Adult Care Home Corrective Action Report (CAR)

I. Facility Name: TerraBella Southport
Address: 1125 E Leonard St. Southport, NC 28461
County: Brunswick
License Number: HAL-010-010

II. Date(s) of Visit(s): 03/17/25, 03/24/25, 04/01/25
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 05/14/25

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

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

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

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

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0901 Rule/Statutory Reference: 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan, and current symptoms. Level of Non-Compliance: Type A1 Violation Findings: This rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the assessed needs, care plan, and current symptoms for 2 of 6 sampled residents (#5 and #2), related to Resident #5 who had a recent history of falls and was unsteady when walking and transferring and Resident #2, a Special Care Unit (SCU) resident who had a history of physical attacks and repeated sexually aggressive behaviors toward other SCU residents. The findings are: Request for the facilities supervision policy on 03/25/25 at 9:05am, on 04/01/25 at 1:45pm, on 04/14/25 at 10:33am, and 04/17/25 at 12:48pm revealed the policy was not available for review.	☐ POC Accepted _____ DSS *Initials*	

1. Review of Resident #5's current FL-2 dated 02/27/25 revealed:
-Diagnoses included asthma, hypertension, obesity, chronic obstructive pulmonary disease, and gastroesophageal reflux disease.
-The resident was oriented, semi-ambulatory, and required assistance with bathing and dressing.
-The recommended level of care was the Assisted Living Unit (ALU).

Review of the Resident #5's Resident Register revealed an admission from the hospital to the facility on 02/25/25.

Review of Resident #5's current Assessment and Care Plan dated 03/06/25 revealed:
-The resident was oriented to person, place, and time and could verbally communicate her needs to staff.
-The resident required assistance with toileting, bathing, transferring.
-The resident was experiencing increasing difficulty with transfers and showed signs of unsteadiness, requiring the assistance of one staff member to ensure proper technique and safety.
-The resident used a rollator for ambulation and needed to wait for staff assistance before ambulating; staff did not need to remind the resident to wait for staff assistance.
-The resident had a history of falling before admission.

Review of Resident #5's Licensed Health Professional Support (LHPS) assessment dated 03/19/25 revealed the resident's LHPS support tasks included assistance with ambulation and transfers.

Review of Resident #5's hospital discharge summary dated 02/23/25 revealed:
-Resident #5 was living independently at home before her hospital admission on 02/22/25.
-The hospital admission was related to several days of coughing, chest pain while coughing, and a family report of altered mental status during the period of sickness.
-The resident was diagnosed with influenza and received treatment while hospitalized.
-The resident had been seen at the hospital Emergency Room (ER) a week prior on 02/18/25 after a fall at home which resulted in a bruised left hip, generalized pain, and gait and balance deficits.
-The physician recommended that the resident consider going to an adult care home to assist in her recovery until she regained better independence with her mobility skills.
-Additional diagnoses included a history of a left femur and left radius fracture in September 2022, hypothyroidism, hyperlipidemia, obstructive sleep apnea, and diverticulosis of the colon.
-On 02/25/25, when the resident was discharged from the hospital to the facility, the resident's cognitive status was noted as oriented to

person, place, time, and situation, and she was considered a "high fall risk."

Review of the audio recording of a 911 call on behalf of Resident #5 on 03/23/25 (no time stated) revealed:
-A third shift medication aide (MA) informed the 911 operator she heard Resident #5 calling out, and when she entered her room, the resident was lying flat on her back, saying she had fallen and hit her back and head.
-She was currently with the resident, and the resident was alert and talking, but was "shaken up pretty bad."
-The resident was breathing like she was nervous and excited.
-The resident told her she was coming out of her bathroom when she became dizzy and fell.
-The MA was informed by the 911 operator that Emergency Medical Services (EMS) responders were on the way.

Review of EMS electronic response transcripts dated 03/23/25 revealed:
-At 7:03am a 911 call was received from the facility on behalf of Resident #5.
-At 7:10am EMS workers arrived and observed the resident lying flat on her back.
-The resident was verbal and oriented.
-The resident was in "acute pain due to trauma from a fall."
-The "duration" of the fall was entered as 7-hours.
-The staff informed responders that the resident was found on the floor a few minutes earlier.
-The resident complained of pain throughout her body, especially in her legs, back, and head.
-The resident stated she had fallen at 12:00am and had been on the floor since then; a responder asked a staff member when the resident was last checked on throughout the night, and the staff member said she had just arrived at work; the staff member inquired with the third shift staff and she said they were unable to give her an answer about when the resident was seen during the night.
-The resident said she was cold and could barely move without pain.
-Upon the initial assessment, bruises were found on the resident's heels.
-The resident was assisted onto a stretcher and transported to the hospital for further assessment.

Review of Resident #5's electronic progress notes for March 2025 revealed:
-On 03/06/25 at 2:25pm, there was an entry, the resident had a bruise on her right hip from a fall she had before her admission, used a rollator but needed stand-by assistance.
-On 03/15/25 at 8:34pm, there was an entry, the resident reported knee

pain from moving things out of her apartment and was given as-needed Tylenol (used to treat moderate pain).
-On 03/19/25 at 2:05pm, there was an entry, the resident reported her feet were swollen, and notification was provided to her PCP.
-On 03/20/25 at 1:49pm, there was an entry, the resident reported her legs were aching, and she was given as-needed Tylenol.
-On 03/20/25 at 3:21pm, there was an entry, the resident was seen at the facility by her PCP and was prescribed multiple new medications.

Review of Resident #5's electronic Primary Care Providers (PCP) after visit summary dated 03/20/25 revealed:
-The PCP saw resident #5 at the facility, and the resident's Power of Attorney (POA) was present.
-The PCP noted the resident was oriented to person, place, and time; her recent and remote memory, judgment, and insight were noted as intact.
-The resident's muscle strength and tone were decreased, and her gait was unsteady.
-With the help of the resident's POA, the PCP completed a medication reconciliation of the resident's medications listed on the pre-admission hospital FL-2 form and the medications the resident was taking at home before her last hospital stay.
-The PCP determined the resident was taking medications at home that had not been listed on the hospital FL-2, and medication orders were given to restart the resident on multiple medications.

Review of Resident #5's Emergency Room (ER) visit summary dated 03/23/25 at 7:39am revealed:
-The 85-year-old was transported from the facility to the hospital by EMS.
-The resident was awake, alert, had normal cognition, and was oriented to person, place, time, and situation.
-The resident was complaining of full-body pain, from her head to her toes, but especially in her legs, back, neck, and head.
-The resident reported that she fell in her room around midnight, was unable to get up, and remained on the floor all night until staff discovered her there that morning.
-EMS responders informed hospital staff that the resident was cold to touch upon their arrival at the facility.
-Upon examination at the hospital, the resident was tender to the touch of her lower back and cried out in pain when the physician rotated her legs to check for stability of her pelvis.
-The resident was assessed for acute traumatic fractures and internal hemorrhages, which were ruled out.
-The resident was discharged back to the facility, but the attending physician and nurses were concerned about the circumstances of the lack of supervision of the resident and the fact that she remained on the

floor all night without assistance.

Review of Resident #5's handwritten Accident and Incident report dated 03/23/25 revealed:
-The "time of accident" was entered as 7:00am.
-Resident #5 was observed on her bedroom floor, flat on her back; the resident stated she was coming from her bathroom, lost her balance, and fell; the resident stated multiple times that her head and back were hurt; 911 was called, and the resident was transported to the hospital.
-The report was signed by the first shift Medication Aide (MA) and the Director of Health and Wellness (DHW).

Second review of Resident #5's electronic progress notes for March 2025 revealed:
-On 03/23/25 at 7:00am, there was an entry, the resident was observed on her bedroom floor lying flat on her back and stated she was coming from her bathroom and lost her balance; the resident reported head and back pain; the resident stated she had been on the floor since 12:00am.
-On 03/23/25 at 10:40am there was a second entry, the resident had been sent to the ER due to her fall.
-On 03/23/25 at 1:40pm, there was a third entry, the resident returned from the ER to the facility, the resident's POA had spoken to the facility's DHW about her concerns related to the circumstances related to the resident's fall; a meeting was scheduled with the DHW and the Executive Director (ED) on 03/24/25 at 1:30pm.
-On 03/23/25 at 2:12pm, there was a fourth entry, the resident returned from the ER with no new orders; the resident was placed on 30-minute "engagement rounds" until further notice, and staff would continue to monitor the resident.
-On 03/23/25 at 4:39pm, there was a fifth entry, the resident was given an as-needed pain medication.
-On 03/23/25 at 4:39pm there was a sixth entry, the resident's POA requested all meals in her room until further notice.
-On 03/24/25 at 4:11am, there was an entry, 30 minutes to 1-hour engagement rounds were being conducted; the resident was toileted during the medication pass; the resident slept in her recliner all night except that she got up at 1:40am and went to the bathroom which required the assistance of two staff members because she was very unsteady on her feet.
-On 03/24/25 at 10:22am, there was a second entry, the resident was too tired to shower, following her fall and ER visit the day before.
-On 03/24/25 at 2:02pm, there was a third entry, the DHW and the ED had a meeting with the residents POA, another family member, and a third person and "reassured them" the resident had been placed on "alert charting" since her fall; as a result of the meeting, referrals were made for physical and occupation therapy to evaluate and treat the Resident #5 due to her fall, a medication review was to be conducted

and a referral was made to the facility's psychiatric provider for medication management of the resident's anxiety medication.

Telephone interview with a local EMS paramedic on 04/06/25 at 12:06pm revealed:
-He responded to the facility on 03/23/25 for Resident #5's fall.
-He and his team of one other paramedic and two emergency medical technicians arrived at the facility shortly after 7:00amand found the resident lying flat on her back, with her feet toward the bathroom door and her head toward the bed; he recalled, with reasonable certainty, seeing a rollator positioned beside her.
-The resident informed him she had fallen at midnight and had been on the floor all night calling for help, but no one came.
-The resident stated she was walking from her bathroom to go to bed but fell before she made it to her bed; her bed did not appear to have been slept in, so that was consistent with what she was reporting.
-The resident indicated the time by pointing to her microwave's digital clock, as well as a second clock, possibly on her coffee maker, that was visible from where she was lying.
-As he spoke with the resident, it was clear that she was "alert and oriented times four" and was not at all confused about what had occurred.
-She complained of generalized pain throughout her body but reported significant pain in her head and back.
-She had bruises on the back of her heels; he did not know if this was from the fall or her trying to use her feet to push up.
-There was a staff member in the room whose job title he did not know; he asked the staff member if the resident's fall was witnessed, and she reported that the fall was not witnessed, and said the resident had just been found on the floor by another staff member a few minutes earlier.
-He asked the staff member when the last time was that the staff checked on the resident during the night; the staff member told him she had just arrived at work a few minutes earlier to work the day shift, and she did not know; a few minutes later the same staff member reentered the room again and said she had asked someone who worked during the night shift, and they were unable to say when the resident had last been seen by staff.
-He completed an assessment and a mini-mental exam, basically assessing her cognitive status for stroke, and the resident was able to answer all questions "spot on."
-He checked her vitals to confirm she was not hypothermic.
- He recalled that a few other staff members entered and exited the room while he was there and he repeatedly asked when the resident was last seen by staff during the night, whether the night shift had been notified, if they had reported when they last checked on the resident, and whether there was a way to obtain that information, but no one was able to provide an answer.

-If there were any staff still there that morning who had been assigned to work with Resident #5 during third shift, they did not identify themselves.
-When they arrived at the hospital with the resident, they informed the physician and ER staff what the resident reported; the resident was present and confirmed to the hospital staff what time she fell and how long she was on the floor.

Interview with a local ER Registered Nurse on 04/17/25 at 11:18am revealed:
-She was on duty at the ER on the morning of 03/23/25 when Resident #5 was brought in by EMS.
-Resident #5 was oriented to person, place, time, and situation, and gave clear and consistent statements about the fact that she fell at the facility at midnight on 03/23/25 and remained on the floor calling for help all night.
-She and the other ER staff who saw the resident at the ER after her fall had no doubt of the accuracy of the resident's accounting of when she fell and her inability to get help; the ER staff were very upset and openly discussed that the matter needed to be investigated.
-The resident was evaluated at the hospital and no fractures or internal bleeding were found, but the resident was emotionally traumatized.
-It was obvious that the resident was trying to be brave, but she was upset and anxious.
-The resident's POA was with her at the hospital, and she was upset when she learned what had happened and very hesitant about letting the resident return to the facility.

