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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on June 5-6, 2019. The complaint investigation was initiated by the Gaston County Department of Social Services on May 23, 2019.	D 000		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to respond immediately in the case of an incident involving a resident and in accordance with the facility's established policy and procedures for 1 of 5 sampled residents (Resident #1) by failing to send the resident to the hospital for medical evaluation after an alleged sexual assault. The findings are: Review of the current FL2 for Resident #1 dated 01/02/19 revealed: -Diagnoses included dementia, anxiety, depression and post traumatic stress disorder	D 271		

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(PTSD).
-Resident #1 ambulated without assistance, needed cues and prompts for dressing and grooming, needed hands on assistance with showering and toileting and was able to eat independently.
-Resident #1 was oriented to self and surroundings.

Review of Accident/Injury Reports for Resident #1 revealed there were no incident reports completed for the alleged sexual assault incident that was reported on 05/22/19.

Telephone interview with the Registered Nurse (RN) Case Manager at the hospital on 06/05/19 at 9:30am revealed:
-She was on duty as the RN Case Manager on 05/23/19 at 10:45am.
-It was reported to her by the Emergency Department (ED) nurse 05/23/19 at 10:45am there was an alleged sexual assault victim she was currently assessing in the ED.
-The alleged sexual assault had not been reported to the police.
-She reported the alleged assault to the Gaston County Police Department on 05/23/19.
-It was not reported to the hospital staff the alleged perpetrator was positive for Hepatitis C.

Review of the ED discharge summary on 05/23/19 revealed:
-The nurse attending to Resident #1 in the emergency department (ED) reported to the RN Case Manager there was a female from an Assisted Living facility that had been the victim of an alleged sexual assault by a male resident in the same facility on 05/22/19.
-The incident was reported to the hospital staff as occurring at approximately 8:00pm on 05/22/19.

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-The attending physician reported Resident #1 stated, "he hurt me", he entered me", when questioned as to the circumstances of last evening.
-A Sexual Assault Nurse Examiner (SANE) conducted a sexual assault exam with Resident #1.
-A pelvic exam was not performed on Resident #1 by the attending physician.

Interview with the medication aide (MA) on 06/05/19 at 4:00pm revealed:
-On 05/22/19 she was the MA on second shift.
-She was administering the 8:00pm medications when she heard the personal care aide (PCA) call for help in the Women's hall of the facility.
-She observed the PCA trying to get a male resident out of Resident #1's room.
-The male resident was combative and yelling at the PCA.
-She telephoned the memory care manager (MCM) and reported the alleged sexual assault.
-The MCM arrived at the facility at approximately 9:00pm.
-Resident #1 was very upset-crying and shaking, and the staff thought she should be sent to the hospital.
-She did not know if anyone had discussed sending Resident #1 to the hospital with the MCM.

Interview with the second shift PCA on 06/06/19 at 4:15pm revealed:
-He had worked on 05/22/19 from 3:00pm to 10:00pm.
-He was performing his rounds of the Women's Hall at approximately 8:00pm.
-He approached Resident #1's room and found it locked.
-He had never known Resident #1 to lock her

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door.
-He unlocked the door and found a male resident with his pants on the floor on top of Resident #1 whose pants were down to her ankles.
-It appeared to him the male resident had penetrated Resident #1.
-The female was sobbing and shaking, and started to cry out to the PCA, but he could not understand what she was trying to say.
-He attempted to get the male resident off Resident #1.
-It took 3 staff persons to remove the male resident from the Resident #1's room.
-He comforted Resident #1 while staff redirected the male resident and the MA contacted the MCM.
-Resident #1 was crying and shaking. She was very upset.

Telephone interview with a third shift PCA on 06/06/19 at 8:55am revealed:
-She arrived at work on 05/22/19 at 9:45am.
-She was informed by the PCAs on second shift to "watch" a male resident who had allegedly forced himself on Resident #1 in her bedroom.
-The PCA entered Resident #1's room to check on her.
-Resident #1 was visibly shaken, crying, trying to communicate to the staff.
-The staff kept the male resident from the Women's hall during the rest of the shift.

