA came outside and told her she was

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needed in the SCU.
-Upon return to the SCU, the PCA told her Resident #1 was in the male resident's room.
-Resident #1 went in and out of other residents' rooms.
-"We were told we have to let her walk; we could not restrain her."
-The other PCA took more than a 15-minute break and that was when the incident occurred.
-The PCA told her she heard someone hollering stop, and saw the male resident, who did not have clothes on and was on top of Resident #1.
-She did not know if Resident #1 had clothes on or not.
-She was told Resident #1 was hypersexual.
-She was not aware of any other incidents with Resident #1 and sexual activity since she started working at the facility 5 months ago.
-Two named staff members told her to call law enforcement.
-When she called the Administrator to report the incident, she told her the PCA reported the male resident was trying to sexually assault Resident #1.
-The Administrator told her not to call law enforcement until she talked to Resident #1's guardian to see how the guardian wanted to handle the situation.
-The Administrator called her back and told her she had heard from the guardian and the guardian said Resident #1 had a history of this behavior and they did not want to press charges against the male resident.
-Resident #1 was not oriented and would not be able to decide to have sex.
-When EMS entered the facility for another resident, the EMS personnel were told about the incident with Resident #1 and that was how law enforcement got involved.

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D 273	Continued From page 42 Interview with the AL MA on 06/10/25 at 5:11pm revealed: -She was the MA on the second shift in the AL on 06/03/25. -She could hear noise coming from the SCU. -She was administering medications in the AL when the SCU PCA came out of the SCU hysterical and stated, "I am the only one back here" and stated she needed help. -The PCA stated that a male resident was on top of Resident #1 and she thought he was sexually assaulting her. -The SCU PCA told her she was in a resident's room changing the resident when she heard moaning. -When she went to check, she saw a male resident on top of Resident #1, and he was sexually assaulting her. -She asked the SCU PCA why she was by herself in the SCU and the PCA told her another PCA was gone for 45 minutes. -She heard the PCA tell the Administrator who was on the telephone exactly what happened, that she thought the male resident was sexually assaulting Resident #1; the PCA was crying. -She asked the Administrator what she wanted her to do, and the Administrator said "Do not call the police" but call EMS on the male resident because of a change in his mental status. -She did not agree with the Administrator about not calling law enforcement because the resident had dementia and she could have been sexually assaulted because of how aggressively the male resident was acting after the incident. -When EMS arrived, law enforcement was with EMS. -It just did not "sit right" with her for the guardian to be okay with this happening to Resident #1. -The PCA called the Administrator and told her that the male resident had punched her in the	D 273		

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face.
-The Administrator said to call EMS and report a resident with a mental health change but not to call 911.
-She did not agree with the decision not to call 911.
-The Activities Director (AD) called and said to call 911 about the suspected sexual assault and not to bathe Resident #1.
-When EMS arrived for the male resident, she told them about Resident #1 being sexual assaulted.
-The Administrator called and wanted to know why she called law enforcement; she told the Administrator she did not call law enforcement.
-The Administrator stated that law enforcement did not need to be called because this was Resident #1's normal behavior.
-She was not aware of Resident #1 having any inappropriate sexual behaviors.
-She did not think Resident #1 had the mental capacity to consent to sexual activity.
-She did not know why anyone would be ok with this incident knowing Resident #1 was sexual assault .
-The Administrator was informed of Resident #1 saying no and stop during the sexual act, and that Resident #1 was sexually assaulted.

Telephone interview with a guardian on 06/09/25 at 8:46am revealed:
-He was the guardian on call on 06/03/25 when a call was received from the Administrator regarding Resident #1 having sex with a male resident.
-He was assured the incident was consensual and was not told it was a sexual assault.
-He asked the Administrator if Resident #1 needed to go to the hospital for a SANE exam (a kit used to gather and preserve physical evidence

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D 273	Continued From page 44 following an instance or allegation of sexual assault) and the Administrator said no it was consensual. -He knew the resident resided in the SCU. -He was not told the PCP wanted Resident #1 to be sent to the hospital to be evaluated. -He only received one call from the facility staff regarding this incident. Telephone interview with Resident #1's court-appointed guardian on 06/09/25 at 12:03pm revealed: -He saw Resident #1 in May 2025. -Resident #1 slept most of the time he was there; she walked around in the hallways. -Resident #1 did not respond to questions when spoken to. -He received an email from the on-call guardian representative about the incident on 06/03/25. -The email stated there was sexual activity between Resident #1 and a male resident and the sex was consensual. -He did not think Resident #1 was able to consent to sex based on her cognitive ability and her diagnosis. -Had he received the call, he would have sent Resident #1 to the ED for evaluation. -He was not aware of Resident #1 having any hypersexual behaviors. -As Resident #1's guardian he should be made aware if Resident #1 had any hypersexual behaviors. Telephone interview with Resident #1's guardians' supervisor on 06/10/25 at 12:37pm and 3:42pm revealed: -The facility should have sent Resident #1 out for evaluation. -She would have had Resident #1 sent out for evaluation.	D 273		

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-The Administrator spoke to the on-call guardian representative they would not have sent Resident #1 out.
-She or the court-appointed guardian should have been contacted.
-She was not aware of Resident #1's hypersexuality.
-A resident who resided in the SCU, who was incompetent and had a court-appointed legal guardian did not have the ability to consent to sexual intercourse.
-This situation was not handled properly.
-Resident #1 should have been sent to the ED for medical treatment.
-She requested that Resident #1 be sent to the ED for evaluation that day, 06/10/25, since Resident #1 had not received medical attention since the sexual assault on 06/03/25.

Review of Resident #1's hospital ED summary dated 06/10/25 reveal:
-Resident #1 was seen for sexual assault.
-Resident #1 was tested for sexually transmitted disease (STD).
-Resident #1 was to repeat the test for STDs in one month.
-Resident #1 was ordered two medications to treat STDs prophylactically.

Telephone interview with the Special Care Coordinator (SCC) on 06/09/25 at 6:41pm revealed:
-She received a telephone call from the Administrator about the incident involving Resident #1 and a male resident.
-The Administrator wanted to know who Resident #1's legal guardian was and said she would call the guardian and handle it.
-She spoke with the MA and told her not to bathe Resident #1 and to call EMS to transfer her to the

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hospital.
-The Administrator called her back after speaking to the on-call guardian representative and she was informed that the on-call guardian representative did not want Resident #1 sent to the hospital because she was frisky.
-She did not know if Resident #1 had been seen by the PCP or the MHP since the incident.