Interview with Resident #5 on 03/24/25 at 10:45pm revealed:
-She had been admitted to the facility just a few weeks earlier, and she did not think she should talk about what happened to her when she fell on 03/23/25 because she was worried she would get someone in trouble.
-After further consideration, although she still had reservations, she would concede to talking about what happened, with the intention of helping the facility to put measures in place to ensure that what happened to her did not happen to anyone else.
-On 03/22/25, she had fallen asleep in her recliner earlier in the evening.
-She awoke, looked at the clock on her microwave, and the time was just before 12:00am.
-She decided to use the bathroom before going to bed, so using her rollator, she stood from her chair and ambulated to the bathroom.
-She would frequently transfer and ambulate from one location to another independently, but if she needed staff, she felt sure they would be willing to help.
-After using the bathroom, and as she was walking from the bathroom

to her bed, she thought perhaps she had become dizzy before falling on the floor.
-She hit the floor "full impact from head to toe"; she landed on her back with her feet by her bathroom entryway and her head on toward her bed; she immediately knew it was a "really bad fall" and that she needed help.
-She pushed her call pendant repeatedly but no staff came.
-She became "really scared" and began to yell out, "Help me! Help me!"
-She thought for sure someone would hear her, but no one came, so after a few hours of yelling "Help me," she began yelling "God help me!"
-"Hours and hours" went by and no one came to help her; her hands were red and raw, and her heels were bruised from her trying to push herself up into a sitting position, but she could not do it because her body "just would not move"; she was "freezing cold" on the floor all night.
-Several hours later, she did not know exactly what time, but it was early in the morning around breakfast time, she was still calling out for help and a female staff member finally came into her room; she told the staff member she had been on the floor all night; the staff member immediately called for help, and she was taken to the hospital by ambulance.
-The staff member who came into her room that morning commented on her being cold to the touch, and the Emergency Management Services (EMS) workers told her the same thing; on the way to the hospital, the EMS workers turned the heat up high in the vehicle and warmed her up with blankets.
-It was ironic that at her last hospital stay, the hospital physician recommended that she be admitted to the facility because he was concerned that she would fall at home and there would not be someone there to help her, so this situation was so shocking.

Second interview with Resident #5 on 04/01/25 at 2:10pm revealed:
-She stated, "Welcome back", and commented that she remembered the last conversation during which her fall was discussed.
-She reiterated that she did not want to get anyone in trouble, but she was hoping that what happened to her when she fell and could not get help had prompted the facility to put measures in place to prevent this from happening to anyone else.
-Before she fell on 03/23/25, she slept in her bed most nights, but since her fall, she has been sleeping in the recliner in her room, as it is more comfortable than lying in bed due to the soreness throughout her body from the fall.
-Her bed was covered with dolls, and each night before she went to bed, she removed her dolls and turned her covers down, but she did not think she had a chance to prepare her bed for sleeping before she fell on

03/23/25.
-When the EMS staff came to get her that morning, it was likely that her bed was still made.
-She had an upcoming appointment with her physician because she was having "pain everywhere" from her fall.
-The hospital completed x-rays after she fell, which showed no sign of fractures, but it was a good idea to follow up with her physician since she was still in pain.
-She was allergic to a lot of pain medications, so she was taking Tylenol for her pain.
-The night she fell and could not get help was "so frightening" she tried not to think about it.

Observation of Resident #5's bedroom on 03/24/25 at 10:47am and 04/01/25 at 2:10pm revealed:
-The microwave clock displayed a time within two minutes of the correct time on both occasions.
-The resident's twin-sized bed, positioned against a wall, was made with a comforter and lined with dolls arranged from the head to the foot of the bed along the wall side, leaving minimal space for sleeping without first removing the items."
-The resident's room was the last room at the end of a long AL hallway.

Telephone interview with a first shift MA on 04/01/25 at 10:01am revealed:
-On the morning of 03/23/25, she arrived at work at around 6:45am for her 7:00am to 7:00pm shift.
-She was relieving the third shift MA for the ALU.
-She began her morning duties and was on hall B of the ALU, preparing to administer medications.
-At around 7:00am, the third shift MA, who was still at work during the shift change period, approached her asking her to come to hall A of the ALU to help her because Resident #5 was on the floor.
-She told the third shift MA to go back and take Resident #5's vitals, and that as soon as she secured her medication cart, she would go there to assist her.
-A couple of minutes later, when she arrived in Resident #5's room, she observed the resident lying on her back on her bedroom floor directly in front of the bathroom door.
-The resident said she was in pain all over, but especially in her back and head.
-She did not ask the resident how long she had been on the floor before exiting the room to call the resident's responsible party; when she returned to the room, EMS responders were already with the resident; the EMS staff began asking her when was the last time the staff saw the resident because the resident informed them she fell at midnight and had been on the floor calling for help until that morning.

-She told the EMS staff she had just arrived at work and had no idea when the resident had been seen during the night.
-The EMS informed her the resident remembered going to the bathroom, falling, looking at the time on her clock at 12:00am, and then calling for help all night.
-She went and informed the third shift MA that the resident said she had been on the floor since midnight, calling for help; the third-shift MA responded that she thought this was unlikely, as staff would have heard the resident yelling; she replied that the resident may not have been yelling the entire time and asked when the resident was last seen during the night; the third-shift MA stated that the only thing she knew was she checked on the resident around 9:30pm the previous night, when she administered medications.
-She had worked a few third shifts in the past, and the frequency of making rounds to check on residents, and who was supposed to complete rounds, "seemed to be all up in the air."
-It should be clear to all staff who was responsible for engagement rounds because if they are assigned to a hallway, they should be up and down the hallway all night.
-Certain MAs did a better job than others with ensuring the Personal Care Aides (PCA) conducted engagement rounds at least every two hours to check on residents; if a resident had increased needs, such as a recent history of falls, the MAs should also check in on them.
-Supervision of residents was now called engagement rounds.
-Staff had been instructed not to document supervision of residents, even if the resident was to receive increased supervision, the staff had been instructed to only "document by exception"; this meant unless a staff member specifically documented that they did not provide supervision of a resident, it was assumed that they did.
-Routine "engagement rounds" to supervise residents were supposed to be conducted at least every two hours.
-At the time of Resident #5's fall, to her knowledge the resident was to receive routine engagement rounds and was to be seen a minimum of every two hours.

Telephone interview with a third shift Personal Care Aide (PCA) on 03/31/25 at 3:58am revealed:
-She had been employed as a PCA at the facility for one month.
-On the evening of 03/22/25, going into the early morning hours on 03/23/25, she was assigned to ALU hall A, which was where Resident #5 resided.
-During the night she entered Resident #5's room and checked on her "every two hours, and every two hours she was in her bed, and she was fine."
-She last saw the resident at 5:30am, and "she was still in her bed."
-The resident had not required supervision for transferring or ambulating before she fell on 03/23/25, but since her fall, staff

had instructed her to call them before transferring or walking so they could be present for supervision and assistance.
-Just before 7:00am on the morning of 03/23/25, she saw Resident #5 being rolled out of the facility on a stretcher by EMS, and she asked them what happened; the EMS responder informed her the resident had fallen around midnight and that said she had been lying on the floor yelling for help all night.
-Hall A was quiet that night, and she "did not hear her yelling, so that could not have been true."
-She was not certain who found Resident #5 on the floor, but she thought it was the third shift MA.
-As far as who was responsible for the supervision of Resident #5 on 03/23/25, the MA was only responsible for seeing her when she administered her medications, so it was her responsibility as the PCA to supervise the resident.
-Resident #5 was oriented, so she did not know why she said she was on the floor all night.

Attempted telephone interview with the third shift MA assigned to work with Resident #5 on 03/23/25 revealed attempts on 03/31/25 at 8:30am, 04/01/25 at 8:33am, 04/17/25 at 4:40pm, and 04/28/25 at 9:27am were unsuccessful.

Telephone interview with Resident #5's POA on 03/31/25 at 4:26 PM revealed:
-Resident #5 was "very alert and in tune and oriented to person, place, time, and situation"; the resident had talked about what happened clearly and consistently since that night, and she was certain the resident's account of what occurred was accurate.
-Resident #5's memory sometimes exceeded her own; for example, the resident often reminded her of tasks she needed to complete or follow up on; she would then check her own calendar to verify the reminder, and each time, the resident's recollection proved accurate.
-Resident #5 was allergic to a lot of pain medications, so she was given Tylenol for pain after her fall, which was consistent with the information provided by Resident #5.
-The resident was genuinely kind, never wanted to rock the boat, and was a "people pleaser"; she did not want staff thinking she got them in trouble and did not want to "upset the apple cart", so she had been hesitant to talk about things with other people besides her.
-Resident #5 came into the facility with a positive attitude and was thriving during those first two weeks, as she was not isolated at home alone anymore, she was making new friends, and her calendar was circled with activities she was interested in doing.
-Since the resident's fall on 03/23/25, during which she was on the floor for nearly seven hours, her confidence had been so severely shaken that she installed cameras in the resident's room to monitor her.

-Before the resident's admission, she had cameras in the resident's home to keep track of her well-being and had looked forward to some relief from having to maintain constant oversight, however, the circumstances surrounding the fall on 03/23/25 caused her to lose confidence in the facility's ability to adequately care for the resident.
-As soon as she received a call from staff on 03/23/25 around 7:00am notifying her that the resident had fallen and was being sent to the hospital, she immediately went straight to the hospital.
-When she arrived at the hospital, the hospital staff informed her that the resident had fallen around midnight and was on the floor all night, and they were concerned about the lack of supervision by staff.
-It was her understanding that before the resident had her fall on 03/23/25, she had fallen asleep in the recliner in her bedroom; upon waking up, the resident decided to go to her bathroom before going to bed; as she was exiting the bathroom, she became dizzy and fell.
-The resident was injured and immediately pressed her call pendant repeatedly, but no one responded.
-The resident was able to see the microwave clock, which was set to the correct time, and noted it was midnight at the time of the fall.
-She began yelling out for help but still received no response.
-The resident remained on her back on the floor in pain throughout the night, continuing to yell out in an attempt to get assistance.
-The resident did not see any staff members during the night.
-She did not know which staff member found her, but the resident was found on the floor around 7:00am that morning.
-The staff called 911, and the resident was transported to the hospital to evaluate her injuries.
-She was heartbroken about the whole situation, as Resident #5 had been placed in the facility specifically to ensure staff would always be available, especially in the event of an emergency.
-On 03/24/25, she met with the Executive Director (ED) and the DHW about the accident.
-The ED and DHW informed her they could not provide the names of the staff on duty when this occurred, but they confirmed it was an MA who found her on the floor.
-The resident had been admitted to the facility for less than a month when this occurred.
-When the decision was made for the resident to move into the facility, both she and the resident felt confident that the facility was a very safe place for her to live, and were so relieved that she would always have staff available to assist her.
-She understood that older residents could be prone to having falls, but she expected staff to come to the resident's assistance within five minutes or so, certainly not seven hours later.
-After this occurred and while the resident was still at the hospital, she offered for the resident to come and live with her for a while; the resident told her she did not want to do that, and she would go back to

the facility.
-The resident was bruised and in pain, but hospital tests confirmed nothing was broken, and she returned to the facility a short time later.
-She was with the resident when she returned from the hospital; the resident's bed was still made from the night before when she returned, which was consistent with what she said about never going to bed that night.
-The DHW was the Manager on Duty (MOD) on 03/23/25 and had arrived at the facility by the time the resident returned from the hospital; She and the DHW joined a conference call placed to the ED; she told both the DHW and the ED "We all need to know how this happened."
-She was extremely hesitant about the resident remaining at the facility that first night, but the ED and DHW advised her they would place her on "engagement rounds," and staff would check on her every thirty minutes.
-She requested to meet with the ED the next day, 03/24/25, and asked if the ED would provide her with information about what she had uncovered related to the incident at the meeting.
-The next day, she and a close friend who was a retired nurse met with the ED and the DHW.
-She took notes during the meeting and referenced them to remember the things that were discussed.
-She asked, "What about walking the halls? Aren't staff supposed to do that at night?"
-The ED and DHW told her the MA and the PCA who worked that night rotated walking the hallway every hour on the hour.
-It was her opinion that, had this been done, one of them would have heard the resident calling out for help.
-The ED informed her that significant training was needed at the facility, both for new staff and for senior staff, to reinforce the expected processes related to resident care.

Second review of Resident #5's electronic progress notes for March 2025 revealed:
-On 03/21/25 there was no progress note entry during any shift.
-On 03/22/25 there was no progress note entry during any shift.

Interview with the DHW on 03/24/25 at 11:13am revealed:
-She was newly hired at the facility on 02/24/25.
-She was the Manager on Duty (MOD) on 03/23/25 and arrived at the facility after Resident #5's had left for the ER after her fall.
-She was still trying to find out exactly what occurred related to Resident #5's fall.
-Resident #5 was well oriented and she interviewed the resident regarding her account of her fall.
-When questioned, the PCA who was assigned to work with Resident

#5 on 03/23/25, said she observed Resident #5 in bed at 5:30am.
-The MA had last observed the resident during the evening medication pass the night before.
-Both MAs and PCAs were supposed to complete routine "engagement rounds" every two hours for all residents, including Resident #5.
-Engagement rounds were formerly referred to as supervision.
-Engagement rounds required staff to enter the resident's room and engage with them, at least every two hours.
-The frequency of engagement rounds increased if a resident's needs called for it and this was usually a group decision that involved the input from multiple staff, including herself.
-Examples of the need for increased engagement rounds would be if a resident had falls or if a resident was on certain new medications, and staff needed to monitor for effectiveness or side effects.
-Staff were not required to document the completion of increased engagement rounds because the organization's policy was that this was only documented by exception; this meant staff were only required to document related to supervision of a resident if they failed to do it.
-Resident #5 was not on increased engagement rounds at the time of her fall, so the requirement for staff to see her would have been every two hours.
-Resident #5 should have been seen at least every two hours, and the MA and PCA were both responsible for ensuring this was done.

