

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/23/2020
NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF GREENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1208 NEW GARDEN ROAD GREENSBORO, NC 27410		
(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 000	Initial Comments The Adult Care Licensure Section conducted a Complaint Investigation and a COVID-19 Focused Infection Control Survey with an onsite visit on 12/17/20, a desk review on 12/18/20 and 12/21/20 through 12/23/20, and an exit via telephone on 12/23/20.	D 000			
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure staff provided personal care assistance to 1 of 5 sampled resident (#1) with bathing and incontinence care. Review of Resident #1's current FL2 dated 08/14/20 revealed: -Diagnoses included encephalopathy, history of falling, unsteadiness on feet, other abnormalities of gait and mobility, muscle weakness, communication deficit, other lack of coordination, and repeated falls. -Resident #1 was semi-ambulatory. -Resident #1 was intermittently disoriented. -Resident #1 was continent of bladder and bowels. Review of Resident #1's service plan/care plan dated 08/17/20 revealed: -Resident #1's service plan/care plan was closed	D 269			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DATE FORM

6899

FXM211

If continuation sheet 1 of 56

Received and Accepted

Keisha Banks

02/23/21

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D 269	Continued From page 1 on 12/16/20 due to discharge. -Resident #1 was continent of bladder. -Staff was to provide assistance as needed or requested to the bathroom so Resident #1 could maintain her continence. -Resident #1 was at risk for altered bladder continence due to recurrent urinary tract infection; Staff was to observe and report any changes in usual bladder pattern such as increased urinary frequency. - Effective 07/31/20, Resident #1 needed 1 person to physically assist to the bathroom. - Effective 08/17/20, Resident #1 was independent and did not need assistance to the bathroom and staff was observe for and report any changes in assistance to the bathroom. -Effective 07/31/20, Resident #1 needed physical assistance of 1 person with bathing. - Effective 08/17/20 Resident #1 was independent with bathing and staff was to observe for and report any changes in her bathing ability. Review of Resident #1's electronic Care Log for October 2020 revealed: -Resident #1 did not receive assistance to the bathroom for 31 of 31 days; Staff documented Resident #1 was independent with assistance to the bathroom and the activity did not occur. -Resident #1 did not receive assistance with bladder incontinence for 31 of 31 days; Staff documented Resident #1 provided self-care and bladder continence; There was no documentation Resident #1 had episodes of incontinence or refused assistance. -The task of bathing was not documented in the electronic Care Log. Review of Resident #1's electronic Care Log for November 2020 revealed: -Resident #1 did not receive assistance to the	D 269		

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D 269	Continued From page 2 bathroom for 30 of 30 days; Staff documented Resident #1 was independent with assistance to the bathroom and the activity did not occur. -Resident #1 did not receive assistance with bladder incontinence for 30 of 30 days; Staff documented Resident #1 provided self-care and bladder continence; There was no documentation Resident #1 had episodes of incontinence or refused assistance. -The task of bathing was not documented in the electronic Care Log. Review of Resident #1's electronic Care Log for December 2020 revealed: -Resident #1 did not receive assistance to the bathroom for 6 of 6 days; Staff documented Resident #1 was independent with assistance to the bathroom and the activity did not occur. -Resident #1 did not receive assistance with bladder incontinence for 31 of 31 days; Staff documented Resident #1 provided self-care and bladder continence; There was no documentation Resident #1 had episodes of incontinence or refused assistance. -The task of bathing was not documented in the electronic Care Log. Review of Resident #1's progress notes revealed: -There was a progress summary completed on 09/01/20, 10/16/20, and 11/16/20 which documented Resident #1 needed reminders with dressing and grooming. Resident #1 had occasional incontinence of bladder. -There was an entry dated 10/16/20 which documented the Assisted Living (AL) Coordinator spoke to Resident #1's responsible party regarding showers and continence care; Resident #1's responsible party shared redirection tips that had worked previously and spoke at length about ways to direct the resident while maintaining her	D 269		

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D 269	Continued From page 3 independence; AL Coordinator would continue to follow-up as needed. -There was no other documentation regarding personal care. Review of Resident #1's local hospital admission summary dated 12/06/20 revealed: -Resident #1 was seen in the emergency room and admitted to the hospital on 12/06/20. -Resident presented to the emergency room with falls. -After testing, Resident #1 was diagnosed with a urinary tract infection. Review of Resident 1's occupational therapy (OT) notes dated 09/01/20 revealed: -Resident #1 was opened for OT services after having 2 falls in August 2020. -Resident #1 presented to therapy services with deficits including safety, balance, bathing, strength and transfers. -Resident #1's initial assessment identified functional deficits with bathing, functional transfers to the shower or tub, and functional transfers to the toilet. -Stand by assist (close enough to reach resident) and contact guard assist (contact with patient due to unsteadiness) were required. Review of Resident #1's OT notes dated 09/17/20 revealed: -Resident #1 required contact guard assist by staff during bathing. -Resident #1 continued to demonstrate impaired standing balance, transfers, and safety. -Resident #1 was educated on safety with transfers, mobility, techniques for activities of daily living management with poor understanding due to cognitive deficits.	D 269			