Interview with the AD on 06/10/25 at 3:11pm revealed:
-She received a voice message from the SCC on 06/03/25 at 5:58pm; she returned the call around 7:30pm.
-The SCC stated she had been notified that a male resident had sexual assaulted Resident #1.
-The SCC stated she could not get anyone to answer the phone at the facility and wanted to know what the SCC needed to do.
-She and the SCC made a three-way call to the MA who gave her phone to the PCA.
-The PCA stated when she was doing rounds, she saw Resident #1 in the male resident's room, and Resident #1 was saying no, help, or something, and the male resident stated it was just sex.
-She and the SCC both told the PCA to not wash or change Resident #1 and to call 911.
-She did not know what happened after that.
-She did not know of any other incidents between Resident #1 and this male resident or any other male resident.
-Resident #1 walked the halls or was sleeping on her bed.
-She had not heard of any other incidents with Resident #1 and sexual activity.

Interview with the Area Clinical Director on 06/09/25 at 11:08am revealed:
-She learned of the incident between Resident #1

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and the male resident yesterday, 06/08/25.
-She was told Resident #1, and the male resident had done "this" in the past and was told by the guardian to not send Resident #1 out to be evaluated.
-She did not think two residents in the SCU could consent to have sex.
-If a resident was saying stop, it would be considered against the resident's consent.
-If the guardian said to not send the resident out, the staff could have strongly encouraged the guardian to have the resident to be sent out.
-If the guardian said to not send the resident out, they would have violated the guardian's right if they went against him and sent her out.

Second interview with the Area Clinical Director on 06/09/25 at 4:04pm revealed:
-She had "learned a lot since we talked to you this morning".
-The PCA viewed the incident as sexual assault and that was how she reported it and the Administrator encouraged the PCA to not report it.
-The PCA was encouraged for "that to not be her story".
-She was concerned staff were encouraged by the Administrator to not do the appropriate thing.

Interview with the Administrator on 06/09/25 at 11:23am revealed:
-When she got home on 06/03/25 at about 6:10pm, she received a telephone call from a MA.
-The MA told her the PCA said a male resident was on top of Resident #1, and she asked if the two residents had been separated, and the MA stated yes.
-She told the MA to do an incident report.
-She did not talk to the PCA "at this point."
-She told the MA she could call her back.

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-She talked to an on-call guardian about the incident.
-The on-call guardian told her with his experience with this type of activity; it would probably happen again and was not forceful sexual assault.
-She thought it was consensual because no one told her anything about screaming or anything.
-The on-call guardian told her Resident #1 had a diagnosis of hypersexuality and this had happened before.
-The first time she was made aware of Resident #1 saying no, was the next day, 06/04/25, when the law enforcement detective told her about his interview with the PCA.
-She asked all the staff that were working on 06/03/25 to write a statement about what happened.
-She wanted to send Resident #1 to the hospital, but the guardian had said no.
-The police officer requested the guardian's number and said he would call the guardian.
-She notified the PCP through the telemedicine system (an electronic communication system).
-The next day, 06/04/25, she told the PCP what had happened, and the PCP said it sounded like she followed protocol.
-She did not contact the guardian or the PCP after being told the incident may have not been consensual.
-She thought Resident #1 could make decisions on what she wanted to do.
-She stated because of Resident #1's dementia, she could not make a decision.
-She thought Resident #1's PCP saw her on 06/04/25.
-She knew the on-call PCP through telemedicine wanted Resident #1 sent to the hospital to be evaluated, but the guardian said he did not want her sent to the hospital.
-She thought the on-call PCP called Resident

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#1's guardian too because of the way it was documented.
-Other than asking staff to write up a statement about what happened, she had not done any further investigation or reporting related to this incident.
-She had not been told anything that she heard from the law enforcement detective before the detective told her about his interviews with staff.
-When she asked the PCA why she was telling the detective one thing and her another thing, the PCA walked off.
-The staff members never provided her with a statement that the resident was heard saying no, so she did not do anything.

Interview with the Administrator on 06/10/25 at 4:07pm revealed:
-She did not know if the PCP saw Resident #1 last week after the incident.
-The MHP saw Resident #1 last week on 06/04/25.
-She thought she was doing the right thing by listening to the guardian and not sending Resident #1 to the ED as requested.
-The word rape or sexual assault was never mentioned to her when she was notified on 06/03/25 about the incident.
-The first time she heard the words rape or sexual assault was from the law enforcement investigator that was in the facility on Wednesday morning, 06/04/25.
-If a resident had been injured, she would have called 911.
-She did not know what the facility's policy was for sexual abuse.
-Her telephone call to the on-call guardian on 06/03/25, was after she had talked to the SCU MA.

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D 273	Continued From page 50 Telephone interview with Resident #1's PCP on 06/06/25 at 2:50pm revealed: -She was not notified of the incident between Resident #1 and the male resident. -She had not been told Resident #1 had been showing signs of being hypersexual. -She was concerned the incident happened "days ago" and the resident was not evaluated. -The resident should have been evaluated right after the incident happened. -She did not know if the guardian refused to let the resident be sent to the hospital what could have been done, but she would have contacted law enforcement. -She thought law enforcement could at least have done a test kit at the facility on the resident to see if sexual assault occurred. Interview with Resident #1's PCP on 06/10/25 at 9:38am revealed: -She was informed by the Administrator today, 06/10/25, of the incident between Resident #1 and a male resident. -The Administrator stated this had happened before between these two residents and the on-call guardian representative did not want Resident #1 sent to the ED. -She was told there were two other incidents with Resident #1 and the same male resident. -She did not know one of the previous incidents with Resident #1 was with a different male resident. -The Administrator gave her the impression it was consensual. -She was not informed by the Administrator that Resident #1 was saying no, no, stop, stop. -Had she been told Resident #1 had said no, she would have called 911 and had the incident investigated as a sexual assault . -If guardianship had been granted for Resident	D 273		

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#1, that meant the resident did not have the capacity to make decisions on her own.
-Resident #1 could have had a sexual assault kit done in the facility by the forensic department.
-Resident #1 could have been dry and intercourse would be painful, causing friction and could cause an injury internally or externally.
-She was concerned that the incident happened on 06/03/25 and there had been no assessment of Resident #1 as of today, 06/10/25.
-She would refer Resident #1 for a gynecological evaluation.

Interview with Resident #1's MHP on 06/11/25 at 10:53am revealed:
-The facility did not notify her regarding the incident dated 06/03/25 between Resident #1 and a male resident.
-Last night she was preparing for the facility visit today, 06/11/25, when she read about the incident in Resident #1's notes.
-The SCC told her that morning that Resident #1 was found having sex with a male resident.
-The SCC did not say whether the incident was consensual or not, but the residents had dementia and required supervision.
-The residents had cognitive impairment and needed redirecting.
-Resident #1 could not consent to sexual activity.
-Resident #1 could not understand a question asked of her.
-Resident #1's cognition was not great, and it had declined.
-When she spoke to the SCC that morning, 06/11/25, she was not told that Resident #1 was sexual assaulted or that Resident #1 was saying no, no, stop, stop.
-If the guardian did not want Resident #1 sent to the hospital, Resident #1 could have been assessed at the facility.