Interview with the ED on 03/24/25 at 12:04pm revealed:
-During her interactions with Resident #5, the resident was well oriented.
-She was attempting to find out exactly what occurred related to Resident #5's fall on 03/23/25.
-Resident #5 was on regular "engagement rounds" on the night of her fall, and she expected that Resident #5 would have been seen by both the MA and the PCA throughout the night on 03/23/25, at least every two hours.
-The third shift MA and PCA had been interviewed about Resident #5's reporting that she fell around midnight on 03/23/25.
-Resident #5 had informed staff that she called out for help all night.
-The third shift PCA said she checked on Resident #5 that evening at 12:00am, 3:00am, and 5:30am and the resident was resting in her bed.
-Both the third shift MA and the PCA reported they would have heard the resident calling out for help during the night, but they did not hear anything.
-Both the MA and the PCA said she must have just fallen that morning, just before 7:00am, when she was found on the floor.
-She was scheduled to meet with Resident #5's POA that day, 03/24/25, to discuss the situation.
-Both the third shift MA and PCA assigned to Resident #5 on 03/23/25 had been working at the facility for approximately one month.

-A lot of the newer staff, of which there were many, and the staff that had worked there for a while needed refresher training related to supervision and other areas of resident care.

Telephone interview with Resident #5's PCP on 04/29/25 at 2:23pm revealed:
-During her interactions with Resident #5, she was well oriented.
-She might occasionally forget some things, like someone's name, but for the most part, she was good at remembering details.
-She knew the resident had a fall on 03/23/25 but had not been informed about the resident's account of the fall until this conversation.
-Staff did not inform her that the resident reported falling at midnight and remaining on the floor all night.
-The resident had a recent fall before she was admitted to the facility, and she had balance deficits, so staff should have checked on the resident at a minimum of every two hours.
-It certainly increased the risks of serious outcomes if the resident remained on the floor all night after she fell.

2. Review or Resident #2's current FL-2 dated 09/12/24 revealed:
-Diagnoses included Alzheimer's disease, advanced Parkinson's disease, and bipolar mood disorder.
-The "Patient Information" section contained no entries, including the subsection labeled "Inappropriate Behaviors", which listed options that included wanderer, verbally abusive, and injurious to self or others.
-The resident's recommended level of care was Special Care Unit (SCU).

Review of Resident #2's Resident Register revealed an admission date of 10/31/21.

Review of Resident #2s current Assessment and Care Plan dated 12/11/24 revealed:
-The resident exhibited wandering with exit-seeking behaviors, was injurious to self and others, and had altercations with other residents.
-The resident was linked with a psychiatric provider and was receiving behavioral health medications that included Seroquel (used to treat bipolar disorder) 50mg 1 tablet two times daily and as needed every 6 hours, Clonazepam (used to treat anxiety) 1mg 1 tablet three times daily and as needed every six hours up to twice
daily, Divalproex (used to treat bi-polar disorder) 125mg 3 tablets (375mg) by mouth 2 times daily, lithium carbonate (used to treat manic episodes) 300mg 1 tablet at bedtime, and Lorazepam gel (used to treat anxiety) 1mg to be applied topically every 6 hours.
-The resident was ambulatory.
-The resident required supervision for eating, toileting, ambulating, transferring, and personal hygiene, and limited assistance for bathing

and dressing.
-Staff were to monitor the resident's behavior and approach calmly and gently.

Review of Resident #2's electronic Progress Notes for September 2024 through March 2025 revealed:
-On 09/22/24 at 4:27am there was an entry, Resident #2 attacked a personal care aide (PCA) by hitting her and scratching her arm; when the PCA tried to get away from the resident, he shoved her against a wall and began kicking her; the resident was given an as-needed medication for agitation, and he went back to bed.
-On 09/23/24 at 4:07pm there was an entry, Resident #2 was seen at the facility by his mental health provider.
-On 10/21/24 at 5:39pm there was an entry, Resident #2 had exit-seeking behaviors.
-On 10/30/24 at 3:15pm there was an entry, Resident #2 was seen by staff walking down the hallway outside the SCU, and he was escorted back into the SCU.
-On 11/03/24 at 11:00am there was an entry, Resident #2 became combative and grabbed a staff member's hands and fingers, trying to break them; the resident kicked staff, tried to throw a chair, and cursed at staff; the resident refused his medications; the resident was sent to the Emergency Room (ER) and the primary care provider (PCP) was notified.
-On 11/04/24 at 4:37am there was an entry, Resident #2's mental health provider was in the facility and was made aware of the resident's behaviors.
-On 11/04/24 at 6:30pm there was an entry, Resident #2 had agitation and exit seeking behaviors and was given as-needed Clonazepam.
-On 11/12/24 at 5:25pm there was an entry, Resident #2 hit another resident.
-On 11/15/24 at 3:30pm there was an entry, Resident #2 put his hands around another resident's neck and pushed him; staff intervened and redirected the resident back to his room.
-On 11/17/24 at 4:33pm there was an entry, Resident #2 was agitated and anxious and was given as-needed Lorazepam.
-On 11/24/24 at 5:00pm there was an entry, Resident #2 was seeking an exit and went into another resident's room; when staff attempted to redirect him, he became violent and was involved in an altercation with another resident before staff "broke the altercation up and separated the residents"; he left one resident upset and took another resident's glasses.
-On 11/24/24 at 7:30pm there was an entry, staff consulted with the facility's Regional Director of Resident Care (RDRC); staff were instructed to send Resident #2 to the hospital for a psychiatric evaluation.
-On 11/24/24 at 7:52pm there was an entry by the RDRC, she contacted

the residents responsible party and discussed the resident's "repeated altercations with other residents"; the resident's Power of Attorney (POA) agreed for the resident to go to the hospital for evaluation; upon speaking with the ER nurse about the residents impending transfer to the hospital, the ER nurse informed the facility staff the hospitals Computed Tomography (CT) equipment was down and suggested the resident be sent to a neighboring hospital; the residents POA was contacted a second time about his preference, at which time he inquired if Resident #2 had been administered his as-needed Ativan, and it was confirmed that he had not; Emergency Medical Services (EMS) arrived at the facility and the RDRC "instructed staff to allow EMS to evaluation and if resident was not currently agitated or combative, and did not wish to go the ER, to administer the resident's Ativan gel, assist him to bed, and monitor him hourly throughout the night"; there were no additional entries that night and the resident did not go to the hospital.
-On 11/25/24 at 11:43am there was an entry, Resident #2 was pacing and anxious and trying to open the SCU door; the resident was given an as-needed medication.
-On 11/25/24 at 2:11pm there was an entry, Resident #2 had been given an as-needed behavioral health medication and was having exit-seeking behaviors.
-On 11/26/24 at 12:23pm there was an entry, Resident #2 had been pacing and had exit-seeking behaviors; the resident was given an as-needed behavioral health medication.
-On 11/26/24 at 2:51pm, there was an entry, Resident #2 grabbed another resident by the shirt and tried to push him; staff intervened and separated the residents.
-On 11/26/24 at 11:43pm, there was an entry, Resident #2 tried to hit a male resident that was walking by and then tried to follow the resident into his room; he was given an as-needed mental health medication and put to bed.
-On 11/27/24 at 11:30am there was an entry, Resident #2 was pacing, anxious, and exit seeking; the resident was given as-needed Clonazepam.
-On 11/27/24 at 11:30am there was an entry, the facility's Director of Health and Wellness (DHW) contacted the resident's mental health provider regarding an increase in his behaviors; upon receiving a return call from the behavioral health clinician, a telehealth visit was completed with the resident and the clinician requested a copy of the residents current medication administration record (MAR).
-On 11/27/24 at 12:18pm there was an entry, Resident #2 had been anxious and crying and was given as-needed Risperidone.
-On 11/28/24 at 2:00am there was an entry, Resident #2 awoke and was putting on his shoes while asking to leave; he was given an as-needed mental health medication.
-On 11/28/24 at 6:50pm there was an entry, Resident #2 had a physical

altercation with his roommate and staff separated and redirected them.
-On 11/29/24 at 4:32am there was an entry, orders were received for mental health medication changes for the resident.
-On 11/29/24 at 10:30am there was an entry, Resident #2 was pacing and going into other residents' rooms and was given as-needed Clonazepam.
-On 11/30/24 at 4:19pm there was an entry, Resident #2 was anxious and exit-seeking and was given an as-needed mental health medication.
-On 12/01/24 at 6:26pm there was an entry, Resident #2 was pacing and exit seeking but "had no altercations today"; he was given an as-needed mental health medication.
-On 12/04/25 at 1:24pm there was an entry, Resident #2 was pacing and exit-seeking and was given as-needed Quetiapine.
-On 12/05/24 at 5:12pm there was an entry, Resident #2 was pacing and trying to open doors and was given as-needed Clonazepam.
-On 12/06/24 at 9:35am there was an entry, the mental health provider provided updated mental health medication orders.
-On 12/06/24 at 10:52 there was an entry, Resident #2 was pacing and going into other residents' rooms; the resident was given as-needed Quetiapine.
-On 12/13/24 at 7:30pm there was an entry, Resident #2 refused all medications; topical as-needed Lorazepam was given.
-On 12/17/24 at 7:51am there was an entry, Resident #2 had exit seeking behaviors and was given as-needed Quetiapine.
-On 12/24/24 at 2:17pm there was an entry, Resident #2 was pacing back and forth.
-On 12/26/24 at 2:45pm, there was an entry, staff were assisting Resident #2 with getting undressed for his shower and told staff it was their turn to undress; when the resident began to masturbate during his shower, staff gave him privacy, but then he continued to do so after his shower; the mental health provider and the PCP were notified.
-On 12/28/24 at 2:21am there was an entry, Resident #2 was agitated and wandering into other residents' rooms; the resident was given as-needed Lorazepam topical gel.
-On 12/28/24 at 1:32pm there was an entry, Resident #2 was pacing back and forth and getting upset that the SCU doors would not open; the resident was given as-needed Lorazepam gel.
-On 12/28/24 at 8:56pm there was an entry, Resident #2 refused his evening medication multiple times; the resident was given as-needed Lorazepam gel.
-On 12/29/24 at 6:57am there was an entry, Resident #2 was anxious and exit-seeking; the resident was given as-needed Clonazepam.
-On 01/01/25 at 10:43pm there was an entry, Resident #2 was agitated, refused his medications, and chased an aide down the hallway; the resident was given as-needed topical gel.
-On 01/10/25 at 7:45pm there was an entry, Resident #2 refused his

evening medications and stated he was not taking any more medication.
-On 01/11/25 at 10:34pm there was an entry, Resident #2 refused his medication all day, and he informed staff he decided he was not taking medications anymore; several attempts with different approaches by staff failed.
-On 01/12/25 at 9:00pm there was an entry, Resident #2 refused his evening medications, and he informed staff he was not going to take any more medications; several attempts with different approaches by staff failed.
-On 01/14/25 at 11:57pm there was an entry, Resident #2 was seen at the facility by his mental health provider.
-On 0/16/25 at 12:39pm there was an entry, the psychiatric provider made medication changes, including moving the administration time for some of the resident's mental health medications so that they would be given with his dinner.
-On 01/17/25 at 9:00pm there was an entry, Resident #2 refused his evening medications, and he informed staff he was not taking any more medications; several attempts with different approaches by staff failed.
-On 01/19/25 at 12:42am there was an entry, Resident #2 continued to refuse his medications, even after several attempts by staff.
-On 01/19/25 at 9:30pm there was an entry, the resident continued to refuse his medication, and he informed staff he was not taking any more medications; staff attempted unsuccessfully to help the resident understand the importance of taking his medications; the staff notified the resident's PCP that he was refusing his medications regularly.
-On 01/23/25 at 1:03pm there was an entry, staff notified the PCP again of Resident #2 refusing his medications; the PCP gave a new order for the remaining medications that were not being given with the resident's dinner, to be moved from an administration time of 8:00pm to 7:00pm.
-On 01/25/25 at 10:07pm there was an entry, Resident #2 refused his evening medications; several attempts by staff failed.
-On 01/26/25 at 5:00pm there was an entry, Resident #2 was seen at the back of the SCU hallway with another resident and began shoving the resident and pushing him against a wall, which led to the other resident falling on his bottom.
-On 01/26/25 at 7:39pm there was an entry, Resident #2 refused his evening medications, and he informed staff he was not taking any more medications; the resident was given as-needed Lorazepam topical gel.
-On 02/08/25 at 11:48pm there was an entry, Resident #2 refused his evening medications, and told the MA to leave him alone after several attempts.
-On 02/10/25 at 1:49pm there was an entry, Resident #2 was pacing back and forth and pushing on the SCU doors trying to get out; the resident was given as-needed Quetiapine.
-On 02/10/25 at 5:35pm there was an entry, Resident #2 was seen at the facility by his behavioral health provider; there were no medication changes.