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D 269	Continued From page 4 Review of Resident #1's OT notes dated 10/07/20 revealed: -Resident #1 required contact guard assist by staff during bathing. -Continued OT services were necessary to maximize safety with bathing transfers and tasks, standing tolerance and endurance. -Self care training included toileting, dressing, and grooming. Review of Resident #1's OT notes dated 10/27/20 revealed: -Resident #1 required contact guard assist by staff during bathing. -Continued OT services were necessary to maximize safety with bathing, safety awareness, balance, and continence management. Review of Resident #1's OT notes dated 11/19/20 revealed: -Resident #1 required contact guard assist by staff during bathing. -Resident #1 was making slight progress with improvements in standing tolerance and upper body strength. -Resident #1 continued to demonstrate impaired safety with mobility and compliance with rolling walker and had multiple episodes of urinary incontinence per day which increased risk for falls, skin breakdown, and urinary tract infections (UTI). Review of Resident #1's OT discharge notes dated 12/08/20 revealed: -Resident #1 was discharged from OT services on 12/08/20. -At discharge, Resident #1 required contact guard assist by staff during bathing, contact guard assist with transfers to the shower/tub, and an assistive device with transfers to the toilet.	D 269			

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D 269	Continued From page 5 -Resident #1's OT goals were not met. Telephone interview with the Director at Resident #1's home health provider's office on 12/23/20 at 3:26pm revealed: -Resident #1 was opened for OT services on 09/01/20 and OT services ended on 12/08/20 as a result of Resident #1's hospitalization. -The OT service provider worked with Resident #1 on bathing, but Resident #1 did not reach her goal to due to difficulty with balance. -Resident #1 required contact assistance and could not transfer in and out of shower/tub or bathe without assistance. -Resident #1 had incontinence episodes, but she tried to hide her incontinence. -Resident was found several times by the OT service provider with a soiled brief. -The OT provider pointed out odor from incontinence to Resident #1 and the provider was told by Resident #1 that her privacy was being invaded. -The OT provider worked more with Resident #1 on pelvic floor strength since she was denying her incontinence. -The OT provider recommended Resident #1 have assistance with bathing, but she refused assistance from staff. -The details of the OT visits were not communicated to facility staff after each visit and detailed notes were not automatically sent to the facility, but OT progress notes were available to the facility upon request. Interview with a Personal Care Aide (PCA) on 12/17/20 at 1:49pm revealed: -Resident #1 was listed as being independent with her personal care. -Resident #1 asked for bath cloths and towels, but she took her own showers.	D 269			

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D 269	Continued From page 6 -Resident #1 did not need assistance with changing her incontinence briefs or with going to the bathroom. -She did not ask Resident #1 if she needed assistance with showers because Resident #1 was listed as independent. -Resident #1 did not ask for assistance. Interview with the AL Coordinator on 12/17/20 at 2:38pm revealed: -Resident #1 refused assistance with bathing often, but she did not know how long she had been refusing. -Resident #1 had been giving herself a "bird bath." -Resident #1 had increased confusion in November 2020, started exhibiting exit seeking behaviors, and had a physician's order for a wander guard. -Resident #1 returned to baseline and was no longer exit seeking; Her wander guard was discontinued on 12/4/20. Telephone interview with Resident #1's responsible party on 12/18/20 at 10:45am revealed: -Resident #1 was very modest. -She spoke to the AL Coordinator when Resident #1 was admitted in August 2020 about her having bladder cancer and that she could not hold her urine. -She spoke to the AL Coordinator again in October 2020 regarding Resident #1 taking showers and gave her some suggestions. -Since Resident #1 woke up early in the morning, she suggested staff assist her with showers in the evening before putting her night clothes on. -Resident #1 needed assistance with set up for a shower, getting in and out of the shower, and with making sure she took a shower.	D 269			

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D 269	Continued From page 7 -Resident #1 did not need assistance with dressing and changing her incontinence briefs. -The AL Coordinator told her Resident #1 liked to do everything on her own. -She did not know Resident #1 had continued to refuse to take a shower. -Resident #1 was admitted to the hospital after falling on 12/06/20. -She received a call from a nurse at the hospital after Resident #1's admission informing her that the hospital staff had to clean Resident #1's private areas and her stomach because she was dirty. -She felt like the hospital staff thought she neglected Resident #1, but she explained Resident #1 was being cared for by the facility. -A different nurse at the hospital who recognized Resident #1 from a hospitalization a year ago informed her Resident #1 had to be washed 3 times on 12/07/20. -Resident #1 had a history of recurrent urinary tract infections (UTI) and she had made several requests to the facility in September and October 2020 for Resident #1 to have a urinary analysis completed. -Resident #1 was diagnosed and treated at the hospital for a UTI. -When she went to the facility to pick up Resident #1's belongings, she found soiled incontinence briefs and soiled nightgowns in Resident #1's closet; She also found 2 soiled incontinence briefs on the floor under a pile of clothes. -She had a window visit with Resident #1 on 12/04/20 and Resident #1 had worn the same clothes to the hospital on 12/06/20; She saw dead skin all over the inside legs of Resident #1's pants. Telephone interview with the Health and Wellness Nurse on 12/21/20 at 1:56pm revealed:	D 269			