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D 273	Continued From page 52 -She thought Resident #1 should have been sent out for medical treatment. -She told staff to monitor Resident #1 closely because of her cognitive decline. -She expected to be notified with incidents involving Resident #1. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. 2. Review of Resident #7's current FL-2 dated 05/24/24 revealed: -Diagnoses included dementia. -She was ambulatory. -The orientation section was blank. Review of Resident #7's care plan dated 02/05/25 revealed: -The care plan was not signed by the Primary Care Provider (PCP). -There were no performance codes documented for activities of daily living (ADL). -She was oriented, but forgetful. -She was ambulatory. Review of Resident #7's ADL log dated 05/15/25 revealed: -Resident #7 had safety checks every 2 hours. -There was documentation that Resident #2 was checked on and was safe every two hours from 12:00am to 12:00pm. Review of video footage from the facility's surveillance camera obtained on 07/02/25 revealed: -The surveillance camera was on the outside of the facility facing the exit door of the dining room. -The video footage was dated 05/15/25 at 4:29am.	D 273		

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D 273	Continued From page 53 -There was a stoop outside the back door that had 5 steps leading to the ground. -At 4:29am, Resident #7 was observed standing at the dining hall exit door, outside of the facility, with her pants around her thighs. -It was noted to be dark outside the facility. -At 4:32am, Resident #7's pants were around her ankles, and she twisted the doorknob. -At 4:37am, Resident #7 was knocking on the exit door of the facility while standing on the stoop with her pants down around her ankles. -At 4:44am, Resident #7 was knocking on a window air conditioning unit to the right of the exit door. -At 4:45am, Resident #7 was hitting her hand repeatedly on the wooden rail. -At 4:46am, Resident #7 was trying to pull her pants up with one hand while holding onto the wooden rail with her other hand. -At 4:48am, Resident #7's pants had not been pulled up. -At 5:19am, Resident #7 was hitting the window air conditioning unit with her hand. -At 5:28am, Resident #7 was standing at the top of the stoop; her pants were pulled up. -It was noted to still be dark outside the facility. -There was no video footage from 5:31am-9:42am. -At 9:42am, Resident #7 was standing at the top of the stoop. -It was noted to be light outside the facility. -At 9:55am, Resident #7 was observed holding onto the handrails on the right side and slowly moving down the steps. -At 10:08am, Resident #7 was observed standing at the bottom of the steps holding onto the handrail. -At 10:40am, Resident #7 was observed on the left side of the bottom step; She was reaching behind her, trying to hold onto the railing.	D 273		

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-The exit door to the dining room was opened, and a contracted construction worker was working on the door handle at the top of the steps and within sight of Resident #7.
-At 10:43am, Resident #7 was lying on the ground beside the bottom of the steps.
-There was no video footage to show how Resident #7 ended up on the ground.
-At 10:59am, the contracted construction worker was working on the door handle, and Resident #7 was still lying on the ground at the bottom of the steps within sight of the door.
-At 11:02am, the contracted construction worker continued to work on the door handle.
-Resident #7 appeared to try to sit up but was unable to and laid back down.
-At 11:07am, the contracted construction worker looked at Resident #7 and returned inside the facility.
-At 11:14am, the Administrator, the Dietary Manager (DM), and the contracted construction worker exited the facility and observed Resident #7 lying on the ground.
-At 11:15am, the DM was standing over Resident #7, the Administrator and the contracted construction worker were standing at the top of the stoop, and the video footage ended.

Review of Resident #7's incident report dated 05/15/25 revealed:
-The incident report was completed on 05/15/25 between 10:00am and 11:00am.
-The description of the incident was that a contracted construction worker was working on the back door of the dining room and notified the DM that Resident #7 was outside.
-The Administrator was immediately notified and paged for the Resident Care Coordinator (RCC), to come to the back of the facility.
-The RCC, who was a Registered Nurse (RN)

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found Resident #7 lying at the bottom of the steps, with her upper body on the last step and her lower body on the ground.
-Resident #7 was fully clothed but her clothes were wet and muddy because of the rain during the night.
-A physical assessment was performed on Resident #7 with no injuries noted.
-Resident #7 denied having pain.
-Resident #7 was assisted off the ground after several attempts.
-Resident #7 was taken inside and immediately received a shower from the personal care aide (PCA).
-No apparent injuries were noted to Resident #7 when a full body assessment was completed during the shower.
-Resident #7 was dressed and walked to her room with assistance from the staff.
-Resident #7 asked to go to bed.
-No further action was required at that time.
-Staff would continue to closely monitor Resident #7 for any new complaints related to the incident.

Review of Resident #7's progress notes revealed:
-There was no documentation of the incident/accident dated 05/15/25.
-There was no documentation that the Mental Health Provider (MHP) was notified of the incident.

Review of Resident #7's MHP triage note dated 05/15/25 revealed:
-The chief complaint was Resident #7 continued to refuse her medications.
-There was an order to discontinue all scheduled medications.
-There was no documentation that the MHP was notified of Resident #7 being found outside.

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D 273	Continued From page 56 Interview with Resident #7's MHP on 06/11/25 at 11:06am revealed: -The staff did not tell her Resident #7 eloped from the facility on 05/15/25, until that morning, 06/11/25, when she arrived at the facility. -The staff should have notified her that Resident #7 was found outside. -It was unacceptable that Resident #7 was outside of the facility. -The staff should be making rounds at least every hour; if the staff did not see Resident #7, they should look for her. Interview with the RCC on 06/10/25 at 2:46pm revealed: -She saw the DM running to the Administrator's office. -The Administrator paged for all assisted living (AL) staff to report to the back of the dining room (DR). -When she arrived, she saw Resident #7 lying on the ground with the upper part of her back lying on the bottom steps. -A contracted construction worker saw Resident #7; he notified the DM who notified the Administrator. -She assessed Resident #7, and no injuries were identified. -She attempted to reach the MHP by telephone but was unsuccessful. -She asked the medication aide (MA) to try to call the MHP since she had not been able to speak to the MHP. Interview with the Administrator on 06/10/25 at 4:07pm revealed: -The contracted construction worker came and got her and the RCC and told them there was a resident outside in the backyard. -The DM came out also.	D 273		

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-Resident #7 was at the bottom of the steps, lying back onto the steps.
-The front of Resident #7's clothing were clean; she did not see the back side of her clothing.
-She had feces on the side of her pants; there was no sign of urinary incontinence and no odor.
-There was stool beside the steps where Resident #1 had a bowel movement.
-The RCC assessed Resident #7; there were no injuries noted.
-The PCA showered Resident #7.
-The RCC was responsible for notifying the MHP.
-She did not know the MHP was not notified.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.