-On 02/15/25 at 9:36pm there was an entry, Resident #2 refused all evening medications.
-On 02/17/25 at 6:12pm there was an entry, Resident #2 went into another resident's room where two staff members were providing care and he pushed the door with his shoulder, so the staff let the door go to avoid hurting the resident; the resident charged toward a staff member with a closed fist and hit the staff member on her shoulder; the staff member explained to the resident that the room belonged to a female resident and he said he did not care because it was his house.
-On 02/20/25 at 3:54pm there was an entry, Resident #2 was agitated and had exit-seeking behaviors; the resident was given an as-needed mental health medication.
-On 02/23/25 at 9:00pm there was an entry, the previous shifts MA had reported to the current MA that the resident had an altercation with a SCU resident and pushed the resident; staff redirected the resident.
-On 02/27/25 at 7:01pm there was an entry, Resident #2 was making sexual comments to staff.
-On 03/11/25 at 2:27pm there was an entry, after visit notes were received from Resident #2's psychiatric provider visit on 03/10/25 with no medication changes.
-On 03/19/25 at 2:09am there was an entry, Resident #2 swung at a PCA and went into this room and slammed the door; he had just received his scheduled medication, so an as-needed medication was not given.
-On 03/19/25 at 3:00pm there was an entry, Resident #2 was discovered in another resident's room lying on a bed "cuddling" with a resident; both residents were clothed, and they were redirected.
-On 03/21/25 at 5:09pm there was an entry, the PCP gave a new order for all of Resident #2's medications to be crushed and given with applesauce, pudding, or yogurt.
-On 03/21/25 at 7:30pm there was an entry, Resident #2 hit another resident with a closed fist and lunged at an MA who attempted to administer his medications.
-On 03/22/25 at 1:14am there was an entry, Resident #2 had become extremely aggressive and hit another resident with a closed fist; EMS was called, and Resident #2 became aggressive with them as well; he was taken to the hospital because staff could not calm him down.
-On 03/22/25 at 11:05am there was an entry, Resident #5 received a notice of an immediate discharge, due to the resident being a safety risk to himself and others.

Review of an audio recording of 911 calls on behalf of Resident #2 for November 2024 through March 2025 revealed:
-On 11/03/24 (no time stated) a staff member informed the 911 operator she was calling because Resident #2 was combative and needed to go to the hospital.
-On 11/24/24 (no time stated) a staff member informed the 911

operator she was calling because Resident #2 had multiple altercations with others that day and the corporate office wanted him to be sent to the hospital for a psychological evaluation because he was a "danger to others".
-On 03/21/25 (no time stated) a staff member informed the 911 operator she was calling because Resident #2 was being aggressive and violent, was pacing up and down the hallway, "made contact with another resident", and would not calm down or take his medication.
-On 03/21/25 (no time stated) a staff member informed the 911 operator that Resident #2 had been sent to the hospital earlier that day because he "beat a resident up"; she requested guidance on having the resident involuntarily committed because she said her corporate office wanted him to be immediately discharged.

Review of Resident #2's Emergency Management Services (EMS) electronic response transcripts from June 2024 through March 2025 revealed:
-On 06/11/24 at 6:10pm EMS was dispatched to the facility for Resident #2 having "psychiatric and abnormal behavior"; upon arrival staff reported the resident was out of control, fighting, and refused to take his medications; staff and law enforcement were adamant that the resident be taken to the hospital for evaluation but upon EMS consultation with the hospital, the hospital was concerned that if they took the resident for evaluation, the facility would not accept him back; the facility staff supervisor was insistent the resident be sent out and the hospital responded if they accepted the resident for evaluation and he was calm upon his arrival to the hospital, he would be released back to the facility; the facility staff on duty said if were up to them, the resident would not be accepted back at the facility; the staff supervisor told EMS if the resident would take his medication and remain calm, she would not force them transporting to the hospital; the resident calmed down and took his medication; the resident remained at the facility and law enforcement advised staff of their option to involuntarily commit the resident.
-On 11/03/24 at 11:08am EMS was dispatched to the facility for Resident #2 having "psychiatric and abnormal behavior"; upon arrival staff reported the resident was combative and would not take his medications; he was transported to the hospital for evaluation and returned to the facility at 12:48pm with no new orders.
-On 11/24/24 at 7:35pm EMS was dispatched to the facility for Resident #2 having "psychiatric and violent behavior"; upon arrival, staff asked EMS to check Resident #5's vital signs and a staff member signed the EMS transport refusal form that stated, "The EMS provider has recommended ambulance transportation. I refuse the care that the attending EMS provider has recommended. I understand that my refusal may result in serious injury or death to the patient. I accept full responsibility for this decision. I accept all risks and consequences

resulting from my refusal of care."
-On 03/21/25 at 7:51pm EMS was dispatched to the facility for Resident #2 having assaulted another resident; upon arrival, the resident was aggressive and began to attack the EMS responders; Resident #2 was transported to the hospital; the facility advised the responsible party the resident was being immediately discharged from the facility.

Review of Resident #2's electronic mental health provider tele-psych visit summaries for September 2024 through March 2025 revealed:
-On 09/13/24 the resident had a tele-psych visit for "multiple chronic and progressive disorders, including bipolar disease, necessitating psychiatric management and treatment; staff reported no mood or behavioral concerns; the current behavioral health medication orders were for Risperidone (used to treat anxiety and agitation) 1mg one tablet by mouth every six hours as needed, Risperidone 2mg take 0.5 tablet by mouth one time daily, Risperidone 2mg take one table by mouth one time daily, Depakote (used to treat bi-polar disease) 125mg three tablets by mouth three times daily, Lithium Carbonate (used to treat manic episodes) one tablet by mouth at bedtime, Clonazepam (used to control aggression and exit seeking behaviors) 1mg one tablet by mouth three times daily and as needed every six hours up to twice daily, and Melatonin (used to induce sleep) 10mg one capsule by mouth at bedtime.
-On 12/05/24 the resident had a tele-psych visit for "ongoing extremely aggressive behaviors"; the resident's menatl health medications were discussed and reconciled and some adjustments were made including adding an as needed topic gel for anxiety and agitation; a conversation with the adults responsible party revealed dissatisfaction with the mental health provider and the facility and he blamed both for Resident #2's behaviors and for the resident's ER visits due to aggression, the responsible party was determined to keep the resident out of a psychiatric hospital.
-On 01/14/25 the resident had a tele-psych visit, and staff reported the resident often refused his medications and had episodes of sundowning; the resident's mental health medications were discussed, and some adjustments were made which included the addition of Quetiapine (used to treat bi-polar disorder) 150mg extended release one tablet by mouth one time daily with dinner.
-On 02/10/25 the resident had a tele-psych visit and staff reported "less sundowning" and that the resident was "doing well"; the residents mental health medications were discussed and reconciled, and some adjustments were made which included an adjustment to the time of administration for Quetiapine 150mg to be given daily at 5:00pm instead of with dinner.
-On 03/12/25 a new electronic medication order was given for Sertraline (used to treat various mental health disorders) 25mg one

tablet by mouth twice daily for "management of mood and decreasing libido".

Review of accident/incident reports for Resident #2 for September 2024 through March 2025 revealed:
-On 01/19/24 at 12:42am, there was an entry, Resident #2 refused his medications; staff made multiple attempts, but the resident continued to refuse.
-On 01/19/25 at 9:30pm, there was an entry, Resident #2 refused his evening medication, and he informed staff he was not taking any more medications; attempts by staff to persuade the resident failed; the PCP was notified that the resident refused his medications on a regular basis.
-No other incident/accident reports were available for review.

Review of Resident #2's Notice of Discharge dated 03/22/25 revealed:
-The resident was involuntarily committed on 03/21/25.
-The resident was issued an immediate notice of discharge effective 03/21/25 and the reason given was that the resident needed a "higher level of care for the safety of himself and others."

Interview with a first-shift PCA on 03/17/25 at 1:55pm revealed:
-Resident #2 had lived in the facility for an extended period and had a longstanding history of behavioral outbursts.
-The resident had physically attacked staff and other residents multiple times, which included punching and pushing residents.
-There had been incidents when the resident had chased her down the SCU hallway, trying to hit her.
-In recent months, he began exhibiting sexually aggressive behavior toward female residents and staff.
-The sexually aggressive behaviors occurred "pretty much every day."
-His sexual aggression toward female residents included kissing and groping female residents, and he often specifically targeted two residents.
-Anytime Resident #2 had a behavioral incident, she provided a verbal report to the supervising MA.
-The MAs were responsible for documenting the resident's behaviors, probably in his progress notes.
-Interventions for the resident's sexually inappropriate behaviors included redirection; however, this often resulted in physical aggression toward others.
-The resident was sometimes sent to the hospital following his behavioral outbursts, but he always quickly returned.
-The resident frequently refused his medications, which included his behavioral health medications.
-Staff did all they could to keep an eye on the resident, but there was no way to know what he was doing all the time, especially if staff were busy helping other residents.

-Other than redirection and notification to the MA of observed behaviors, she had not been given any other directives in to follow in response to the resident's bahaviors.

Interview with a second first-shift PCA on 03/17/25 at 2:01pm revealed:
-She attempted to maintain her distance from Resident #2 due to his unpredictable behaviors.
-The resident needed someone watching him at all times, which was impossible since that would require a one-on-one worker.
-There was a behavioral incident with a former aide in which he had grabbed her by her throat and slammed her against a wall.
-The resident exhibited unpredictable behaviors that were sexual in nature or suddenly violent, and these behaviors had occurred toward staff and other residents.
-The resident frequently kissed and inappropriately touched female residents, with particular focus on a couple of female residents in particular.
-She had recently observed the resident fondling his groin area while kissing and feeling on a female resident in the SCU dining room; the resident ceased the behavior when redirected and while under staff supervision, but as soon as staff walked away, he resumed the behavior and had to be redirected again.
-Staff tried to keep an eye on the resident, but he was always looking for an opportunity, and staff could not always know what he was doing.
-There was one female resident who Resident #2 often kissed and fondled, but the female resident allowed him to do it; she told the female resident she should not allow him to do that because she was married.
-Whenever she observed the resident's inappropriate behaviors, she redirected him and reported it to the medication aide on duty.
-She was not sure what had been done to address Resident #2's behaviors, except perhaps medication changes and redirection, neither of which had been particularly successful.
-The sexually aggressive behaviors had been witnessed by most everyone who had worked with the resident.

Interview with a third first shift PCA on 03/17/25 at 2:04pm revealed:
-Resident #2 has a history of multiple incidents involving aggressive and sexually inappropriate behaviors.
-Interventions for the resident included redirection, medication adjustments, and sending the resident to the ER following the more severe behavioral outbursts.
-The resident had physically assaulted her by punching her in the face.
-There had been an incident involving a staff member who no longer worked there, where the resident put his hands around her neck and picked her up off the ground while he was choking her.

-On 02/23/25, Resident #2 shoved two different male residents on the same day, and she reported it to the MA on duty.
-There was an incident around November or December 2024, when she heard a female resident yelling and telling someone to stop; she ran to the end of the SCU hallway, and a female resident was sitting in a chair in the hallway; Resident #2 was kissing her face and neck and groping her; she immediately redirected Resident #2 away from the female resident.
-When she arrived for one of her recent shifts, the PCA who worked the preceding shift told her to keep an eye on Resident #2 because he had been following a female resident up and down the hall all day with his hands in his pants.
-There was a female SCU resident who Resident #2 often kissed and fondled; the female resident was married, and she had heard some staff say the resident allowed Resident #2 to touch her when her husband was not present, so the staff thought it was ok since she was not trying to stop him.
-The resident's sexually inappropriate behaviors occurred "daily" and his aggressive behaviors happened "pretty often."
-The resident frequently refused his behavioral health medications, but even when he took them, it usually did not seem to help his behaviors.
-The resident might have been placed on increased "engagement rounds" after the times he went out to the hospital for psychiatric evaluations, but there would not be any documentation of that since the staff had been instructed to only document by exception for supervision; she had never seen a staff member document something they "did not" do.

Interview with a first shift MA on 03/24/25 at 3:06pm revealed:
-Resident #2 was known to have physical outbursts toward staff and residents that had escalated starting around November 2024.
-The resident was known to have sexually driven behaviors that started a few months ago.
-He had noticed the resident had become very "touchy-feely" toward staff and residents.
-Staff tried to supervise the resident, but it was challenging to keep eyes on him constantly.
-There had been an incident last week, he did not know the date, between Resident #2 and a female resident.
-This was the same female who Resident #2 was often seen kissing and fondling.
-The PCA on duty saw Resident #2 whisper in a female resident's ear, and they tried to walk away together, but the PCA redirected them.
-A little later, the PCA realized Resident #2 and the female resident were missing, and she went to look for them.
-The PCA found Resident #2 lying on top of the female resident on the bed of another resident, kissing her.

-Both residents had their clothing on, but he did not know how far the situation would have escalated if the PCA had not found them.
-Staff had been instructed to redirect Resident #2 when he exhibited physically aggressive or sexually inappropriate behaviors, but he was very unpredictable.

Interview with a first shift PCA on 03/24/25 at 3:38pm revealed:
-One day last week, she was working as a PCA in the SCU assigned to Resident #2.
-She kept redirecting Resident #2 and a female resident to go sit down in the dayroom.
-At some point, she realized she did not see them and immediately went to look for them; she found them on another male resident's bed with Resident #2 lying on top of the female resident with his arms around her.
-She did not remember if they were kissing, but she knew they both had their clothing on.
-She redirected them off the bed and back to the dayroom.

Telephone interview with a third shift Personal Care Aide (PCA) on 03/31/25 at 3:58am revealed:
-Resident #2 had a long history of physical outbursts with staff and residents.
-Anytime there was an incident, the PCAs were to inform the MA, which she always did.
-On 03/21/25 when Resident #2 physically attacked another male resident; she was working in the SCU; that evening, Resident #2 wandered into another male resident's room and saw a female resident, whom both he and the other male resident were very fond of, lying in the male resident's bed.
-It was "pretty common" that the female resident would go and lay in the bed in different rooms where there were male residents that she liked.
-The male resident was sitting nearby in his room; Resident #2 began to get aggressive and was trying to get the female resident to leave the room; Resident #2 began punching the other male resident in his side and shoulders.
-She was trying to get the female resident out of the room, but the physical assault on the male resident was happening right in the doorway of the room, so she could not get to her.
-The male resident did not understand what was happening, so he was just standing there, allowing Resident #2 to punch him.
-There were two different attacks on the male resident that night because staff finally broke up the physical attack that was occurring in the other male resident's doorway, and then a few minutes later, Resident #2 started attacking him again outside the room in the hallway.