Interview with the MCM on 06/06/19 at 10:05am revealed:
-She was contacted by the MA regarding the alleged sexual assault of Resident #1.
-She arrived at the facility at approximately 9:00pm.
-Resident #1 was crying and " a bit shaky".
-Resident #1 did not appear to be injured.

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-She reported this information to the Administrator.
-She was not directed to send Resident #1 to the hospital.
-She instructed the staff to 'keep an eye " on the male resident and make sure he did not approach Resident #1's room.

Interview with the Administrator on 06/06/19 at 11:00am revealed:
-She was contacted by the MCM about 8:30pm on 05/22/19 regarding the alleged sexual assault between a male resident and Resident #1.
-She instructed the MCM to direct the staff to keep the male resident away from Resident #1's room.
-The MCM reported to the Administrator neither resident appeared to be injured.
-It was unclear to the Administrator whether the sexual incident was consensual. "I didn't know how they ended up together."
-She thought it was their right to have sexual relations, so she did not send Resident #1 to the ED promptly.
-She would have sent Resident #1 to the ED that night (05/22/19) for evaluation if she thought it was a sexual assault.
-No one recommended to her Law Enforcement should be contacted.
-She sent Resident #1 to the hospital on 05/23/19 after speaking with the PCA on second shift who observed the male resident on top of Resident #1. He was so upset regarding the incident.
-The PCA reported the behavior he witnessed was a sexual assault.
-She did not call Law Enforcement on 05/23/19 because hospital personnel had informed the MCM they were contacting the authorities.

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D 271	Continued From page 5 The facility failed to respond immediately to 1 of 5 sampled residents (Resident #1) by neglecting to follow their procedure of sending a resident to the hospital immediately for medical evaluation in response to an alleged sexual assault. Resident #1 was in the advanced stage of dementia and was unable to articulate the circumstances of the assault by another male resident or articulate her medical condition. She was not sent immediately to the hospital for medical evaluation and/or treatment after the alleged sexual assault on 05/22/19 and was not sent to the hospital until mid morning of the next day (05/23/2019). This failure resulted in substantial risk for harm and neglect of the resident which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/06/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 6, 2019.	D 271		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident.	D 453		

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D 453	Continued From page 6 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to immediately notify local law enforcement authorities as required for 1 of 5 sampled residents (Resident #2) after staff reported an allegation of sexual assault. The findings are: Review of Resident #2's FL2 dated 05/15/19 revealed: -Diagnoses included dementia, major depressive disorder, hypertension and Hepatitis C. -He was ambulatory and oriented to person and place. Telephone interview with a third shift personal care aide (PCA) on 06/05/19 at 3:45pm revealed: -Resident #2 was admitted on 05/05/19 and he spent a lot of time in his room. -At times he was aggressive and somewhat combative when staff approached him. -The medication aides (MAs) would administer an as needed (PRN) medication at these times. -She had worked from 10:00pm on 05/22/19 to 6:00am on 05/23/19. -The staff on second shift reported there was an alleged sexual assault by Resident #2 toward a female resident at approximately 8:00pm that evening. -The staff notified the Memory Care Manager (MCM) who arrived at the facility shortly after the alleged sexual assault. -The MCM told the staff to "keep an eye on him" and redirect Resident #2 if he attempted to go down the Women's hall to Resident #1's room. -She also told the staff to document his behaviors.	D 453		

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-The staff had to redirect Resident #2 several times during the evening.
-He paced the hallways all during third shift.
-The behavior he exhibited the night of 05/22/19-05/23/19 was more aggressive and threatening than his previous behaviors.

Interview with the MA on 06/05/19 at 4:00pm revealed:
-On 05/22/19 she was the MA on second shift.
-She heard the PCA call for help in the Women's hall of the facility.
-She observed the PCA trying to remove Resident #2 from the resident's room.
-Resident #2 was combative and yelling at the PCA.
-She telephoned the MCM and reported the behavior of Resident #2.
-The MCM arrived at the facility at approximately 9:00pm.
-The MCM told the MA to administer the PRN medication, lorazepam 0.5 mg TID, immediately and again before the MA left at 10:00pm.
-Resident #1 was very upset-crying and shaking.