3. Review of Resident #8's FL-2 dated 11/14/24 revealed:
-Diagnoses included dementia, respiratory failure with hypoxia, cerebral infarction, and epileptic seizures.
-He needed assistance with bathing and dressing.

Review of Resident #8's care plan dated 11/14/24 revealed he required extensive assistance with bathing, dressing, and grooming.

Review of Resident #8's charting notes from May 2025-June 2025 revealed there was no documentation regarding Resident #8's toenails or contact with a podiatrist.

Observation of Resident #8's toenails on 06/11/25 at 9:59am revealed:
-The skin on top of the resident's feet was dry and flaky.
-There was a buildup of debris and dried skin

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under and between his toes on the bottom of his left and right foot.
-All of his toenails were discolored and thick.
-The first toenail on his left foot extended past the end of his toe by ¾ inch.
-The second toenail on his left foot extended past the end of his toe by ¼ inch and was curved toward the first toe.
-He had a blister on top of the second toe.
-The third and fourth toenails on the left foot had grown over the end of the toe and were curled toward the bottom side of the toe.
-The fifth toenail on the left foot was broken off with a small piece of toenail remaining.
-The first toenail on his right toe extended past the end of his toe by ½ inch and had deep ridges in the toenail.
-The second toenail on his right foot extended past the end of his toe by ¼ inch and was beginning to curve under.
-The third toenail on his right foot extended past the end of his toe by ½ inch
-The fourth toenail on his right foot extended past the end of his toe by ¼ inch and was beginning to curve under.
-The fifth toenail on his right foot was broken with one piece of the toenail extended past the end of the toe and curling under.

Interview with Resident #8 on 06/11/25 at 9:59am revealed:
-He was not wearing shoes because they hurt his toenails.
-He had not had anyone ask to cut his toenails.
-He had not refused to have his toenails cut.
-He did not know if he had told anyone his toenails needed to be cut.

Interview with a personal care aide (PCA) on 06/11/25 at 10:10am revealed she had not

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noticed Resident #8's toenails needed to be cut.

Interview with the Special Care Unit Coordinator (SCC) on 06/11/25 at 10:18am revealed Resident #8 usually wore shoes, so she was not aware his toenails were long.

Interview with an Administrator/Consultant from a sister facility on 06/11/25 at 1:01pm revealed the resident should have been referred out to a podiatrist if his toenails needed to be cut.

Attempted telephone interview with Resident #8's family member on 06/11/25 at 11:27am was unsuccessful.

Attempted telephone interview with a representative from the facility's contracted podiatry services on 06/11/25 at 10:50am was unsuccessful.

Attempted telephone interview with the facility's contracted primary care provider (PCP) on 06/11/25 at 1:25pm was unsuccessful.

4. Review of Resident #6's FL-2 dated 01/28/25 revealed:
-Diagnoses included hypertension and dementia with behavioral disturbance.
-He needed assistance with bathing, dressing, and feeding.

Review of Resident #6's care plan dated 01/20/25 revealed he was dependent on staff assistance for bathing, dressing, and grooming.

Review of Resident #6's charting notes from May 2025-June 2025 revealed there was no documentation regarding Resident #6's toenails or contact with a podiatrist.

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D 273	Continued From page 60 Observation of Resident #6's toenails on 06/11/25 at 9:51am revealed: -The skin on top of the resident's feet was dry and flaky. -There was a buildup of dark-colored debris and dried skin under and between his toes on the bottom of his left and right foot. -He had multiple calluses on the ball of his left and right foot. -The resident's first toenail on his right foot extended past the end of the toe by ½ of an inch. -The second toenail on his right foot had grown over the end of the toe and the right side of the toenail was pushing into the underside of the toe. -The third toenail on the right foot was black, broken, and jagged. -The fourth and fifth toe on the right foot had grown over the end of the toe and was curled under the bottom side of the toe. -The resident's first toenail on his left foot extended past the end of the toe by ¼ of an inch. -The second toenail on his left foot had grown over the end of the toe and was curled under the bottom side of the toe. -The third toenail extended past the end of the toe by ¼ of an inch and was jagged. -The fourth toe on the left foot had grown over the end of the toe and was curled under the bottom side of the toe. Interview with a personal care aide (PCA) on 06/11/25 at 9:54am revealed: -She helped Resident #6 with a shower on Monday, 06/09/25. -She did not look at Resident #6's toenails. -Resident #6 would not let anyone touch his feet. Interview with a second PCA on 06/11/25 at 10:10am revealed she had not noticed Resident	D 273		

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D 273	Continued From page 61 #6's toenails needed to be cut. Telephone interview with Resident #6's family member on 06/11/25 at 11:28am revealed: -She expected one of the facility's staff members to cut Resident #6's toenails. -If Resident #6's toenails could only be cut by a podiatrist, she would not expect the facility to wait for 2 months for the podiatrist to return to the facility. -She was surprised to hear Resident #6's toenails still had not been cut. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Attempted telephone interview with a representative from the facility's contracted podiatry services on 06/11/25 at 10:50am was unsuccessful. Attempted telephone interview with the facility's contracted primary care provider (PCP) on 06/11/25 at 1:25pm was unsuccessful. _____ Interview with two PCAs on 06/11/25 at 10:42am revealed the PCAs did not cut or file any resident's toenails, only fingernails. Interview with the SCC on 06/11/25 at 10:18am and 1:03pm revealed: -The staff made nail kits for each resident. -Certain days of the week staff cut the residents' toenails. -Staff members who cut toenails included PCAs, the MAs, the Activities Director (AD), and the nursing staff. -The last time residents' toenails were cut she thought was on Friday, 06/06/25, or Monday	D 273		

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D 273	Continued From page 62 06/09/25. -Every resident's toenails should be looked at to see whose toenails needed to be cut. -The AD kept a list of whose toenails had been cut. -She remembered some residents needed bigger nail clippers because their toenails were so thick and those were purchased. -Two residents' toenails were trimmed by staff but needed to be seen by the podiatrist, but she did not recall which two residents. -The podiatrist was scheduled to be back at the facility on 06/19/25-06/20/25. -There were no residents in the special care unit (SCU) whose toenails were so "bad" that they needed to see a podiatrist immediately. -If a resident's toenails were too long, it could cause a problem with walking. Interview with the AD on 06/11/25 at 10:40am revealed: -She only cut the residents' fingernails. -The nail care kits were for the residents' fingernails. -Residents' toenails were cut by podiatry. _____ The facility failed to ensure referral and follow-up for 4 sampled residents including a resident, who was sexually assaulted and was not sent to the hospital for an evaluation until one week after the incident occurred (#1), a resident who was found outside the facility laying on the ground and the PCP or the MHP were not notified of the incident (#7) and a resident whose toenails were long and causing pain who was not referred to podiatry services (#8). This failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation. _____ The facility provided an acceptable plan of	D 273		