-The male resident continued to just allow Resident #2 to punch him; the male resident was not knocked down, but did become pretty winded.
-She did not think the other male resident had any injuries, but Resident #2 was sent out to the hospital that night after the second physical attack on the male resident.

Confidential interview with two staff revealed:
-Staff had been asking for something to be done about Resident #2 for a long time because it was evident that he needed more supervision than what the facility could provide.
-The resident who was attacked by Resident #2 on 03/21/25 had been attacked by him during previous incidents and Resident #2 had been physically and sexually aggressive for a long time.

Interview with the Memory Care Coordinator (MCC) on 03/24/25 2:41pm revealed:
-Resident #2's history of behaviors in the facility "went back years."
-Many of Resident #2's attacks on other residents happened when another resident would wander into his bedroom.
-Resident #2 was very unpredictable and would suddenly snap with no warning.
-It was difficult to pinpoint what was going to set him off or trigger his behavioral outbursts, but he was very territorial, so any resident being in what he considered to be his space would most likely cause the resident to lash out.
-The facility's mental health provider managed Resident #2's mental health medications, and there had been medication adjustments to try to address his behavioral outbursts.
-The resident had so many medications and so many medication adjustments that there had been times the PCP and the mental health provider each wanted the other one to write something new to try to get a handle on the resident's behaviors.
-In recent months, the resident frequently exhibited sexually aggressive behaviors.
-The resident had been placed on medication to try to reduce his libido, maybe last week.
-He kissed and fondled female residents, and you could always "kind of feel the vibe" of his sexually aggressive intentions.
-Staff tried to separate Resident #2 from female residents, but needed to watch him at all times.
-On 03/21/25, Resident #2 went into a male residents bedroom and a female resident lying in the male residents bed; the male resident assigned to the room was near the bed; Resident #2 probably thought the female resident was his wife so he began hitting the male resident; Resident #2 was sent out to the hospital and subsequently issued an immediate discharge due to safety concerns for the other residents.

-She heard there was a recent incident involving the resident being found kissing and touching a female resident, and her becoming upset, but she did not witness it.
-The facility leadership staff held "stand-up" meetings regularly, and issues with resident behaviors were one of the topics, so all in attendance should have been aware of Resident #2's physical outbursts and his sexually inappropriate behaviors.
-Interventions included redirection, medication adjustments, and sending Resident #2 to the ER for the more serious altercations with other residents.
-Resident #2 might have been placed on increased "engagement rounds" after his behavioral outbursts, but if he was not, it was because the SCU was small, so it made it easier to supervise residents.

Interview with the DHW on 03/24/25 at 11:13am revealed:
-Behavioral outbursts would be included in the reasons that warranted a resident to be placed on increased engagement rounds.
-Resident #2 had likely been placed on increased engagement rounds at some intervals following his behavioral outbursts, but there would not be any documentation of it because the facility staff had been instructed by the corporate leadership to only document by exception, meaning if they did not do it.
-When a resident was placed on increased engagement rounds, this was communicated verbally.
-This process was not what she was used to previous employers, so she was still learning how this process worked.
-When SCU residents like Resident #2 acted out, they were trying to tell staff something, and staff needed to take time to figure out what it was that the resident was trying to convey.
-Her first reaction when SCU residents like Resident #2 had behavioral outbursts was usually to call the facility's RDRC to get feedback on the appropriate next steps, especially since she was new to her job.
-The RDRC's recommended interventions for Resident #2 included medication changes and sending the resident to the hospital for evaluation.
-She was not working at the facility during much of the resident's history of behaviors, but she was pretty sure the ED had consulted with the RDRC about the resident's behaviors a while back.
-She did not know anything about the resident having sexually inappropriate behaviors, only physically aggressive.
-The resident was given a notice of discharge after a final incident that occurred last weekend, 03/21/25, in which he had a physical altercation with another resident.

Interview with the Executive Director (ED) on 03/17/25 at 2:10pm revealed:
-She had no concerns or issues related to behaviors or supervision for

any specific SCU resident.
-No staff members had expressed concerns to her related to the behaviors of any specific SCU residents.

Second interview with the ED on 03/24/25 at 10:15pm revealed:
-She began her position as the ED in December 2025.
-Soon after she began her position as the ED, a staff member had spoken to her about concerns about Resident #2's behavioral outbursts.
-The resident had multiple behavioral incidents during the past few months, starting with 5 or 6 incidents of physically aggressive behaviors in November 2024 and at least one incident in January 2025.
-The behavioral outbursts involved some incidents with staff and some with other residents.
-She did not know what interventions were put in place when several incidents occurred in November 2024 since she was not there, but in January 2025 she was there, and interventions included redirection and medication changes.
-There had been ongoing problems with the resident refusing his mental health medications, so this probably contributed to the number of behaviors.
-The resident's POA was unlike any she had ever dealt with before, and he had been asked to communicate directly with her or the RDRC because of the way he treated staff; he was very threatening and blamed everyone else, including the facility, for the resident's behaviors; she did not think this impacted the decision not to discharge the resident, but they were trying to work with the POA regarding his desire the resident remain in the facility as opposed to being discharged to a mental health facility.
-After reviewing Resident #2's resident records around the beginning of 2025, she thought he had an excessive number of behavioral incidents and had consulted with her RDRC regarding Resident #2's behaviors; at that time, the decision was made that the resident was appropriate to remain at the facility; the plan was for staff to continue to monitor and redirect the resident.
-There had been concerns that perhaps the one staff member who had reported concerns was the problem because it was thought that maybe that staff member just aggravated Resident #2; that staff member had been reassigned to the Assisted Living Unit (ALU) and was no longer working in the SCU.
-The resident could be very kind at times, but at other times was unpredictable.
-She was involved with the one incident in January 2025, and that was the last incident she was aware of before last Friday night on 03/21/25, when Resident #2 hit another male resident; Resident #2 was sent to the hospital following the incident for a psychological evaluation.
-Resident #2 was issued a notice of immediate discharge on 03/22/25, related to this incident, because it was determined that he posed a risk

to other residents.
-She guessed the reason the resident had not been issued a notice of discharge before 03/22/25 was because the incident on 03/21/25 that led to the notice of discharge seemed more aggressive; the resident became enraged and hit a male SCU resident with his closed fist; there was a January 2025 incident involving the same resident, but it was more of a shove than a hit.
-She would not necessarily say SCU residents, such as Resident #2, were placed on increased engagement rounds after incidents occurred because there were only thirteen residents in the SCU, so it should be easy to keep an eye on them.
-She was not aware of Resident #2 exhibiting any sexually inappropriate behaviors before his discharge.
-Resident #2 liked to hug, but there had not been anything that would be considered touchy-feely.

Telephone interview with RDRC on 03/24/25 at 12:45pm revealed:
-She had asked the ED to put her on speaker phone to discuss the questions being asked about Resident #2 having sexually inappropriate behaviors.
-She knew Resident #2 had some incidents of aggressive behaviors, but she nor the ED had any knowledge of the resident exhibiting sexually inappropriate behaviors.
-She did not think Resident #2's behaviors created an unsafe environment for the residents until the incident that occurred on 03/21/25, after which the resident received an immediate notice of discharge.
-She nor the ED knew anything about Resident #2 ever touching staff or other residents inappropriately.
-If this conversation was about the one incident about a week ago which involved Resident #2 and a female SCU resident being found lying on a bed hugging, she did not "see a problem with that."
- She planned to conduct an internal investigation to determine which staff members were aware of Resident #2's sexually inappropriate behavior but failed to report it, and that those staff members would be terminated.
-The times that staff had increased engagement rounds for the resident related to his aggressive behaviors would not be documented because the staff had been instructed to only document by exception, meaning they were only required to document supervision if they did not do it; with the old way of documenting increased supervision, if a staff member forgot to document supervision of a resident, it could be misconstrued that the supervision was not completed at the assigned intervals.
-Increased engagement rounds were initiated by word of mouth only and would not be documented anywhere.

Interview with a first shift PCA on 03/17/25 at 2:15pm revealed:
-She had been very concerned about resident safety due to Resident #2's behaviors and reported these concerns appropriately, always to her direct supervisors, the MAs on each shift; additionally, she voiced her concerns in person to the previous ED and again to the current ED shortly around the beginning of 2025, shortly after the new ED was hired.
-She knew the resident required more supervision than what the facility could or was providing.
-She continued to see an escalation of the residents behaviors so on 02/18/25 she left a handwritten letter for the ED detailing her concerns about Resident #2 to ensure the ED was aware of the ongoing physically and sexually aggressive behaviors; she did not hear back from the ED so she followed up with her a week later and asked for an update; the ED confirmed she received the letter and told her she had shared the letter with the RDRC, but did not have an further update for her; since then, she had not received an follow-up from anyone regarding the information.
-"Yes" she had a copy of the letter she provided to the ED and provided a copy of the letter upon request.
-She had to do what was right for the safety of the residents.

Review of a printed copy of a handwritten letter (not dated) revealed:
- The letter stated, "I am very concerned about the sexual and physical harassment occurring in the SCU by (Resident #2). This has been reported previously, and nothing has changed his behavior. On 02/17/25 at 6:12 p.m., (a PCA's name) and I were putting (a female SCU resident's name) to bed when (Resident #2) entered the room. He was asked to leave, but he did not. I walked to the door to close it so (female resident's name) could have privacy. He pushed the door open with his shoulder, so I let go of the door to avoid injuring him. He charged toward me with a closed fist and struck my shoulder. I caught his hand, moved him away from me, and walked off. I kept telling him it was a woman's room, but he said he didn't care and that it was his house. He is very touchy with staff, (a female resident's name), and (a second female resident's name). It has also been reported about him kissing and feeling (a third female resident's name), to the point that she yells at him to stop, and we had to separate him from her. He is aggressive when staff try to redirect him in any way. Please speak with (a female staff member's name) and other staff to confirm what is happening. Should I report this to anyone else inside or outside the building? He is getting worse."
-The letter was signed by a first shift PCA.

Interview with Resident #2's PCP on 04/29/25 at 2:23pm revealed:
-She was well aware of Resident #2's behavioral outbursts and that he could potentially seriously injure other residents.

-Resident #2 required constant supervision; the amount of supervision provided to him did not stop him from physical attacks on both residents and staff.
-She remembered there had been a lot of conversation among staff leadership about needing to discharge him from the facility because it was felt he posed a risk to other residents.
-The resident's behaviors were extremely difficult to manage and she had deferred to the mental health provider to manage his mental health medications.
-The resident could go from "zero to sixty" in a matter of seconds, meaning he could be fine one minute, and he would suddenly fly into a rage.
-He often refused his medications, but had been given an order for a topical medication to be used as needed when he would not take his medications; because his behavior happened so suddenly, sometimes he was too out of control to administer the topical medication.
-She did not remember being notified about him having sexually inappropriate behaviors, but there had been so many conversations about the resident, she could not be sure
-She did not know why the resident had been allowed to remain in the facility but one reason may have been the conduct of POA; she had never been afraid of a residents POA before, but she had heard the way the POA talked to staff, and it was scary, so she and others were afraid of him; he constantly intimidated and threatened staff, so that likely was a contributing factor to why the resident had not been discharged; the POA wanted facility leadership to think he would sue them if they discharged the resident; she had even spoken to a Department of Social Services county monitor that she happened to see in person at another county facility, to inquire on the facility's behalf about what they should do if a resident needed to be discharged but the POA was using threats and intimidation to keep it from happening.

Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable.

The facility failed to provide supervision consistent with the assessed needs, care plans, and symptoms for Residents #5 and #2. Resident #5 had a recent history of falls, was weak and unsteady, required assistance with toileting and transfers, had experienced a fall on 03/23/25 at 12:00am, and remained on the floor for approximately seven hours before being discovered by staff. Resident #2, who was known to be a danger to others, had a documented history of resident-to-resident attacks, which included hitting, choking, shoving, punching, knocking down, and sexually aggressive behaviors. The facility's failure to provide supervision resulted in physical harm to residents and constitutes a Type A1 Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 received on 03/24/25.

THE CORRECTIVE DATE FOR THIS VIOLATION SHALL NOT EXCEED 06/13/25.

Rule Number: 10A NCAC 13F .0909

Rule/Statutory Reference: 10A NCAC 13F .0909 Residents Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.
131D-21 Declaration of Residents' Rights
(4) To be free of mental and physical abuse, neglect, and exploitation.

Level of Non-Compliance: Type A1 Violation

Findings:

This Rule is not met as evidenced by:

Based on interviews and record reviews, the facility failed to protect 4 of 4 sampled residents (#1, #3, #4, and #6) from physical abuse by another Special Care Unit resident who had an extensive number of violent attacks on others.