Telephone interview with another third shift PCA on 06/06/19 at 1:30pm revealed:
-She worked from 10:00pm on 05/22/19 to 6:00am on 05/23/19.
-On 05/22/19 she was assigned to the back hall, the Women's hall.
-The MA reported there was an alleged sexual assault between Resident #2 and a female resident at approximately 8:00pm.
-The MCM had returned to the facility and told the staff to "keep an eye" on Resident #2 so he did not get back to the female's room.
-For the majority of the shift, Resident #2 was out of his room roaming the halls, agitated, heading down to the Women's hall.

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-It was necessary for Resident #2 to have one on one supervision during the shift.
-Shortly after 10:00pm, staff redirected Resident #2 away from the resident's room.
- Resident #2 "raised his fists to her and stated, "Expletive, I'll knock your head off'."
-Resident #2 retreated when he saw a second staff approaching them.
-At 3:30am she attempted to redirect Resident #2 away from the resident's room.
-Resident #2 stated, "I am going to burn this building down with you in it."
-It was a stressful night for the staff.
-We had to be on our guard the entire shift.

Telephone interview with another third shift PCA on 06/06/19 at 8:55am revealed:
-She arrived at work on 05/22/19 at 9:45am.
-She was informed by the PCAs on second shift to "watch" Resident #2 because he had forced himself on another female resident in her bedroom.
-She went into the resident's room to check on her and when she left the room, Resident #2 was outside in the hall.
-She told Resident #2 to return to the Men's area, this was the Women's hall.
-Resident #2 replied, "I'll come where I want to come."
-Resident #2 raised his fists to her, started swinging and said "Expletive, I'm going to punch you in the face."
-He started to swing his arms at her again with closed fists.
-She put her arms up to block his fists.
-Another staff approached them, and Resident #2 dropped his arms and pulled back.
-She was very upset and called the Administrator who said she would handle it..
-She called the responsible family member of

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Resident #2 to come to the facility and intervene with the resident.
-The family member stayed with Resident #2 for approximately 35 minutes.
-After the family member left the facility, Resident #2 resumed pacing the halls and attempted to return to the Women's hall.
-He continued this all night until about 5:30am. He would not give up.
-At one point during the evening, he threatened to burn down the building with a staff person in it.
-The staff never left the Women's hall unattended throughout the shift.
-Resident #2 was like a "raging man-he had such a look in his eyes and his face."
-He had a mean streak in him since admission.
-He would curse and yell at the staff when they would try to perform ADLs or encourage him to go to meals.

Interview with the second shift PCA on 06/06/19 at 4:15pm revealed:
-He had worked on 05/22/19 from 3:00pm to 10:00pm.
-He was performing his rounds of the Women's Hall at approximately 8:00pm.
-He approached one of the female rooms and found it locked.
-He unlocked the door and found Resident #2 with his pants on the floor on top of the female resident whose pants were down to her ankles.
-It appeared to him Resident #2 had penetrated the female resident.
-The female was sobbing and shaking, and started to cry out to the PCA, but he could not make out what she was trying to say.
-He attempted to "get Resident #2 off the female".
-Resident #2 was combative and the PCA called for assistance.
-Resident #2 attempted to choke the PCA and

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stated, "I should kill you for that."
-It took 3 staff to remove Resident #2 from the resident's room.
-He comforted the female resident while staff redirected Resident #2 and the MA contacted the MCM.

Telephone interview with the Adult Home Specialist (AHS) on 06/06/19 at 9:27am revealed:
-The Administrator of the facility contacted the AHS on the morning of 05/23/19.
-The Administrator inquired as to the proper procedure for the immediate discharge of Resident #2.
-The Administrator did not report the alleged sexual assault by Resident #2 during the phone conversation.
-The AHS was not informed of the incident until a complaint was initiated by the hospital which treated the female victim of the alleged assault in the emergency department (ED) on 05/23/19 at 10:40am.