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D 273	Continued From page 63 protection in accordance with G.S. 131D-34 on 06/30/25. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 7, 2025.	D 273		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#3 and #4) including a vitamin supplement (#3), and a laxative (#4). The findings are: 1. Review of Resident #3's current FL2 dated 02/25/25 revealed diagnoses included dementia, anxiety, depression, and hypothyroidism. Review of Resident #3's signed physician's orders dated 04/01/25 revealed an order for vitamin D3 (a vitamin supplement used to treat deficiency) 1,000 units(s) 2 tablets every morning. Review of a physician's progress note by	D 358	All medications should be administered as ordered. Facility will be switching to cycle fill on 8/15 to assist in monitoring of accurate medication administration. MARs and carts will be audited by RCC/Director/Administrator/ Designee weekly x4 and monthly ongoing.	8/15/2025

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D 358	Continued From page 64 Resident #3's primary care provider (PCP) dated 04/17/25 revealed: -Resident #3 had a vitamin D deficiency and was prescribed vitamin D supplementation. -Resident #3's vitamin D level from 02/13/25 was 39.9. -The normal reference range for vitamin D was 30-100. Review of Resident #3's April 2025 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin D3 1,000u 2 tablets every morning with a scheduled administration time of 8:00am. -Vitamin D3 1,000u 2 tablets every morning was documented as administered from 04/02/25 to 04/30/25. -The vitamin D3 1,000u 2 tablets every morning was circled on the eMAR as not administered, but there was no reason why. Review of Resident #3's May 2025 eMAR revealed: -There was an entry for vitamin D3 1,000u 2 tablets every morning with a scheduled administration time of 8:00am. -Vitamin D3 1,000u 2 tablets every morning was documented as administered from 05/01/25 to 05/31/25. Review of Resident #3's June 2025 eMAR from 06/01/25 to 06/09/25 revealed: -There was an entry for vitamin D3 1,000u 2 tablets every morning with a scheduled administration time of 8:00am. -Vitamin D3 1,000u 2 tablets every morning was documented as administered from 06/01/25 to 06/09/25.	D 358		

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D 358	Continued From page 65 Observation of Resident #3's medications on hand on 06/09/25 at 11:41am revealed: -Sixty tablets of vitamin D3 1,000u were dispensed on 04/23/25. -Forty-nine tablets remained in the punch card. -There was a second punch card of vitamin D3 1,000u that contained 60 tablets dispensed on 06/01/25; 60 tablets remained in the punch card. Telephone interview with a representative from the facility's contracted pharmacy on 06/09/25 at 12:30pm revealed: -Resident #3 had an active order for vitamin D3 1,000u 2 tablets every morning dated 12/10/24. -Vitamin D3 was used as a supplement; in the elderly it helped the absorption of calcium. -Sixty tablets (a 30 day supply) of vitamin D3 1,000u were dispensed on 03/27/25. -Sixty tablets (a 30 day supply) of vitamin D3 1,000u were dispensed on 04/23/25. -Sixty tablets (a 30 day supply) of vitamin D3 1,000u were dispensed on 06/01/25. -There should not be any tablets left in the punch card that was dispensed on 04/23/25. Interview with Resident #3's PCP on 06/10/25 at 9:44am revealed: -She did not know why the vitamin D3 for Resident #3 was originally ordered but thought it was probably because she was deficient. -When vitamin D3 was prescribed due to a deficiency, it would help the resident feel better, have more energy, and improved quality of life. -If the medication was not given as ordered, Resident #3 could have difficulty with calcium absorption, and it could cause osteoporosis. -She expected medications to be administered as ordered. Interview with a medication aide (MA) on	D 358		

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06/10/25 at 9:00am revealed:
-Resident #3 did not refuse her medication.
-She administered vitamin D3 to Resident #3 daily.
-She could not explain why there was still vitamin D3 1,000u from April 2025.

Interview with the Special Care Unit (SCC) Coordinator on 06/10/25 at 3:20pm revealed she could not explain why there were still so many vitamin D3 tablets in the punch card dated 04/23/25; sometimes MAs would start using medications from the new card before the old card was empty.

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

Refer to interview with the SCC on 06/10/25 at 3:20pm.

Refer to interview with the Administrator on 06/10/25 at 4:05pm.

2. Review of Resident #4's current FL2 dated 02/18/25 revealed:
-Diagnoses included dementia, rheumatoid arthritis, major depressive disorder, and hypertension.
-There was an order for senna laxative (used to treat constipation) 8.6mg 2 tablets at bedtime.

Review of Resident #4's April 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for senna laxative 8.6mg 2 tablets at bedtime with a scheduled administration time of 8:00pm.
-Senna laxative 8.6mg 2 tablets at bedtime was

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documented as administered from 04/01/25 to 04/30/25.

Review of Resident #4's May 2025 eMAR revealed:
-There was an entry for senna laxative 8.6mg 2 tablets at bedtime with a scheduled administration time of 8:00pm.
-Senna laxative 8.6mg 2 tablets at bedtime was documented as administered from 05/01/25 to 05/31/25.

Review of Resident #4's June 2025 eMAR from 06/01/25 to 06/09/25 revealed:
-There was an entry for senna laxative 8.6mg 2 tablets at bedtime with a scheduled administration time of 8:00pm.
-Senna laxative 8.6mg 2 tablets at bedtime was documented as administered from 06/01/25 to 06/09/25.

Observation of Resident #3's medications on hand on 06/10/25 revealed:
-Sixty tablets of senna laxative were dispensed on 04/10/25.
-Forty-four tablets remained in the punch card.
-There was no other senna laxative available for administration for Resident #4.

Telephone interview with a representative from the facility's contracted pharmacy on 06/10/25 at 12:03pm revealed:
-Resident #4 had an active order for senna laxative 8.6mg 2 tablets at bedtime.
-Sixty tablets (a 30 day supply) of senna laxative 8.6mg were dispensed on 01/08/25.
-Sixty tablets (a 30 day supply) of senna laxative 8.6mg were dispensed on 02/03/25.
-Sixty tablets (a 30 day supply) of senna laxative 8.6mg were dispensed on 04/10/25.