The findings are:

Review of the facility's Residents' Rights and Personal Rights policies dated 06/11/24 revealed:
-Residents were to be treated with dignity, respect, and consideration.
-Residents would not be subject to physical abuse or sexual abuse, or assault.
-Resident abuse was prohibited, including abuse from other residents.
-Staff would not be terminated or reprimanded for reporting suspected or actual cases of resident abuse.
-Any staff member who observed, suspected, or had knowledge of, or if told by a resident or other staff member of an incident which appeared to be any form of abuse, the incident was to be immediately reported to the Director of Health and Wellness (DHW) and the Executive Director

(ED).
-Upon notice of reported, observed, suspected, or an imminent risk of any form of abuse, immediate steps were to be taken to ensure the resident was protected from potential future abuse while the investigation was conducted, and a a thorough investigation was to be conducted by the DHW and the ED.

1. Review of Resident #1's current FL-2 dated 10/10/24 revealed:
-Diagnoses included dementia and hypertension.
-The resident's recommended level of care was Special Care Unit (SCU).

Review of Resident #1's Resident Register revealed an admission date of 09/01/23.

Review of Resident #1's current Assessment and Care Plan dated 12/04/24 revealed:
-The resident ambulated with a walker.
-The resident required limited assistance with eating, toileting, ambulation for safety, dressing, grooming, and personal hygiene and required extensive assistance for bathing.

Review of Resident #1's hospice provider visit notes dated 02/10/25 revealed:
-Resident #1 had a Hospice service certification period that began on 01/30/25 with supporting diagnoses of dementia, fall risk, hypertensive heart disease, and atrial fibrillation.
-The resident's expected life prognosis was six months or less.

Review of Resident #1's electronic Progress Notes for November 2024 through March 2025 revealed:
-On 11/12/24 at 7:00pm there was an entry, the resident was "in an altercation with another resident".
-On 03/21/25 at 7:30pm there was an entry, the resident was hit with a closed fist in the shoulder and rib area by a male resident.
-On 03/22/25 at 1:09am there was an entry, the resident was hit with a closed fist on 03/21/24 in his shoulder and rib area; the resident's hospice provider assessed the resident and stated no visible marks; the resident was shaken up but calmed down and went to bed after the incident.

Review of the other male SCU resident's electronic Progress Notes for November 2024 through March 2025 revealed:
-On 11/12/24 at 5:25pm there was an entry, staff informed the second shift Medication Aide (MA) that the male resident went into another male resident's (#1) room and hit him.

-On 03/21/25 at 7:30pm there was an entry, the male resident became extremely aggressive and hit another resident (#1) with a closed fist.

Review of the other male SCU resident's handwritten Accident/Incident report dated 03/21/25 revealed the resident was "observed being aggressive towards another resident and was transported to the hospital."

Review of audio recording of 911 calls on behalf of the other male resident on 03/21/25 (no time stated) revealed:
-A staff member informed the 911 operator she was calling because a male resident was being aggressive and violent, was pacing up and down the hallway, "made contact with another resident", and would not calm down or take his medication.
-A second staff member placed a second call to 911 to ask a question about an incident that occurred earlier in the day, during which a male resident who was being violent had been sent to the hospital because he "beat a resident up".

Interview with a first shift personal care aide (PCA) on 03/17/25 at 2:04pm revealed:
-On 02/23/25 she witnessed Resident #1 get shoved by another male resident.
-This was not the first time Resident #1 had been attacked by the male resident, and Resident #1 seemed to be one of the residents the other male resident targeted on a regular basis.

Interview with the Memory Care Coordinator (MCC) on 03/24/25 at 2:41pm
revealed:
-On 03/21/25, a male resident entered Resident #1's bedroom and saw a female resident lying in Resident #1's bed; Resident #1 was near the bed; the male resident began hitting him.
-Staff separated the residents and the male resident was sent to the hospital for a psychiatric evaluation.

Telephone interview with a third shift PCA on 03/31/25 at 3:58am revealed:
-On 03/21/25 Resident #1 was physically attacked by another male resident who had a long history of physical outbursts with residents.
-There was a female resident whom both Resident #1 and the other male resident were very fond of, and that evening, the other male resident wandered into Resident #1's room and saw the female resident in Resident #1's bed.
-Resident #1 was sitting nearby, and the male resident began to get aggressive and was trying to get the female resident to leave the room; he began punching Resident #1 in his side and shoulders.

-She was trying to get the female resident out of the room, but the physical assault on Resident #1 was happening right in the doorway of the room, so she could not get to her.
-Resident #1 did not understand what was happening, so he was just standing there, allowing the male resident to punch him.
-There were two different attacks on Resident #1 that night because staff finally broke up the physical attack that was occurring in Resident #1's doorway, and then a few minutes later, the other male resident started attacking him again outside the room in the hallway.
-Resident #1 continued to just allow the male resident to punch him; he was not knocked down but did become pretty winded.

Confidential interview with two staff revealed there had been previous incidents of the male resident attacking Resident #1.

Interview with the Executive Director (ED) on 03/24/25 at 10:15pm revealed:
-On 03/21/25 Resident #1 was hit by a male SCU resident.
-The male resident was sent to the hospital and issued an immediate discharge related to this incident because it was determined that he posed a risk to other residents.
-She guessed the reason the male resident had not been issued a discharge notice before now was because the incident on 03/21/25 seemed more aggressive; the resident became enraged and hit Resident #1 with his closed fist; there was a January 2025 incident involving the male resident and Resident #1, but it was more of a shove than a hit.

Refer to a review of an audio recording of a 911 call from the facility on 11/24/24 (time not provided).

Refer to an interview with a first-shift PCA on 03/17/25 at 1:55pm.

Refer to an interview with a second first-shift PCA on 03/17/25 at 2:01pm.

Refer to an interview with a third first-shift PCA on 03/17/25 at 2:04pm.

Refer to a second interview with a third first-shift PCA on 03/17/25 at 2:15pm.

Refer to a review of a printed copy of a handwritten letter (not dated) from a first-shift PCA.

Refer to an interview with the Memory Care Coordinator (MCC) on 03/24/25 2:41pm.

Refer to an interview with the Director of Health and Wellness (DHW) on 03/24/25 at 11:13am.

Refer to a second interview with the DHW on 04/01/25 at 4:04pm

Refer to a telephone interview with the RDRC on 03/24/25 at 12:45pm.

Refer to an interview with the Executive Director (ED) on 03/17/25 at 2:10pm.

Refer to a second interview with the Executive Director (ED) on 03/24/25 at 10:15am.

Refer to a confidential interview with two staff.

Refer to a telephone interview with a SCU male resident's PCP on 04/29/25 at 2:23pm.

2. Review of Resident #3's current FL-2 dated 11/22/24 revealed:
-Diagnoses included Alzheimer's dementia, hypertension, dyslipidemia, anxiety, and vitamin D deficiency.
-The resident's recommended level of care was Special Care Unit.

Review of Resident #3's Resident Register revealed an admission date of 11/27/23.

Review of Resident #3's current Assessment and Care Plan dated 12/04/24 revealed:
-The resident was unsteady and had limited ability with ambulation.
-The resident required limited assistance with eating, toileting, ambulation for safety, dressing, grooming, and personal hygiene and bathing and supervision for transferring.

Review of Resident #3's Accident/Incident Report dated 01/27/25 revealed the resident was shoved yesterday (01/26/25) by another male resident and he fell on his bottom and he had no visible injuries or complaints of pain; today the resident complained of pain in his lower back, right hip, and upper right leg and he was sent to the hospital for an evaluation; the resident returned with no fractures or new orders.

Review of Resident #3's electronic Progress Notes for November 2024 through March 2025 revealed:
-On 01/26/25 at 5:00pm there was an entry, a male resident shoved Resident #3 and he fell on his bottom.
-On 01/27/25 at 7:03am there was an entry, the resident complained of lower back pain, right hip pain, and upper leg pain associated with his fall on 01/26/25; the resident was sent to the Emergency Room (ER)

for an evaluation and returned with no new orders.
-On 02/23/25 at 9:00pm there was an entry, the resident was shoved by another resident.

Interview with a first shift Personal Care Aide (PCA) on 03/17/25 at 2:04pm revealed:
-On 02/23/25 she witnessed Resident #3 get shoved by another male resident.
-During a previous incident around the end of January 2025, Resident #3 was pushed by the same resident, which resulted in him falling and having to go to the hospital.

Refer to a review of an audio recording of a 911 call from the facility 11/24/24 (time not provided).

Refer to an interview with a first-shift PCA on 03/17/25 at 1:55pm.

Refer to an interview with a second first-shift PCA on 03/17/25 at 2:01pm.

Refer to an interview with a third first-shift PCA on 03/17/25 at 2:04pm.

Refer to a second interview with a third first-shift PCA on 03/17/25 at 2:15pm.

Refer to a review of a printed copy of a handwritten letter (not dated) from a first-shift PCA.

Refer to an interview with the Memory Care Coordinator (MCC) on 03/24/25 2:41pm.

Refer to an interview with the Director of Health and Wellness (DHW) on 03/24/25 at 11:13am.

Refer to a second interview with the DHW on 04/01/25 at 4:04pm

Refer to a telephone interview with the RDRC on 03/24/25 at 12:45pm.

Refer to an interview with the Executive Director (ED) on 03/17/25 at 2:10pm.

Refer to a second interview with the Executive Director (ED) on 03/24/25 at 10:15am.

Refer to a confidential interview with two staff.

Refer to a telephone interview with a SCU male resident's PCP on 04/29/25 at 2:23pm.

3. Review of Resident #4's current FL-2 dated 04/13/24 revealed:
-Diagnoses included dementia, hypertension, hyperlipidemia, depression, and anxiety.
-The resident's recommended level of care was Special Care Unit.

Review of Resident #4's Resident Register revealed an admission date of 04/29/22.

Review of Resident #4's current Assessment and Care Plan dated 06/05/24 revealed:
-The resident ambulated with a walker.
-The resident required supervision with eating, ambulation, and transferring and limited assistance with toileting, bathing, dressing, and personal hygiene.

Review of Resident #4's electronic Progress Notes from November 2024 through March 2025 revealed:
-On 03/19/25 at 3:00pm there was an entry, Resident #4 was discovered in another resident's room "lying on the bed cuddling"; both residents were clothed, and there was no evidence of anything inappropriate.
-Both residents were redirected.

Interview with a first-shift Personal Care Aide (PCA) on 03/17/25 at 1:55pm revealed:
-There had been incidents when a male resident kissed and fondled Resident #4.
-Resident #4 would become upset and would tell him to stop.
-Staff would separate and redirect the male resident.

Interview with a second first-shift PCA on 03/17/25 at 2:04pm revealed:
-There was an incident around November or December 2024, when she heard Resident #4 yelling and telling someone to stop; she ran to the end of the SCU hallway and saw Resident #4 sitting in a chair in the hallway; a male resident was kissing her face and neck and groping her; she immediately redirected the male resident away from Resident #4.
-This was not the first time the male resident had touched Resident #4 inappropriately, and she was sure it would happen again.

Second interview with a first-shift PCA on 03/17/25 at 2:15pm revealed:
-She had been very concerned about resident safety due to the male resident's behaviors and reported these concerns appropriately, always

to her direct supervisors, the medication aides (MA) on each shift; additionally, she voiced her concerns in person to the previous ED and again to the current ED shortly around the beginning of 2025, shortly after the new ED was hired.
-She continued to see an escalation of the residents behaviors so on 02/18/25 she left a handwritten letter for the Executive Director (ED) detailing her concerns about the male resident to ensure the ED was aware of the ongoing physically and sexually aggressive behaviors; she did not hear back from the ED so she followed up with her a week later and asked for an update; the ED confirmed she received the letter and told her she had shared the letter with the Regional Director of Resident Care (RDRC), but did not have any further update for her; since then, she had not received a follow-up from anyone regarding the information.

Review of a printed copy of a handwritten letter signed by a first shift PCA (not dated) revealed:
-The SCU male resident was very touchy with Resident #4.
-It has also been previously reported that the male resident had been kissing and feeling Resident #4, to the point that she was yelling at him to stop, and staff had to separate the male resident from Resident #4.

Interview with a first shift MA on 03/24/25 at 3:06pm revealed:
-There had been an incident during the preceding week, he did not know the date, between Resident #4 and a male resident.
-Resident #4 was a resident whom the male resident was often seen "kissing and fondling."
-The PCA on duty saw the male resident whisper in Resident #4s ear, and they tried to walk away together, but the PCA redirected them.
-A little later, the PCA realized Resident #4 and the male resident were missing, but when she realized it, she went to look for them.
-The PCA found the male resident lying on top of Resident #4 on the bed of another resident, kissing her.
-Both residents had their clothing on, but he did not know how far it would have escalated if the PCA had not found them and separated them.

Interview with a first shift PCA on 03/24/25 at 3:38pm revealed:
-One day last week, she was working as a PCA in the SCU.
-She kept redirecting Resident #4 and a male resident to go sit down in the dayroom.
-At some point, she realized she did not see them and immediately went to look for them; she found them on another male resident's bed with Resident #4 lying under the male resident with his arms around her.
-She did not remember if they were kissing.
-They were fully clothed.
-She redirected them off the bed and back to the dayroom.

Telephone interview with RDRC on 03/24/25 at 12:45pm revealed:
-There had been one incident about a week ago that involved the male resident.
-The male resident and Resident #4 were found lying on a bed, hugging, and she did not see a problem with that.

Refer to a review of an audio recording of a 911 call from the facility on 11/24/24 (time not provided).

Refer to an interview with a first-shift PCA on 03/17/25 at 1:55pm.

Refer to an interview with a second first-shift PCA on 03/17/25 at 2:01pm.