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D 269	Continued From page 8 -Resident #1 was independent with all her personal care. -Resident #1 was more independent when she was first admitted to the facility than she was now. -Resident #1 had one incontinence episode, "1 or 2 months ago," that she was aware of and staff assisted her with getting cleaned up. -Resident #1 was "strong willed" and did not want anyone to do anything for her. -She did not know if Resident #1 was able to get in and out of the shower by herself. -She never smelled a body odor on Resident #1. -Resident #1 had on different clothes daily, but she did not know what she had on underneath. Telephone interview with the Health and Wellness Coordinator on 12/21/20 at 2:37pm revealed: -Resident #1 was very modest and very independent when she was first admitted to the facility. -She did not like for staff to help her and did not want staff to see her undressed. -She "believed" staff offered to assist Resident #1 with bathing, but she heard from staff that Resident #1 refused assistance. -She did not know what staff did when Resident #1 refused assistance with personal care. -She did not think Resident #1 was able to bath herself without assistance. Interview with a PCA on 12/22/20 at 2:43pm revealed: -Resident #1 required staff to stand by and prompt her with bathing. -Sometimes she would not bathe until staff left her room. -If staff prepared Resident #1's shower for her, she would get in, but she was not willing to shower with staff in the bathroom with her.	D 269		

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D 269	Continued From page 9 -He had only assisted Resident #1 with a shower set up once. -He assisted Resident #1 after her responsible party called and requested staff assist her with a shower. -Resident #1's responsible party had spoken to Resident #1 on her personal landline and Resident #1 told her responsible party she had soiled her linen. -Resident #1 needed reminders to change her incontinence briefs. -He had not noticed any increased confusion with Resident #1, but he did not know if Resident #1 was able to understand when she needed a shower. Interview with a second PCA on 12/22/20 at 2:55pm revealed: -She had brought Resident #1 wash cloths, towels and linen, but she had never assisted Resident #1 with a shower or with incontinence care because Resident #1 was listed as independent with all of her activities of daily living. -She assumed Resident #1 was able to provide her own personal care because her Service Plan/Care Plan had her listed as independent. -She never noticed Resident #1 with any body odor. Telephone interview with the Senior Resident Care Director on 12/23/20 at 4:26pm revealed: -She did not know the OT provider had assessed Resident #1 as needing assistance with incontinence care and bathing. -The PCAs should have alerted management if there were any changes with Resident #1's ability to provide her own personal care. Interview with the AL Coordinator on 12/22/20 at	D 269			

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D 269	Continued From page 10 3:11pm revealed: -Resident #1's responsible party contacted her in October 2020 to check on Resident #1. -She talked to Resident #1's responsible party regarding Resident #1 not taking a shower and was hoping Resident #1's responsible party could come to the facility for a compassionate care visit to assist with bathing. -She was under the impression as PCAs told her Resident #1 had been taking sink baths and had not gotten into the shower. Telephone interview with a PCA on 12/23/20 at 4:33pm revealed: -She had not assisted Resident #1 with bathing or with incontinence care. -She had not asked Resident #1 if she needed assistance because Resident #1's Service Plan/Care Plan documented her to be independent with bathing and incontinence care. Telephone interview with the Executive Director (ED) on 12/22/20 at 2:35pm revealed: -She was told Resident #1 was independent with personal care tasks. -Service Plans/Care Plans were updated every 6 months unless there was a change in care needs. -She did not know of any changes in Resident #1's bathing habits and never noticed any body odors. Telephone interview with the ED on 12/23/20 at 4:08pm revealed: -She received a call from Resident #1's responsible party after Resident #1 was admitted to the hospital and this call prompted her to look at Resident #1's Service Plan/Care Plan. -She noticed on Resident #1's service plan/care plan for personal care tasks, there were some areas of the task that documented the need for 1	D 269			

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D 269	Continued From page 11 person assist and other areas that documented there was no assistance needed. -The facility was planning to reassess Resident #1 when she returned from the hospital, but she did not return to the facility.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 5 sampled residents (#1, #2 and #3) related to a male resident (Resident #3) found undressed in a female resident's room (Resident #2) on 3 occasions and on one occasion both residents engaged in sexual activity, and a resident who had multiple falls (#1). The findings are: 1. Review of Resident #2's current FL2 dated 04/04/20 revealed: -Diagnoses included dementia without behavioral disturbances, amnesia, diverticulosis of intestine, and anxiety. -Resident #2 recommended level of care was memory care unit (MCU). -Resident #2 was intermittently disoriented.	D 270		