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D 358	Continued From page 68 -Senna laxative was used to treat constipation. Telephone interview with Resident #4's primary care provider (PCP) on 06/10/25 at 2:30pm revealed: -Resident #4 took senna laxative for chronic constipation. -She saw Resident #4 on 04/22/25 and documented in her progress note that Resident #4 also received other medications for constipation and despite having a bowel movement on 04/21/25, she still felt constipated. -She was concerned Resident #4 could become constipated if she did not take the medication as ordered. -She expected the medication aides (MA) to administer medications as ordered. Interview with a MA on 06/10/25 at 9:00am revealed: -Resident #4 did not refuse her medication. -She administered senna laxative to Resident #4 daily. -Resident #4 had bowel movements daily; she did not complain of constipation to her and did not strain when she used the bathroom. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Refer to interview with the SCC on 06/10/25 at 3:20pm. Refer to interview with the Administrator on 06/10/25 at 4:05pm. _____ Interview with the Special Care Unit (SCC) Coordinator on 06/10/25 at 3:20pm revealed: -She checked medications daily if they were	D 358		

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D 358	Continued From page 69 waiting on a medication to be delivered from the pharmacy. -Other times, she conducted medication cart audits randomly and checked dispensed dates. -She did not fill out a form when she completed the medication cart audits. Interview with the Administrator on 06/10/25 at 4:05pm revealed: -The SCC Coordinator was responsible for completing medication cart audits. -The medication cart audits included availability of medications, checking for out-of-date medications, expired medications, and making sure medications were labeled. -There was a form for the medication cart audits that should get sent to corporate. -She was concerned medications were not being administered. -Her expectation was that medications were administered as ordered.	D 358		
D 377	10A NCAC 13F .1006 (a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication room door was closed and locked in the Assisted Living (AL), and that the medication cart was locked in the Special Care Unit (SCU) when not under the direct supervision of a medication aide (MA).	D 377	All medication carts will be locked when not in use. All med techs will be inserviced. Inservice will be completed by Administrator/Director/Designee. Excess/left over medications will be sent back 2x weekly and as needed. All medications will be kept behind locked doors until picked up by pharmacy. A 2 hour check will be completed of medication storage doors, check sheet will be placed in 2 hour check binder. RCC/Designee will monitor 2 hour check daily.	8/15/2025

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D 377	Continued From page 70 The findings are: 1. Observation of the SCU on 06/06/25 from 12:34pm to 12:54pm revealed: -The medication cart was in the hallway across from the television room. -The medication cart was unlocked. -The surveyor was able to open the drawers on the medication cart, exposing eye drops, nasal sprays, inhalers and multiple medication punch cards. -There were no staff in the hallway or the television room. Interview with the personal care aide (PCA) on the SCU on 06/06/25 at 12:42pm revealed: -The Resident Care Coordinator (RCC) worked as the MA today, 06/06/25. -She thought the RCC was at lunch. Interview with the RCC on 06/06/25 at 12:54pm revealed: -She administered medications in the SCU today, 06/06/25, because the MA called out. -She administered medication from 11:00am to 12:15pm, locked the medication cart and went to lunch. -She did not know how the medication cart got unlocked or who unlocked it. -She had the key to the medication cart. -There may be a spare key in the Administrators office. Interview with the Special Care Unit Coordinator (SCC) on 06/11/25 at 10:23am revealed: -The MA administering medication would have the keys to the medication cart and the emergency key was in the Administrator's office. -The medication cart in the SCU should only be	D 377		

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unlocked when the MA was preparing medication for administration.
-A resident could remove the medications from the medication cart and take them or leave the medications lying in a room and another resident take them.
-The medications could be harmful to residents even causing death.
-She expected the medication cart to always be locked.

Interview with the Administrator on 06/10/25 at 4:07pm revealed:
-The medication cart should be locked when not under the direct supervision of the MA.
-There was only one set of keys to the medication cart and the MA administering medications was the one who had the keys; the extra key was in the Administrators office.
-Residents could open the drawers to the medication cart and remove medications and take them if the cart was not locked.

2. Observation of the medication room in the AL on 06/06/25 at 3:26pm revealed:
-The medication room door was opened about 10 inches.
-The surveyor pushed the door, and it opened fully into the medication room.
-There was no one in the medication room.
-There were 14 medication punch cards lying on the counter in the medication room.
-The refrigerator was unlocked and contained 1 insulin pen.
-There was no one in the medication room or standing outside in the common area, outside the medication room door.

Interview with the MA on 06/11/25 at 9:52am revealed:

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-She did not know how the medication room was left unlocked.
-Everyone knew the code to enter on the keypad to unlock the medication room door.
-The resident charts, a computer used for documentation, and the printer were in the medication room.
-Any staff could have entered the medication room and left the door open.
-The medication room door should always be closed; it automatically locked when the door was closed.
-There were medications to be returned to the pharmacy in the medication room.
-The medications in the cabinets and refrigerator were not locked; these medications would be accessible to residents who could enter an unlocked medication room.
-There were many ambulatory residents on the AL hall-way that could have easily walked into the medication room.
-She had seen the medication room door opened when she came to work; she would close the door.
-She had told the Administrator and the Resident Care Coordinator (RCC) that the medication door was found opened several times.
-The her knowledge, nothing had been done to ensure the medication door stayed closed and locked.

Interview with the RCC on 06/11/25 at 1:15pm revealed:
-The medication room door should be closed and locked when the MA was not in the medication room.
-There were unsecured medications in the medication room and residents could walk in and take the medications.
-There was a keypad on the door and a code was

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D 377	Continued From page 73 needed to enter the medication room. -The staff had the code to the keypad. -She had told the staff multiple times to keep the medication room door closed because she did not want resident to get into the medication room and take medications. -Some of the residents were confused and could take the medications. -She expected the mediation room door to be closed and locked when a MA was not in the medication room. Interview with the Administrator on 06/10/25 at 4:07pm revealed: -The medication rooms should be locked when not under the direct supervision of the MA. -There was only one set of keys to the medication cart and the MA administering medications was the one who had the keys; the extra key was in the Administrator's office. -Resident could walk into the medication room and take medications off the counter, from the cabinet and from the refrigerator and take them. -She expected the medication room to remain locked at all times unless there was a MA in the medication room.	D 377		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident.	D 453	All required reportables will be reported within the required time frame. Accidents/Incidents will be reported to DSS by Administrator/Director/ Designee within the 48 hour regulation. All staff will be inserviced by Administrator/Director/ Designee.	8/15/2025

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This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to immediately notify law enforcement for 1 of 1 resident (#1) residing in the special care unit (SCU) when the resident was allegedly sexually assaulted by another resident.

Review of Resident #1's current FL-2 dated 02/11/25 revealed:
-Diagnoses included dementia, major neurocognitive disorder, hyperlipidemia, and pre-diabetes.
-She was constantly disoriented.
-She was ambulatory and wandered.

Review of Resident #1's care plan dated 02/04/25 revealed:
-Diagnoses included major neurocognitive disorder, insomnia, seizure disorder, and dementia.
-She was ambulatory.
-She was always disoriented.
-She had significant memory loss; she had to be directed.