Refer to an interview with a third first-shift PCA on 03/17/25 at 2:04pm

Refer to a second interview with a third first-shift PCA on 03/17/25 at 2:15pm.

Refer to a review of a printed copy of a handwritten letter (not dated) from a first-shift PCA.

Refer to an interview with the Memory Care Coordinator (MCC) on 03/24/25 2:41pm.

Refer to an interview with the Director of Health and Wellness (DHW) on 03/24/25 at 11:13am.

Refer to a second interview with the DHW on 04/01/25 at 4:04pm

Refer to a telephone interview with the RDRC on 03/24/25 at 12:45pm.

Refer to an interview with the Executive Director (ED) on 03/17/25 at 2:10pm.

Refer to a second interview with the Executive Director (ED) on 03/24/25 10:15am.

Refer to a confidential interview with two staff.

Refer to a telephone interview with a SCU male resident's PCP on 04/29/25 at 2:23pm.

4. Review of Resident #6's current FL-2 dated 11/28/25 revealed:
-Diagnoses included Alzheimer's dementia, essential hypertension,

pure hypercholesterolemia, and chronic kidney disease.
-The resident's recommended level of care was Special Care Unit.

Review of Resident #6 Resident Register revealed an admission date of 01/31/25.

Review of Resident #6's current Assessment and Care Plan dated 12/04/24 revealed:
-The resident ambulated with a walker.
- The resident required limited assistance with eating, toileting, ambulation for safety, dressing, grooming, personal hygiene and bathing, and supervision for transferring.
-The resident was disoriented and confused.

Review of Resident #6's mental health provider note dated 01/31/25 revealed the provider met with the adult's Power of Attorney (POA) to discuss her "advancing dementia with behavioral disturbance."

Interview with a first shift personal care aide (PCA) on 03/17/25 at 2:04pm revealed:
-Resident #6 was often kissed and fondled by a male resident; she was married and she had heard some staff say Resident #6 allowed the male resident to touch her when her husband was not present, so some of the staff seemed to think it was okay for the male resident to touch her if she was not trying to stop him; those staff did not seem to be taking into consideration the fact that the female resident was cognitively impaired.

-During another recent shift, the PCA who worked the preceding shift told her to keep an eye on the male resident because he had been following Resident #6 up and down the hall all day with his hands in his pants.

Interview with a second first-shift PCA on 03/17/25 at 2:01pm revealed:
-She had recently observed a male resident fondling his groin area while kissing and feeling on Resident #6 in the SCU dining room; the resident ceased the behavior when redirected and while staff were looking, but he tried to resume the activity when he believed he was no longer being observed, and she had to stop him again.
-The male resident often kissed and fondled Resident #6, but she often allowed him to do it.
-She told Resident #6 she should not allow the male resident to do that because she was married.

Interview with a third first shift PCA on 03/24/25 at 2:53pm revealed:
-A SCU male resident was known to have physical outbursts and

sexual behaviors.
-Staff were instructed to use redirection to address his behaviors, but this was frequently ineffective.
-There was a recent incident, she did not remember the date, when she was showering the resident and he began to masturbate in front of her; redirection was not effective, and he continued this after his shower.
-She was concerned that if he was demonstrating this type of behavior with staff, he would do it with female residents, especially since he would often touch the female residents while fondling himself.
-The male resident was almost always doing something inappropriate.

Refer to a review of an audio recording of a 911 call from the facility on 11/24/24 (time not provided).

Refer to an interview with a first-shift PCA on 03/17/25 at 1:55pm.

Refer to an interview with a second first-shift PCA on 03/17/25 at 2:01pm.

Refer to an interview with a third first-shift PCA on 03/17/25 at 2:04pm.

Refer to a second interview with a third first-shift PCA on 03/17/25 at 2:15pm.

Refer to a review of a printed copy of a handwritten letter (not dated) from a first-shift PCA.

Refer to an interview with the Memory Care Coordinator (MCC) on 03/24/25 2:41pm.

Refer to an interview with the Director of Health and Wellness (DHW) on 03/24/25 at 11:13am.

Refer to a second interview with the DHW on 04/01/25 at 4:04pm

Refer to a telephone interview with the RDRC on 03/24/25 at 12:45pm.

Refer to an interview with the Executive Director (ED) on 03/17/25 at 2:10pm.

Refer to a second interview with the Executive Director (ED) on 03/24/25 at 10:15am.

Refer to a confidential interview with two staff.

Refer to a telephone interview with a SCU male residents PCP on 04/29/25 at 2:23pm.

Review of an audio recording of a 911 (time not provided) from the facility on 11/24/24 revealed a staff member informed the 911 operator she was calling because the corporate office wanted a male resident to be sent to the hospital for a psychological evaluation because he was a "danger to others"; the resident had multiple altercations that day.

Interview with a first-shift PCA on 03/17/25 at 1:55pm revealed:
-The SCU male resident had lived in the facility for an extended period and had a longstanding history of behavioral outbursts.
-The resident had physically attacked other residents' multiple times.
-In recent months, he began exhibiting sexually aggressive behavior toward female residents and staff.
-The sexually aggressive behaviors occurred "pretty much every day."
-The male resident's sexual aggression toward female residents included kissing and groping.
-Interventions for the resident's sexually inappropriate behaviors included redirection; however, this often resulted in physical aggression toward others.
-The male resident "definitely" posed a risk to other residents.
-The male resident's responsible party was verbally abusive and threatening to staff, so part of the reason the resident was not discharged from the facility may have been because they were afraid of how the responsible party would react.

Interview with a second first-shift PCA on 03/17/25 at 2:01pm revealed:
-The male resident exhibited unpredictable behaviors that were sexual in nature or suddenly violent, and these behaviors had occurred toward staff and other residents.
-The resident frequently kissed and inappropriately touched female residents.
-Staff tried to keep an eye on the male resident, but he was always looking for an opportunity, and they could not always know what he was doing.
-Whenever she observed the male resident's inappropriate behaviors, she redirected him and reported it to the MA on duty.
-She was not sure what had been done to address the male resident's behaviors, except perhaps medication changes and redirecting the resident, neither of which had been particularly successful.
-She agreed that the male resident posed a risk to other residents.
-The resident's sexually aggressive behaviors had been witnessed by most everyone who had worked with the resident, including a class of local high school students in training for their Certified Nursing

Assistant certification, but their teacher stopped bringing them because of the resident exhibiting sexual behaviors in front of them, including pleasuring himself in front of the students during their shower training.

Interview with a third first-shift PCA on 03/17/25 at 2:04pm revealed:
-The SCU male resident has a history of multiple incidents involving aggressive and sexually inappropriate behaviors.
-Due to previous incidents when the resident attempted to enter rooms during personal care, she had learned to lock the door to prevent him from entering the room.
-The male resident's sexually inappropriate behaviors occurred "daily" and his aggressive behaviors happened "pretty often."
-No staff wanted to deal with the male resident's responsible party because he was threatening and intimidating to everyone, and that may be why the male resident was allowed to remain in the facility.
-About a month ago, while she and another PCA were providing personal care to a female resident in her bedroom, the male resident repeatedly attempted to force the door open; she attempted to explain that he could not enter, but the male resident continued to pound and push against the door until he forced his way into the room, shoved her forcefully, and began punching her in her arms.
-Due to previous incidents where the male resident attempted to enter rooms during personal care, she had learned to lock the door to prevent the male resident from entering the room.

Second interview with a third first-shift PCA on 03/17/25 at 2:15pm revealed:
-She had been very concerned about resident safety due to the male residents behaviors and she had reported this as she was supposed to, always to her direct supervisors which were the MAs for each shift; in addition, she verbalized her concerns in person to the previous ED and to the current ED just after she was hired around the beginning of the 2025.
-She continued to see an escalation of the male residents behaviors so on 02/18/25 she left a letter for the ED about the male resident to ensure the ED was aware of the ongoing concerns about the male resident physically and sexually aggressive behaviors; she did not hear back from the ED so she followed up with the ED a week later and asked for an update; the ED confirmed she received the letter and told her she had shared the letter with the Regional Director of Resident Care (RDRC) but did not have an further update; since then, she had not received an follow-up from anyone regarding the information.
-"Yes" she had a copy of the letter she provided to the ED; upon request, it was made available for review.
-After she gave the letter to the ED, her scheduled work hours had been reduced, and she was reassigned from the SCU to the ALU, so other staff who knew about this had reservations about saying anything about

the male resident, because they were afraid of retaliation.

Review of a printed copy of a handwritten letter (not dated) revealed:
- The letter stated, "I am very concerned about the sexual and physical harassment occurring in the SCU by (the SCU male residents name). This has been reported previously, and nothing has changed his behavior.
-The letter provided detailed accounts of residents rights issues due to the SCU male residents behaviors and stated "He is getting worse."
-The letter was signed by a first shift PCA.

Interview with the Memory Care Coordinator (MCC) on 03/24/25 2:41pm revealed:
-The male resident's history of behaviors in the facility "went back years."
-The male resident was very unpredictable and would suddenly snap with no warning.
-It was difficult to pinpoint what was going to set him off or trigger his behavioral outbursts, but he was very territorial, so any resident being in what he considered his space would most likely cause the male resident to lash out.
-In recent months, he had frequently exhibited sexually aggressive behaviors.
-There was an incident when a PCA notified her that she was giving the resident a shower, and he began to masturbate in front of her; she had wondered if the resident might do this in front of the female residents.
-He had been placed on medication to try to reduce his libido, maybe last week.
-He tried to kiss and touch females, and you could always "kind of feel the vibe" of his sexually aggressive intentions.
-Staff tried to separate the male resident from the female residents.

Interview with the DHW on 03/24/25 at 11:13am revealed:
-She was not working at the facility during much of the male residents history of behaviors, but she was pretty sure the ED had consulted with the RDRC about the residents behaviors a while back.
-The resident was given a notice of discharge after a final incident that occurred the last weekend, 03/21/25, in which he had a physical altercation with another resident.

Second interview with the DHW on 04/01/25 at 4:04pm revealed:
-There was a SCU male resident who had a long history of behaviors that started long before she was hired.
-The behaviors she knew about involved pushing and hitting, which included residents.
-It was her understanding from speaking with facility staff, that before she started working there, recommendations were made to "try to get

something done" about the resident because of his behaviors, but since she was not involved, she did not know exactly what happened with that.

Telephone interview with RDRC on 03/24/25 at 12:45pm revealed:
-She knew the male resident had some incidents of aggressive behaviors, but she nor the ED had any knowledge of the resident exhibiting sexually inappropriate behaviors.
-She did not think Resident #2's behaviors created an unsafe environment for the residents until the incident that occurred on 03/21/25, after which the resident received an immediate notice of discharge.
-She nor the ED knew anything about the resident ever touching other residents inappropriately.
-She was going to conduct an internal investigation to determine what staff knew about the male residents sexually inappropriate behaviors and did not report it, and they would be terminated.

Interview with the Executive Director (ED) on 03/17/25 at 2:10pm revealed:
-She had no concerns or issues related to the behaviors of any specific SCU resident.
-No staff members had expressed concerns to her related to the behaviors of any SCU residents.

Second interview with the Executive Director (ED) on 03/24/25 at 10:15am revealed:
-She began her position as the ED in December 2025.
-Soon after she began her position as the ED, she was informed by a staff member of concerns about a SCU male resident's behavioral outbursts.
-The behavioral outbursts involved some incidents with other residents.
-The male resident had multiple behavioral incidents during the past few months, starting with 5 or 6 incidents of aggressive behaviors in November 2024 and at least one incident in January 2025.
-After reviewing the male resident's records around the beginning of 2025, she thought he had an excessive number of behavioral incidents and had consulted with her regional leadership staff regarding his behaviors; at that time, the decision was made that the resident was appropriate to remain at the facility.
-The male resident's POA was unlike any she had ever dealt with before, and he had been asked to communicate directly with her or the RDRC because he of the way he treated staff; he was very threatening and blamed everyone else, including the facility, for the resident's behaviors.
-She had only been involved with the one incident in January 2025, and that was the last incident she was aware of before last Friday night on

03/21/25, when the male resident hit another resident and was sent to the hospital.
-She was not aware of the male resident exhibiting any sexually inappropriate behaviors; he liked to hug, but there had not been anything that would be considered touchy-feely.
-On 03/22/25 the male resident was issued an immediate discharge related to this incident because it was determined that he posed a risk to other residents.

Confidential interview with two staff revealed the SCU male resident had been physically and sexually aggressive for a long time.

Telephone interview with the SCU male resident's PCP on 04/29/25 at 2:23pm revealed:
-She was well aware of the SCU male resident's behavioral outbursts.
-The resident's behaviors were extremely difficult to manage and she had deferred to the psychiatric provider to manage his behavioral health medications.
-The resident could go from "zero to sixty" in a matter of seconds, meaning he could be fine one minute, and he would suddenly fly into a rage.
-He attacked both staff and other residents.
-She remembered there had been a lot of conversation among staff leadership about needing to discharge him from the facility because it was felt he posed a risk to other residents.
-She did not know he had been allowed to remain in the facility, but one reason may have been the conduct of the POA; she had never been afraid of a resident's POA before, but she had heard the way the POA talked to staff, and it was scary, so she and others were afraid of him; he constantly intimidated and threatened staff, so that likely was a contributing factor to why he had not been discharged because he wanted them to think he would sue them if they discharged the resident; she had even spoken to a county monitor that she ran into at another county to inquire on the facility's behalf about what they should do if a resident needed to be discharged but the family was using threats and intimidation to keep it from happening.
-She had been very concerned that the resident was a danger to other residents.
-She agreed that the resident was not appropriate for the facility because he could seriously injure another SCU residents.