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D 270	Continued From page 12 Review of Resident #3's current FL2 dated 09/15/20 revealed: -Diagnoses included dementia, diabetes mellitus, hypothyroid and gastroesophageal reflux disease. -Resident #3 recommended level of care was the special care unit (SCU). -Resident #3 was ambulatory, constantly disoriented and wandered. a. Review of Resident #2's Resident Register revealed an admission date of 04/03/17. Review of Resident #2's service plan/care plan dated 11/09/20 revealed: -Resident #2 was independent with ambulation and transferring. -Resident #2 needed supervision with bathing. -Resident #2 needed step-by-step cueing for dining. -Resident #2 needed 1 person assistance with washing hair, grooming, and dressing. Review of the Resident #2's current service plan/care plan revealed: -On 11/23/20 the service plan was updated with the focus on "behavioral expression." -The intervention system was for staff to assess and anticipate needs, comfort level, body positioning, security and affection, self-expression; identify recent changes in level of alertness, and lack of sleep. "... known needs sexual at times." -The staff were to "observe for and monitor behavioral expression episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, possible triggers and situations. Report findings to the nurse/medication care manager/Supervisor." Review of Resident #2's accident/incident report	D 270		

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D 270	Continued From page 13 completed by the Executive Director (ED) on 11/20/20 revealed: -On 11/13/20 at 7:15am, team member reported to Supervisor on 11/18/20 she (team member) had walked in on a male resident (#3) with his face between Resident #2's legs. -The place of incident was Resident #2's room. -Plan of treatment indicated was moving Resident #2 to another room, family took Resident #2 to emergency room, and implemented 30 minutes checks on Resident #2. Review of Resident #2's latest annual physical examination encounter documentation dated 10/26/20 revealed documentation for mental status exam as follows: -Judgement, insight was "poor". -Orientation was "oriented to person, only". -Mentation was "alert but disoriented". Review of Resident #2's annual physical examination encounter documentation for 09/30/19, 09/05/18, and 07/31/17 revealed: -Orientation was documented as "oriented to self only". -Memory was documented as "abnormal". -Recall was documented as "poor recent recall". -Comprehension was documented as "normal" for 2017 and 2018, and "abnormal" for 2019. -Judgement, insight was not listed on the examination form until 2020. Review of Resident #2's progress notes revealed: -On 11/16/20 at 12:47pm, the Memory Care Unit Coordinator (MCUC) documented "family made aware of other resident's [#3] fondness of his family member and that they were observed in her room their clothing off over the weekend." -On 11/19/20 at 2:47pm, the Senior Resident Care Director (RCD) spoke with Resident #2's	D 270		

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D 270	Continued From page 14 Power of Attorney/responsible person (POA/RP) regarding another resident observed in resident's room with his face between her legs last week. (According to the facility incident report the incident occurred on 11/13/20 at 7:15am). The POA/RP would rather follow-up through PCP than the emergency department. Resident #2 had a potential room change. Staff was to continue to monitor. -On 11/20/21 at 4:55pm, there was documentation by a facility Wellness Nurse regarding a telephone call from a local emergency department physician requesting additional information related to the 11/13/20 incident between Resident #2 and Resident #3. -On 11/21/20 at 12:42pm, the MCUC documented the POA/RP contacted the facility for an update and was told Resident #2's room had been switched (for easier observation from the medication room). -On 11/21/20 at 3:00pm, a facility Wellness Nurse documented "resident returned from the hospital yesterday". POA/RP had hospital discharge papers and would bring to the facility. -On 11/23/20 at 2:21pm, the Senior RCD documented she was notified "Resident #2 was up all night looking for the male resident [#3] that was previously observed in her room." Staff redirected Resident #2, and would continue to monitor. -On 11/25/20 at 12:10pm, the Senior RCD documented a conversation with Resident #2's PCP's assistant regarding a follow-up appointment after the 11/20/20 emergency department visit. The POA/RP would be scheduling a follow-up appointment with gynecology as requested by the PCP. -On 12/01/20 at 4:29pm, the Senior RCD documented she had lengthy conversation with POA/RP about expression of intimacy related to	D 270		

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D 270	Continued From page 15 Resident #2 "sometimes seeks out another resident." The POA/RP would like to think about consent and talk with the RCD later was documented. -On 12/11/20 at 1:15pm, Senior RCD was notified by the MCUC that Resident #2 was found in Resident #3's room laying in bed with her pants off (no date or time documented). "resident states that's my friend". The PCP was notified and there was no answer with attempted call to POA/RP. -On 12/14/20 at 1:26pm, Senior RCD spoke with the POA/RP regarding Resident #2 being in a male resident's room. Review of Resident #2's "Behavioral Tracking Log" revealed: -On 11/16/20 at 2:15pm, Resident #2 was observed in her room with her clothes off sitting on the bed. Resident #3 was sitting on the bed with no clothes on. Resident #3 was removed from Resident #2's room and staff did a 30 minute check. -On 11/19/20 at 12:00am, Resident #2 was walking the floor asking where to go and where was her room. -On 11/21/20 no time indicated, Resident #2 was walking the floor asking where to go and where was her room. Review of Resident #2's electronic safety checks documentation log revealed: -Resident #2 had documented 30-minute safety checks that started on 11/20/20 after the MCUC became aware of the incident that occurred on 11/13/20. -The resident was checked every 30 minutes from 11/20/20 at 3:00pm to 11/23/20 at 10:00pm except for 12/22/20 from 6:00am to 2:30pm.	D 270		