Review of Resident #1's incident report dated 06/03/25 revealed:
-The incident report was completed on 06/03/25 at 6:30pm.
-The description of the incident was a male resident was on top of Resident #1 with their clothes off.
-The question of whether they needed to be sent

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out for treatment was checked as 'no'.
-There was no signature of the staff who completed this report.
-The Administrator signed the report on 06/04/25.

Review of Resident #1's progress notes dated 06/03/25 revealed:
-The Administrator received a call from the facility staff member that a personal care aide (PCA) had walked in on a male resident having sex with Resident #1.
-The Administrator called Resident #1's on-call guardian and informed them of what was communicated to her by the staff.
-The guardian informed the Administrator to contact the primary care provider (PCP) and keep moving.

Review of the service note sheet from Resident #1's court-appointed guardianship program dated 06/03/25 at 9:18pm revealed:
-The on-call guardian specialist received a telephone call from the facility's Administrator.
-The Administrator provided information that Resident #1 was located in the bedroom of a male resident and was engaging in sexual activity with the male resident.
-She indicated the encounter appeared to be consensual, there was no indication of coercion or force by the male resident and Resident #1 was not traumatized by the encounter.
-The Administrator wanted to inform the guardian, and she stated that she would complete an incident report and would also notify the facility's PCP.

Review of the local law enforcement investigation report dated 06/03/25 at 9:53pm revealed:
-The law enforcement officer responded to a call at the facility for a male resident in the SCU with

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an altered mental status who was holding people down and punching them.
-Emergency Medical Services (EMS) were already on the scene speaking with the male resident.
-The law enforcement officer spoke with a PCA who stated the male resident sexually assaulted Resident #1 earlier in the evening, around 6:00pm.
-The PCA stated she contacted the Administrator about the sexual assault and was told not to call law enforcement.
-EMS advised the law enforcement officer that they had gotten in contact with the Administrator, and the Administrator had spoken to the PCP, and the PCP replied not to call law enforcement because Resident #1 had a history of having sex with other residents.

Telephone interview with the law enforcement Investigator 06/11/25 at 1:10pm revealed:
-He had a problem with the way the incident between Resident #1 and a male resident on 06/03/25 was handled.
-The staff did not call law enforcement and Resident #1 was not sent out for medical treatment.
-It was reported to him that the sexual assault was not reported because the Administrator advised the staff not to report it to the local law enforcement.
-On 06/04/25, he went to the facility to speak to the Administrator.
-The Administrator told him the PCP instructed her not to report the incident and to have the male resident removed from the facility today, 06/04/25.
-The Administrator stated the sexual encounter was consensual and that she was not informed that Resident #1 was yelling no, no, stop, stop.

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D 453	Continued From page 77 Interview with a SCU medication aide (MA) on 06/09/25 at 10:39am revealed if Resident #1 said for the male resident to stop, law enforcement should be called because that would be considered rape. Interview with another SCU MA on 06/09/25 at 2:53pm and 4:16pm revealed: -She was working in the SCU on 06/03/25 when the incident occurred between Resident #1 and the male resident, but she was not in the SCU at the time the incident occurred. -She had stepped outside of the facility to get something out of her car. -The PCA told her she heard someone yelling stop, and saw the male resident, who did not have clothes on, on top of Resident #1. -Two named staff members told her to call law enforcement. -When she called the Administrator to report the incident, she told her the PCA reported the male resident was trying to sexual assault Resident #1. -The Administrator told her not to call law enforcement until she talked to Resident #1's guardian to see how the guardian wanted to handle the situation. -When EMS entered the facility for another resident, the EMS personnel were told about the incident with Resident #1, so that was how law enforcement got involved. Interview with the assisted living (AL) MA on 06/10/25 at 5:11pm revealed: -She was the MA on the second shift in the AL on 06/03/25. -She heard the PCA tell the Administrator who was on the telephone exactly what happened, that she thought the male resident was raping Resident #1 because of Resident #1 saying no	D 453		

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and stop during the sexual act; the PCA was crying.
-She asked the Administrator what she wanted her to do, and the Administrator said "Do not call the police" but call EMS on the male resident because of a change in his mental status.
-She did not agree with the Administrator about not calling law enforcement because the resident had dementia and she could have been sexual assaulted because of how aggressively the male resident was acting after the incident.
-When EMS arrived, law enforcement was with EMS.
-The Activities Director (AD) called the SCU MA and told her to call 911 about the suspected rape and not to bathe Resident #1.
-The SCC had called the AD.
-When EMS arrived for the male resident, she told them about Resident #1 being sexual assaulted.
-The Administrator called and wanted to know why she called law enforcement; she told the Administrator she did not call law enforcement.
-The Administrator stated that law enforcement did not need to be called because this was Resident #1's normal behavior.

Interview with the AD on 06/10/25 at 3:11pm revealed:
-She and the SCU Coordinator (SCC) both told the PCA to not wash or change Resident #1 and to call 911.
-She did not know what happened after that.

Interview with the Administrator on 06/09/25 at 11:23am revealed:
-She thought the incident between Resident #1 and the male resident on 06/03/25 was consensual because no one told her anything about screaming or Resident #1 saying no.

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D 453	Continued From page 79 -The first time she was made aware of Resident #1 saying no, was the next day, 06/04/25, when the law enforcement detective told her about his interview with the PCA. -She asked all the staff that were working on 06/03/25 to write a statement about what happened. -She wanted to send Resident #1 to the hospital, but the guardian had said not to send her out. -Other than asking staff to write up a statement about what happened, she had not conducted any further investigation or reporting related to this incident. -She had not been told that Resident #1 was saying no and stop during the sexual encounter, and the word rape was not reported to her. -The law enforcement detective reported to her on the morning of 05/16/25 that his investigation showed where Resident #1 was saying no and stop, and that the male resident sexual assaulted Resident #1. -When she asked the PCA why she was telling the detective one thing and her another thing, the PCA walked off. -The staff members never provided her with a statement that the resident was heard saying no, so she did not do anything. -She did not do an investigation because she thought the sexual act was consensual. Telephone interview with Resident #1's PCP on 06/06/25 at 2:50pm revealed: -If the guardian refused to let Resident #1 be sent to the hospital, she did not know what could have been done, but she would have contacted law enforcement. -She thought law enforcement could at least have done a test kit at the facility on the resident to see if sexual assault occurred.	D 453		