Interview with the Administrator on 06/06/19 at 11:00am revealed:
-She was contacted by the MCM about 8:30pm on 05/22/19 regarding the alleged sexual assault between Resident #2 and a female resident.
-The MCM reported the PCA was completing his rounds and found the female resident's door locked.
-He unlocked the door to check on the resident and saw Resident #2 on top of the female, both unclothed from the waist down, in her bed.
-The resident was crying and shaking.
-The staff attempted to pull Resident #2 from the resident.
-Resident #2 was combative and refused to leave the room.
-She instructed the MCM to direct the staff to

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keep Resident #2 away from the resident's room.
-The MCM reported to the Administrator neither resident appeared to be injured.
-The Administrator received a telephone message some time later from a third shift PCA Resident #2 continued to attempt entrance into the female's room.
-She instructed the staff to place Resident #2 on 30 minute checks.
-It was unclear to her whether the sexual incident was consensual. "I didn't know how they ended up together."
-She thought it was their right to have sexual relations, so she did not send Resident #1 to the emergency department (ED) promptly.
-She would have sent Resident #1 to the ED that night (05/22/19) for evaluation if she thought it was a sexual assault.
-No one recommended to her Law Enforcement should be contacted.
-She sent Resident #1 to the hospital on 05/23/19 after speaking with the PCA on second shift that found Resident #2 on top of the female resident. He was very upset regarding the incident.
-The PCA reported the behavior he witnessed was a sexual assault.
-She did not call Law Enforcement because hospital personnel said they were informing the authorities.

Interview with the responsible party for Resident #1 on 06/06/19 at 12:30pm revealed:
-He received a call from the hospital staff informing him that his family member was raped.
-He spoke to his family member on the phone and asked what had happened.
-She became emotional and he could not make out what she was telling him.
-He lives in another state and was very removed from his family member's day to day activities or

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mental status.
-He tried to contact the facility staff after speaking with the hospital staff that morning, but there was no answer.
-The Administrator contacted him on the afternoon of 05/23/19.
-She reported it was unclear if this was a consensual relationship or a sexual assault-"they just couldn't tell".

Review of the facility's Guidelines for Supervision of Residents who exhibit difficult behaviors revealed:
-"Any behavior which escalates to a threat to the resident or others shall require immediate intervention to assure safety as to move residents out of harms way and call 911(EMS/Authorities).
-Notification should be made to the Supervisor, Care Manager, Executive Director, Regional Director of Operations, DSS, Physician, Mental health provider and Guardian/Responsible party.
-Behavior may require involuntary commitment to be initiated with local authorities."

Attempted telephone interview with Resident #2's primary care physician on 06/06/19 at 9:05am was unsuccessful.

Attempted telephone interview with Resident #2's mental health provider on 06/06/19 at 9:25am was unsuccessful.

The facility failed to immediately notify local law enforcement authorities as required for 1 of 5 sampled residents (Resident #2) after staff reported an allegation of sexual assault. This failure of immediate notification allowed Resident #2 to continue to try and gain entrance to Resident #1's room. This failure resulted in

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 453	Continued From page 13 substantial risk for harm and neglect of the resident which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/06/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 6, 2019.	D 453		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were free of neglect and physical abuse in compliance with federal and state laws and rules and regulations related to Personal Care and Supervision and Reporting of Accidents and Incidents. The findings are: 1. Based on record reviews and interviews, the facility failed to respond immediately in the case of an incident involving a resident and in accordance with the facility's established policy and procedures for 1 of 5 sampled residents (Resident #1) by failing to send the resident to the hospital for medical evaluation after an alleged sexual assault. [Refer to tag 271, 10A NCAC 13F.	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036031	A. BUILDING: _____ B. WING _____	R-C 06/06/2019

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D914	Continued From page 14 0901(c) Personal Care and Supervision (Type A2 Violation).] 2. Based on interviews and record reviews, the facility failed to immediately notify local law enforcement authorities as required for 1 of 5 sampled residents (Resident #2) after staff reported an allegation of sexual assault. [Refer to tag 0453, 10A NCAC 13F. 1212(d) Reporting of Accidents and Incidents (Type A2 Violation).]	D914		