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D 270	Continued From page 16 Review of Resident #2's notes from the facility's electronic Care Log for November 2020 used for documenting behavior symptoms daily and by each shift of the three shifts revealed: -Documentation was blank for first shift (6:30am-2:30pm) on 11/12/20, and 11/13/20. -Documentation for behavior symptoms on 11/16/20 for first shift was "none noted". -There were wandering behavior symptoms with "one on one" intervention documented on 11/21/20 at 4:44pm, 11/21/20 at 10:49pm, and 11/23/20 at 6:09am. Review of Resident #2's notes from the facility's electronic Care Log for December 2020 revealed: -Documentation was blank on 12/07/20, 12/08/20, and 12/09/20 for 6:30am-2:30pm, and 12/11/20 for 10:30pm-6:30am. -Documentation for behavior symptoms entered on 12/12/20 for first shift was Resident #2 was wandering. The intervention noted was staff had listened with empathy. Review of Resident #2's Progress Notes' progress summary documented by a facility Licensed Practical Nurse dated 12/03/20 at 9:53am revealed: -Resident #2 had an encounter with a male resident (#3) where Resident #3 had his head between the Resident #2' legs. -Resident #2 went to the emergency room (ER) for evaluation and followed up with her gynecologist. -All labs were negative for any abnormal findings. -No acute distress noted and resident stable at this time. Review of Resident #2's local hospital emergency department after visit summary dated 11/20/20 revealed Resident #2 was seen at the local	D 270			

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D 270	Continued From page 17 hospital emergency department on 11/20/20 for screening and examination for sexually transmitted disease from the encounter on 11/13/20. Interview with the Memory Care Unit Coordinator (MCUC) on 12/17/20 at 12:30pm revealed: -On 11/18/20 during a second shift stand-up meeting, he was informed of an encounter between Resident #2 and Resident #3 on 11/13/20 at 7:15am involving the Resident #2 being in bed partially clothed and Resident #3 at the end of the bed partially clothed. -He reported the information to the Senior Resident Care Director (RCD) and the Executive Director (ED) on 11/18/20 or 11/19/20. -No staff had reported the encounter on 11/13/20 to him prior to stand-up on 11/18/20. -Responsible parties for both residents were notified about the 11/13/20 occurrence by the Senior RCD on 11/19/20. -An internal investigation was started on 11/19/20 for the 11/13/20 incident. -Resident #2 had been seen by medical providers twice on 11/20/20 and 12/01/20. -A sitter was hired for the Resident #3 from 11/23/20 to 12/09/20. -Since 11/20/20 MCU staff have been instructed to "keep and eye on" Resident #2 to make sure her whereabouts were known throughout the day. -Resident #2 has been reported to him by staff to go to Resident #3's room looking for him. The residents held hands occasionally. -Resident #2 had not shown seeking behaviors toward another resident since he took over the MCUC position in August 2020. -There was another encounter on 11/16/20 between the 2 residents reported to him by the MCU second shift MA on 11/16/20. The residents (#3 and #2) had their pants off sitting on the bed	D 270		

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D 270	Continued From page 18 in Resident #2's room. -After the internal investigation of the 11/13/20 incident, the facility had training for staff, including him, on recognizing signs of intimacy and residents' rights; and documenting behaviors; the male resident had a hired sitter for 24 hour a day monitoring from 11/23/20 to 12/09/20; and Resident #2 had 30 minutes checks for a couple of days; staff were supposed to keep an eye on her whereabouts and redirect her from going into a bedroom with Resident #3. Telephone interview with Resident #2's Power of Attorney/Responsible Party (POA/RP) on 12/17/20 at 1:00pm revealed: -He was notified of the incident that occurred on 11/13/20 between Resident #2 and a male resident (#3) involving the residents being unclothed in Resident #2's room. -He had not been notified that Resident #2 was involved in any physical or emotional type relationship with another resident prior to 11/19/20. -He contacted Resident #2's long time primary care provider (PCP) to see if the resident should be checked out at the local emergency department or at the PCP office. -He was advised Resident #2 should be seen by a local emergency department chosen and coordinated by the PCP. -He took Resident #2 to a local emergency department and a follow-up GYN appointment. -He had not been contacted to inform him of Resident #2's interest in another resident. -He did not think Resident #2 was able to make decisions regarding relationships. -He had not given consent regarding Resident #2's physical relations with another resident. -He was concerned that Resident #2 was not being supervised properly if she was found	D 270		