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D 453	Continued From page 80 Interview with Resident #1's PCP on 06/10/25 at 9:38am revealed that if she had been told Resident #1 had said no, she would have called 911 and had the incident investigated as a sexual assault . Interview with the Administrator on 06/10/25 at 4:07pm revealed: -She had contacted Resident #1's PCP and mental health provider (MHP) through the telemedicine triage on Tuesday, 06/03/25 after the incident occurred between Resident #1 and the male resident. -She did not know if the PCP saw Resident #1 last week after the incident. -The MHP saw Resident #1 last week on 06/04/25. -She thought she was doing the right thing by listening to the guardian and not sending Resident #1 to the ED as requested. -She did not think to call the guardian, PCP, or MHP after she was informed of possible rape or sexual assault on 06/04/25 and that the incident was not consensual. -If a resident had been injured, she would have called 911. -She did not know what the facility's policy was for sexual abuse.	D 453		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such	D 454	All responsible parties will be notified of accidents/ incidents. Staff will put who is contacted on the Incident Report. Incident Reports will be reviewed by Director/Administrator/Designee.	8/15/2025

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D 454	Continued From page 81 notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the responsible party of 1 of 1 sampled resident who was found outside of the facility (#7). The findings are: Review of Resident #7's current FL-2 dated 05/24/24 revealed: -Diagnosis included dementia. -She was ambulatory. -The orientation section was blank. Review of Resident #7's care plan dated 02/05/25 revealed: -The care plan was not signed by the Primary	D 454		

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Care Provider (PCP).
-There was no performance codes documented for activities of daily living (ADL).
-She was oriented, but forgetful.
-She was ambulatory.

Review of Resident #7's ADL log dated 05/15/25 revealed:
-Resident #7 had safety checks every 2 hours.
-There was documentation that Resident #7 was checked on and was safe every two hours from 12:00am to 12:00pm.

Review of video footage from the facility's surveillance camera obtained on 07/02/25 revealed:
-The surveillance camera was on the outside of the facility facing the exit door of the dining room.
-The video footage was dated 05/15/25 at 4:29am.
-There was a stoop outside the back door that had 5 steps leading to the ground.
-At 4:29am, Resident #7 was observed standing at the dining hall exit door, outside of the facility, with her pants around her thighs.
-It was noted to be dark outside the facility.
-At 4:32am, Resident #7's pants were around her ankles, and she twisted the doorknob.
-At 4:37am, Resident #7 was knocking on the exit door of the facility while standing on the stoop with her pants down around her ankles.
-At 4:44am, Resident #7 was knocking on a window air conditioning unit to the right of the exit door.
-At 4:45am, Resident #7 was hitting her hand repeatedly on the wooden rail.
-At 4:46am, Resident #7 was trying to pull her pants up with one hand while holding onto the wooden rail with her other hand.
-At 4:48am, Resident #7's pants had not been

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pulled up.
-At 5:19am, Resident #7 was hitting the window air conditioning unit with her hand.
-At 5:28am, Resident #7 was standing at the top of the stoop; her pants were pulled up.
-It was noted to still be dark outside the facility.
-There was no video footage from 5:31am-9:42am.
-At 9:42am, Resident #7 was standing at the top of the stoop.
-It was noted to be light outside the facility.
-At 9:55am, Resident #7 was observed holding onto the handrails on the right side and slowly moving down the steps.
-At 10:08am, Resident #7 was observed standing at the bottom of the steps holding onto the handrail.
-At 10:40am, Resident #7 was observed on the left side of the bottom step; She was reaching behind her, trying to hold onto the railing.
-The exit door to the dining room was opened, and a contracted construction worker was working on the door handle at the top of the steps and within sight of Resident #7.
-At 10:43am, Resident #7 was lying on the ground beside the bottom of the steps.
-There was no video footage to show how Resident #7 ended up on the ground.
-At 10:59am, the contracted construction worker was working on the door handle, and Resident #7 was still lying on the ground at the bottom of the steps within sight of the door.
-At 11:02am, the contracted construction worker continued to work on the door handle.
-Resident #7 appeared to try to sit up but was unable to and laid back down.
-At 11:07am, the contracted construction worker looked at Resident #7 and returned inside the facility.
-At 11:14am, the Administrator, the Dietary

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D 454	Continued From page 84 Manager (DM), and the contracted construction worker exited the facility and observed Resident #7 lying on the ground. -At 11:15am, the DM was standing over Resident #7, the Administrator and the contracted construction worker were standing at the top of the stoop, and the video footage ended. Review of Resident #7's incident/accident report dated 05/15/25 revealed: -The incident report was completed on 05/15/25 between 10:00am and 11:00am. -The description of the incident was a contracted construction worker was working on the back door of the dining room and notified the DM that Resident #7 was outside. -The Administrator was immediately notified and paged for the Resident Care Coordinator (RCC), to come to the back of the facility. -The RCC, who was a Registered Nurse (RN) found Resident #7 lying at the bottom of the steps, with her upper body on the last step and her lower body on the ground. -Resident #7 was fully clothed, and her clothes were wet and muddy because of the rain during the night. -A physical assessment was performed on Resident #7 with no injuries noted. -Resident #7 denied having pain. -Resident #7 was assisted off the ground after several attempts. -Resident #7 was taken inside and immediately received a shower by the personal care aide (PCA). -No apparent injuries were noted to Resident #7 when a full body assessment was completed during the shower. -Resident #7 was dressed and walked to her room with assistance from the staff. -Resident #7 asked to go to bed.	D 454		

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-No further action was required at that time.
-Staff would continue to closely monitor Resident #7 for any new complaints related to the incident.
-There was no documentation on the incident report that the court-appointed guardian was notified.

Review of Resident #7's progress notes revealed:
-There was no documentation of the incident/accident dated 05/15/25.
-There was no documentation that the court-appointed guardian was notified of the incident.

Telephone interview with Resident #7's court-appointed guardian on 06/11/25 at 11:35am revealed:
-He did not know Resident #7 was outside the facility on 05/15/25 from 4:28am to 10:45am.
-He did not receive an email or voice message from the facility staff.
-He expected to be notified of all incidents/accident that occurred with Resident #7.

Interview with the Resident RCC on 06/11/25 at 11:48am revealed:
-She completed the incident report for Resident #7 being found outside of the facility on 05/15/25.
-She called Resident #7's court-appointment guardian and left a message about Resident #7 being found outside of the facility on 05/15/25.
-She did not document in Resident #7's progress notes that she called the court-appointment guardian and left a voicemail on 05/15/25.
-She instructed the medication aide (MA) to attempt to reach the court-appointment guardian.
-She did not know if the MA contacted the court-appointment guardian.

Interview with the Special Care Coordinator

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D 454	Continued From page 86 (SCC) on 06/11/25 at 1:20pm reveled: -The resident's guardian was called each time an incident occurred. -She was not aware Resident #7's guardian was not notified when Resident #7 was found outside on 05/15/25. -Resident #7's guardian should have been contacted about the incident on 05/15/25 and the information should have been documented on the incident report and the progress notes.	D 454		