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

The facility failed to keep residents free of physical assault by a male resident who had repeated incidents of physical violence, resulting in abuse of Resident #1, who had incidents of being hit and "beat up",

Resident #3, who was shoved to the floor and required a hospital visit for back, hip, and leg pain, and Resident's #4 and #6, who were repeatedly subjected to aggressive sexually inappropriate behaviors that included kissing, touching, and groping both residents. The facility's failure resulted in resident-to-resident assault and constitutes a Type A1 Violation.

The facility provided a plan of protection in accordance with G.S. 131-D-34 received on 03/24/25.

THE CORRECTIVE DATE FOR THIS VIOLATION SHALL NOT EXCEED 06/13/25.

Rule/Statute Number: 10A NCAC 13F .0311
Rule/Statutory Reference: 10A NCAC 13F .0311 Other Requirements
(i) In newly licensed facilities without live-in staff, an electrically operated call system shall be provided connecting each resident bedroom and bathroom to a staff station. The resident call system activator shall be such that they can be activated with a single action and remain on until deactivated by staff at a point of origin.
Level of Non-Compliance: Type B Violation
Findings:
This rule is not met as evidenced by:

1. Review of Resident #5's current FL-2 dated 02/27/25 revealed:
-Diagnoses included asthma, hypertension, obesity, chronic obstructive pulmonary disease, and gastroesophageal reflux disease.
-The recommended level of care was the Assisted Living unit (ALU).

Review of the Resident #5's Resident Register revealed an admission date of 02/25/25.

Review of Resident #5's current Assessment and Care Plan dated 03/06/25 revealed:
-The resident was oriented to person, place, and time and could verbally communicate her needs to staff.
-The resident required assistance with toileting, bathing, transferring,
-The resident was experiencing increasing difficulty with transfers and showed signs of unsteadiness, requiring the assistance of one staff member to ensure proper technique and safety.
-The resident used a rollator for ambulation and needed to wait for staff assistance before ambulating; staff did not need to remind the resident to wait for staff assistance to transfer.

-The resident had a history of falling before admission and required staff assistance in the event of a fall.

Review of Resident #5's handwritten Accident and Incident report dated 03/23/25 revealed:
-The "time of accident" was entered as 7:00am.
-Resident #5 was observed on her bedroom floor flat on her back; the resident stated she was coming from her bathroom,
lost her balance and fell; the resident stated multiple times that her head and back were hurting; 911 was called, and the resident was transported to the hospital.
-The report was signed by the first shift Medication Aide (MA) and the Director of Health and Wellness (DHW).

Review of Resident #5's electronic progress notes for March 2025 revealed:
On 03/23/25 at 7:00am, there was an entry, the resident was observed on her bedroom floor lying flat on her back and stated she was coming from her bathroom and lost her balance; the resident reported head and back pain; the resident stated she had been on the floor since 12:00am.
-On 03/23/25 at 10:40am, there was a second entry, the resident had been sent to the ER due to her fall.
-On 03/23/25 at 1:40pm, there was a third entry, the resident returned from the ER to the facility, the resident's POA had spoken to the facility's Director of Health and Wellness (DHW) about her concerns related to the circumstances related to the residents fall; a meeting was scheduled with the DHW and the Executive Director (ED) to take place on 03/24/25 at 1:30pm; the battery in the residents call pendant had been replaced and tested in the presents of the POA.
-On 03/23/25 at 2:12pm, there was a fourth entry the resident returned from the ER with no new orders; the resident was placed on 30-minute "engagement rounds" until further notice; the new replacement battery in the residents call bell pendant was working properly.
-On 03/24/25 at 2:02 pm, there was a third entry, the DHW and the ED had a meeting with the residents POA, another family member, and a third person, and reassured them the resident's call pendant had been replaced with a new one, as they had requested.

Interview with Resident #5 on 03/24/25 at 10:45am revealed:
-She always wore her call pendant around her neck because she had some falls at home before she was admitted to the facility and having the call pendant gave her a sense of security that she would be able to alert someone if she needed help.
-When she fell on her bedroom floor on 03/23/25, she immediately began pushing her call pendant because she was injured, could not get up.
-She was in a lot of pain.

-She pushed the call pendant over and over throughout the night, but no staff responded.
-When the staff found her on the floor the next morning, they checked her call pendant and told her it was not working.
-After she returned from a visit the ER that morning (03-23-25), the staff told her they had repaired her call button by replacing the battery because it had gone dead.

A second interview with Resident #5 on 04/01/25 at 2:10pm revealed:
-After she returned from her ER visit on 03/23/25, staff informed her, staff informed her they checked her pendant and it was not working, but the staff changed the battery, pendant began working again.
-After a request from her daughter, they replaced her call pendant with a new one just as an extra precaution.

Telephone interview with a first shift MA on 04/01/25 at 10:01am revealed:
-On the morning of 03/23/25, she was present during the EMS staff's response to her fall.
-When Resident #5 was speaking about being on the floor all night, the EMS worker asked her if she used her call pendant; the resident stated she used her pendant all night, but no one responded.
-It was around this time that a staff member, she did not remember who, discovered that the resident's call pendant was not working.
-She thought is was around 9:00am when the Manager on Duty (MOD) arrived at the facility.
-The MOD for that weekend was Director of Health and Wellness (DHW), who was new to the position, and had never changed a pendant battery, but other staff assisted her, and once the battery was replaced, the pendant began working again.

Observation of the Director of Maintenance (DOM) on 03/24/25 at 10:53am revealed:
-The DOM and a second male staff member entered Resident #5's bedroom with a pager and asked if he could test her call pendant.
-Upon pressing Resident #5's call pendant, the pager alerted.

Interview with the DOM on 03/24/25 at 10:53am revealed:
-After Resident #5 fell on 03/23/25 and was using her call pendant but did not get a response, the staff on duty determined that the battery in her call pendant had died, and a new battery was installed.
-He was in the process of going room to room to confirm all residents' call buttons were in working order.
-When working properly, the call buttons alerted staff by ringing their pagers; in order to end any call button pager alert, staff had to respond to the resident and clear the alert using a magnetic swipe over the pendant itself.

-Call buttons also sent pendant notifications and pendant call alerts to a main electronic "pendant alert call system" located in the chart room at the front end of the Assisted Living hallway, and call button alerts could be cleared from the main system as well.
-When Resident #5's call pendant battery began running low, the call system would have automatically triggered a low battery alert on the main call system.
-For the low battery alert to be turned off, it would have required someone "manually clearing it" in the electronic system.
-When Resident #5's low battery alert was triggered on the main call system, the only way it would have ended the alert was if someone closed it out manually in the system.
-After Resident #5's pendant died, the system would not have sent any further alerts.
-He had not been checking the pendants before the incident with

Resident 5 occurred, but he was going to start routinely checking them to ensure they were working properly.
-It was unfortunate that this happened to Resident #5, especially since her room was at the end of the hall and it was more difficult to hear her if she was calling for help.

Second interview with the DOM on 04/01/25 at 2:20pm revealed:
-Pendant alert batteries likely lasted around 6 months, depending on the frequency of use.
-When residents are discharged, the pendant they were using is then given to the next resident admitted.
-The main screen of the pendant alert system consistently displayed notifications when a resident's pendant battery was low, including a loud alert tone and the message 'low battery' on the screen
-He did not work on the weekend Resident #5's pendant battery died, but the staff on duty knew how to change the battery, and they did so.
-Since then, Resident #5 had been given a new pendant, and this made her and her family feel better knowing she had a brand new one.
-The system likely could filter reports just for Resident #5's pendant for the weekend of her fall.

Review of filtered data on the facility's electronic pendant alert systems main screen for Resident #5's call pendant from 03/21/25 through 03/23/25 revealed:
-On 03/21/25 at 12:47am., the system displayed a battery alert for Resident #5's call pendant, along with the device identification number and an event notification reading "Low Battery"; the response status was marked as "Completed" 6 hours and 18 minutes later, with "admin" listed as the responding person.
-After a pendant alert call from Resident #5 at on 03/21/25 at 2:58pm, no further activity was recorded for the next 40 hours."

-On 03/23/25 at 6:47am, around the time Resident #5 was found on the floor, the system displayed activity for Resident #5's call pendant, with the event type listed as 'Fault'; the response status was marked as "Completed" 2 hours and 54 minutes later, with "admin" recorded as the responding person.

Interview with the DHW on 03/24/25 at 11:13am revealed:
-After Resident #5 fell on 03/23/25 and said she used her call bell and did not get a response from staff, she checked the electronic pendant alert's main system it did not display any missed calls from Resident #5.
-After the resident returned from the hospital that morning, she and another staff member changed the battery in Resident #5's device and the device began working, so the resident's device was not working at the time of her fall, which was why it did not alert staff.

Telephone interview with a third shift Personal Care Aide (PCA) on 03/31/25 at 3:58am revealed:
-Residents wore call pendants to alert staff when they needed assistance.
-After Resident #5 was found on the floor on 03/23/25, she said she had been pushing her call pendant all night, but the pager never alerted her Resident #5 was calling for help; it was later discovered by staff that her call bell battery had gone dead, and her pendant was not working.
-The pendant alert system did not notify staff when a battery was dying, so staff had no way of knowing.
-That morning, after Resident #5 was taken to the hospital, the third shift MA told her the resident's call pendant had stopped working and that she checked the battery, and it had died; she was told where to find replacement batteries for future reference.

Telephone interview with Resident #5's Power of Attorney (POA) on 03/31/25 at 4:26 PM revealed:
-Resident #5 was "very alert and in tune and oriented to person, place, time, and situation"; the resident had talked about what happened clearly and consistently since that night, and she was certain the resident's account of what occurred was accurate.
-It was her understanding that on the night Resident #5 fell, the resident had fallen asleep in the recliner in her bedroom.
-Upon waking, the resident decided to go to her bathroom before getting into bed; as she exited her bathroom, she became dizzy and fell on her back.
-The resident was injured and immediately pressed her call pendant repeatedly, but no one responded.
-The resident was able to see the microwave clock, which was set to the correct time, and noted it was midnight at the time of the fall.
-The resident remained on the floor in pain throughout the night and

pressed her call pendant over and over, receiving no response.
- She did not know which staff member found her, but the resident was found on the floor at 7:00am that morning.
-The staff called 911 and the resident was transported to the hospital to evaluate her injuries.
-She was shocked and upset, as Resident #5 was placed in the facility specifically to always have staff available, particularly in case of an emergency.
-She was with the resident when she returned to the facility a few hours later, and as soon as she got to the residents room, she tested her call pendant several times and it was clearly not working; other staff came into the room, asked to see the call pendant, and confirmed it clearly was not working.
-Staff changed the battery, and the device began working, but she requested a new one just to be on the safe side, and a new one was provided.
-The DHW was the MOD that day, and she spoke with her about the pendant, at which time the DHW confirmed it was not working.
-On 03/24/25, she met with the Executive Director (ED) and the Director of Health and Wellness (DHW), and they confirmed the resident's call pendant had not been working when the resident fell on 03/23/25.
-During the meeting, she inquired whether the call system notified staff when a battery was running low. The ED stated the system *should* have alerted staff, but it failed to do so—no alert or ping was received.
-The POA stated this was unacceptable, and she could not understand how such a failure was possible.
-The ED informed her she had implemented a new process for the MOD to routinely check about ten call pendants a day, to ensure they were working properly.
-The MOD informed Resident #5 that he had tested several residents' call pendants on the morning of 03/24/25 and found several that were not working; she provided this information to the ED.
-If any good came from all this, she hoped that at least things had been implemented that created a safer environment for the residents.

Interview with the ED on 03/24/25 at 12:04pm revealed:
-After Resident #3 fell on 03/23/25 and reported receiving no response from staff when she used her call pendant, it was determined that the battery had died in the device.
-After the resident returned from the hospital on 03/23/25, the battery was replaced, and the device began working again.
-Since the incident, she has implemented new protocols requiring the DOM to routinely check a specified number of call pendants each day to ensure they were functioning properly.
-She had no way to know when the call pendant battery died.
-She did not know, until this conversation, that she could filter data on

the facility's electronic pendant alert systems main screen for Resident #5's call pendant.
-She was not aware that on 03/21/25 at 12:47am., the system displayed a battery alert for Resident #5's call pendant and an event notification reading "low battery" that had been cleared by a staff member.

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

The facility failed to ensure that Resident #5's call pendant was functioning properly, resulting in the electronic call system not alerting staff when the resident repeatedly attempted to call for assistance following a fall during the night of 03/23/25. This failure was detrimental to the resident's health and safety and constitutes a Type B Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 received on 04/01/25.

THE CORRECTIVE DATE FOR THIS VIOLATION SHALL NOT EXCEED 06/28/25.

IV. Delivered Via:	Email	Date: 05/14/25
DSS Signature:	Jena Robinson	Return to DSS By: 06/04/25

V. CAR Received by:	Administrator/Designee (print name): Jena Christenbury	
	Signature: X Jena Christenbury	Date: X 05-14-25
	Title: Executive Director	

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

VII. Agency's Review of Facility's Plan of Correction (POC)

☐ ***POC Not Accepted***	By:	Date: 0

Comments:

☐ ***POC Accepted***	By:	Date:

Comments:

Facility Name:

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*		