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D 270	Continued From page 19 unclothed in her room with another resident. -He was told Resident #2 was relocated to a room more visible by staff on 11/20/20 for increased supervision. -Going forward, he requested to be informed regarding ongoing or increasing relationship with a male resident. Interview with a MCU first shift Lead Care Manager on 12/17/20 at 1:45pm revealed: -Routine supervision for residents in the MCU was to perform incontinent care and check on resident every 2 hours. -Staff should document checks and person care aide task on the electronic personal care logs. -Resident #2 had not been attracted to other residents prior to arrival of the current male friend September 2020. -Resident #2's room was relocated closer to the medication room and common area as a result of 11/13/20. -Resident #2 can associate with Resident #3 but not in a resident's room and not after bedtime. -Resident #2 has "eyes on him all day". -She was instructed by the MCUC that Resident #2 could walk with, sit with, and even holds hand with Resident #3 but only if in common areas and visible by staff. Otherwise, staff should redirect Resident #2 to the common area when with Resident #3. Telephone interview with the Senior RCD on 12/21/20 at 2:03pm revealed: -Resident #2's POA/RP was contacted on 11/19/20 by the Senior RCD regarding the 11/13/20 encounter between Resident #2 and a male resident. -The POA/RP needed some time to process information and did not give consent for Resident #2 to be have anything but a friendly relationship	D 270			

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D 270	Continued From page 20 with Resident #3. -The MCU staff were instructed on 11/19/20 to redirect Resident #2 and Resident #3 if they got into a bedroom together and to monitor the residents' whereabouts every 1 to 2 hours. Based on record review, observation on 12/17/20 at 10:50am, it was determined Resident #2 was not interviewable. Refer to the interview on 12/17/20 at 11:43am with the activity assistant. Refer to the interview with the MCU first shift medication aide (MA) on 12/17/20 at 1:50pm. Refer to the interview with a second shift MA on 12/17/20 at 3:00pm. Refer to the telephone interview with the MCUC on 12/17/20 at 12:30pm and 12/18/20 at 12:33pm. Refer to the telephone interview with the Senior RCD on 12/21/20 at 2:03pm. Refer to the telephone interview with a personal care aide (PCA) on 12/23/20 at 6:19pm. Refer to the telephone interview with the Executive Director (ED) on 12/23/20 at 1:22pm b. Review of Resident #3's service plan/care plan dated 09/24/20 revealed: -Resident #3 was independent with eating, ambulation, transferring, toileting, and grooming. -Resident #3 needed supervision with dressing. -Resident #3 needed hands on assistance with bathing. -On 11/11/20 the service plan was updated with	D 270			

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D 270	Continued From page 21 the focus on "behavioral expression." -The intervention system was for staff to intervene to protect the rights and safety of others. -The direction given was for staff to remove Resident #3 and suggest an alternate and relationship based redirection. Review of Resident #3's accident/incident report completed on 11/20/20 revealed: -On 11/13/20 at 7:15am a MA reported she observed Resident #3 in a female resident's bed (Resident #2) with his head between her legs. Review of Resident #3's progress notes revealed: -On 11/07/20 at 5:40pm, Resident #3 was in a physical altercation with another male resident. -On 11/16/20 at 12:53pm, "family made aware Resident #3 was with Resident #2 resident and both were observed having taken their clothes off." -On 11/19/20 at 2:53pm, spoke with Resident #3's family regarding an incident that occurred on 11/13/20 at 7:15am, when Resident #3 was observed in a female resident's room (Resident #2) with his face between her legs. Review of Resident #3's "behavioral tracking log" revealed: -On 11/16/20 at 2:15pm, Resident #3 was observed in a female resident's (Resident #2) room with his clothes off sitting on the bed. -On 11/22/20 at 4:00am, Resident #3 was wandering the hall trying to go in a female resident's (Resident #2) room. Review of Resident #3's November 2020 electronic safety checks revealed: -Resident #3 was on every 30-minute safety checks that started on 11/07/20 due to an	D 270			

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D 270	Continued From page 22 altercation with another resident. -On 11/12/20 there was no documented 30-minutes safety for Resident #3 until 10:09am. There was no documentation Resident #3 was checked again until 2:30pm. -On 11/13/20 there was no documentation Resident #3 was checked every 30-minutes from 6:30am through 11:36am. -On 11/16/20 there was no documentation Resident #3 was checked from 6:18am through 1:49pm. Interview on 12/18/20 at 12:33pm with the MCUC revealed: -Resident #3 was already on 30 minutes checks due to a physical altercation with another male resident on 11/07/20, so he did not increase supervision on Resident #3. -On 11/20/20, Resident #3's family member was made aware of the incidents and asked to provide a sitter to monitor the resident for twenty-four hours. Resident #3's family approved the sitter until 12/09/20. -He did not know how the resident was able to go to another resident's room, take his clothes off, and get into a compromising position without staff being aware. -He thought either some staff did not watch Resident #3 every 30 minutes as instructed or staff possibly were helping another resident and it took longer than 30 minutes. -PCAs were to monitor Resident #3 and observe the residents whereabouts. -The PCAs were to document in the system every 30-minutes showing they had observed Resident #3. Based on record review, observation and attempted interview on 12/17/20 at 10:50am, it was determined that Resident #3 was not	D 270		

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D 270	Continued From page 23 interviewable. Attempted interview with Resident #3's Primary Care Provider (PCP) on 12/22/20 at 9:05am was unsuccessful. Attempted interviews with Resident #3's legal power of attorney (POA) on 12/18/20 at 1:34pm, 12/21/20 at 8:48am, and 12/22/20 at 9:25am were unsuccessful. Refer to the interview on 12/17/20 at 11:43am with the activity assistant. Refer to the interview with the MCU first shift medication aide (MA) on 12/17/20 at 1:50pm. Refer to the interview with a second shift MA on 12/17/20 at 3:00pm. Refer to the telephone interview with the Memory Care Unit Coordinator on 12/17/20 at 12:30pm and 12/18/20 at 12:33pm. Refer to the telephone interview with the Senior RCD on 12/21/20 at 2:03pm. Refer to the telephone interview with a personal care aide (PCA) on 12/23/20 at 6:19pm. Refer to the telephone interview with the Executive Director (ED) on 12/23/20 at 1:22pm. Interview on 12/17/20 at 11:43am with the activity assistant revealed: -On 12/12/20 at 3:30pm she was delivering snacks to residents. -She went to a resident's room (Resident #2), she knocked on the door and Resident #3 said "wait, wait."	D 270		

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D 270	Continued From page 24 -She got the door open 3 to 4 inches and Resident #3 pushed the door closed. -She did not try to enter the room, she went to get the lead medication aide from first shift and the medication aide from second shift. -Residents #2 and #3 had been friends for several weeks prior to the incident. -On several occasions she had observed Resident #3 sitting in a chair in Resident #2's room, the two residents were talking, and she did not think anything about the residents being together. -Resident #2 had called Resident #3 by her spouse's name last week (around 12/12/20). Interview with the first shift medication aide (MA) on 12/17/20 at 1:50pm revealed: -She had noticed that Resident #3 was attentive to Resident #2 helping with seating during meals, getting her a blanket if she expressed being cold, walking down the hallway holding hands, and expressing that he loved Resident #2. -The first incident that she observed was on 11/12/20 around 3:30pm. -The activity staff told her that Resident #3 was in the room with Resident #2 undressed from the waist down. -She and the second shift MA went to Resident #2's room and observed both residents were sitting on the bed undressed. -They helped both residents get dressed and she reported the incident to the Memory Care Unit Coordinator (MCUC). -The MCUC gave no instructions regarding supervising the residents to prevent them from undressing. -The second incident that she observed was on 11/13/20 at 7:15am. -At 7:15am, she started her morning medication pass.	D 270		

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D 270	Continued From page 25 -Resident #2's room was the first room and the first stop on the medication pass. -When she opened the room, Resident #3 was standing by the railing at the foot of the bed. -Resident #3 proceeded to walk towards her and she noticed Resident #3's pants and underwear were off. -She asked Resident #3 to put his clothes on, and he responded, "why?" -Resident #2 was lying in the bed on her back. -Resident #2's incontinent brief was pulled down to her knees. -Resident #2 asked her "so what do we do now?" -She helped both residents get dressed and she told staff to watch the residents and keep them out of the same room. -She did not tell the MCUC because he was off work. -She did not tell the RCD or the ED because the previous RCD had told her that residents in the memory care unit had the right to engage in sexual activity if desired. -Prior to this incident, no training or instructions had been given regarding supervising residents, documenting incidents of sexual activity, contacting residents' power of attorney or PCP when residents were observed engaged in sexual activity. Interview with a second shift MA on 12/17/20 at 3:00pm revealed: -On 11/12/20, around 2:45pm the activity assistant told her and the first shift MA that Resident #3 was in Resident #2's room and would not allow her in the room. -When they got to Resident #2's room they observed both residents sitting on the bed with no clothes on. -They got both residents dressed and the first shift MA went to tell the MCUC.	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/23/2020
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D 270	Continued From page 26 -On 11/16/20, the time was after 2:15pm, she was walking down the hallway in the memory care unit and she observed Residents #2 and #3 in Resident #2's room, -Both residents were sitting on the bed with their clothes off. -She helped Resident #3 get dressed and assisted him with leaving the room. -She then helped Resident #2 get dressed and she went to report the incident to the MCUC. -She told the MCUC and he said that he would contact the resident's family. -The MCUC told staff to monitor both residents and keep them from going in bedrooms together. -She did not tell the MCUC of the incident on 11/12/20, because she thought the first shift MA told him. -No increased supervision was put in place after this encounter. -She did not know about the incident on 11/13/20. -Resident #3 was already on 30-minute safety checks resulting from a physical altercation with another male resident on 11/07/20. -Prior to this incident no instructions had been given related to what do when memory care unit residents engaged in sexual activity. -Currently, both residents still followed each other to their individual rooms, but they were redirected. -Resident #3 got upset when he was redirected and not allowed to be alone with Resident #2, saying, "I am a man." -She was shocked to find Resident #2 in a room with her clothes off. Interview on 12/17/20 at 12:30pm with the MCUC revealed he had been told by the ED and Senior RCD that it was against Residents rights to deny residents to have relationships if both residents consented.	D 270			

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D 270	Continued From page 27 Telephone interview on 12/18/20 at 12:33pm with the MCUC revealed: -On 11/16/20, a MA informed him that Residents #2 and #3 were caught in the room together and both were undressed from the waist down. -He notified both residents' legal guardians. -Resident #3 was already on 30 minutes checks due to a physical altercation with another male resident on 11/07/20, so he did not increase supervision on Resident #3. -He informed staff to keep the residents in common areas and not to allow the residents to gather in rooms. -On 11/18/20, during a crossover stand-up meeting with the personal care aides (PCAs) on the first and second shifts, the topic of discussion was Residents #2 and #3 and how to keep the residents separated. -MAs were usually not present during the crossover meeting, the first shift MA was in the room and she told of an incident on 11/13/20 when she observed Resident #3 with his head between Resident #2's legs. -The next morning, he informed the Senior RCD and the ED. -The Senior RCD and the ED started an internal investigation. -During the investigation, a MA told of an incident that occurred on 11/12/20, when Residents #2 and #3 were in a room with their clothes off. -The MA said that she had made him aware of the incident, but he was unable to recall the incident. -On 11/20/20, Resident #3's family member was made aware of the incidents and asked to provide a sitter to monitor the resident for twenty-four hours. Resident #3's family approved the sitter until 12/09/20. -Facility staff did not know they needed to document and report the incidents that occurred	D 270		

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D 270	Continued From page 28 with Resident #2 and #3 on 11/12/20 and 11/13/20. -Resident #3 was already on 30-minute checks, and he did not know how the resident was able to go to another resident's room, take his clothes off, and get into a compromising position without staff being aware. -He thought either some staff did not watch Resident #3 every 30 minutes as instructed or staff possibly were helping another resident and it took longer than 30 minutes. -PCAs were to monitor Resident #3 and document in the system. -During the investigation it was determined that several incidents had occurred between Residents #2 and #3. -Prior to the investigation he was not aware if staff had been trained regarding behavioral expressions, reporting incidents and documentation. -Staff training was provided 12/01/20 through 12/03/20 after the facility completed their investigation. -Staff had been instructed to monitor both residents and to try to keep residents in common areas visible by all staff. Telephone interview with the Senior RCD on 12/21/20 at 2:03pm revealed: -She was made aware that something happened on 11/13/20 with Residents #2 and #3. -She was not made aware of the incident until 11/19/20 by the MCUC. -The MCUC came to her and told her that during a crossover stand-up staff meeting a MA said she had observed Resident #3 had his head between Resident #2's legs on 11/13/20. -As far as she knew the incident on 11/13/20 was the first incident between the two residents. -During her part of the investigation no one	D 270			

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D 270	Continued From page 29 mentioned other encounters when the two residents were observed together and undressed. -Training was provided after the incident, but prior to the incident no training had been provided to staff regarding reporting incidents of sexual nature between residents and supervising residents that engaged in sexual encounters. Telephone interview on 12/23/20 at 6:19pm with a third shift PCA revealed: -She worked varied shifts at the facility as a PCA in the memory care unit, but she mostly worked the third shift. -She had observed that Resident #3 followed Resident #2 to her room, but she mostly saw them talking. -She had on two occasions observed Residents #2 and #3 together with their clothes off/undressed, but nothing was happening. -In October 2020 (unable to recall exact date) both residents were in Resident #2's room and both were undressed. -She informed the MCUC and the wellness nurse. Both informed her to watch the residents. -On Sunday, 12/20/20 at 2:00pm she observed Resident #3 and Resident #2 in Resident #2's room. Resident #3 was undressed, but Resident #2 had her clothes on. -She told the MA that was on duty, which was the facility's protocol. The MA was supposed to inform the MCUC. -In November 2020, Resident #3 was supposed to be checked every 30-minutes due to a physical altercation with another resident that happened on 11/07/20, the 30-minute checks were not because of the incidents with Resident #2. -In November 2020, she "probably" saw Resident #3 every 30-minutes, but she did not always document that she had observed the resident because she forgot or she was busy with other	D 270		

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D 270	Continued From page 30 residents. -She did not know if Resident #3 was currently on 30-minute checks because lately the resident was not on her work assignment sheet. -She was sure Resident #3 knew what he was doing when he was undressing because when re-directed he got upset and would said "we are adults." -She was sure Resident #2 mentally did not understand the relationship with Resident #3, but Resident #2 mostly liked the attention she received from Resident #3. Also, Resident #2 always did what she was told to do. -She had observed Resident #3 was possessive of Resident #2 and he would get upset if another male showed Resident #2 attention or spent time with Resident #2, even if the male was a PCA or therapy. -On 11/16/20 instructions were given to supervise Residents #2 and #3 and for staff to keep the residents from being alone by themselves. Telephone interview with the Executive Director (ED) on 12/23/20 at 1:22pm revealed: -Residents have a right to engage in consensual sexual relationships even if they are in a dementia unit- provided both parties agree. -Resident #2 seeks the male resident whereabouts and does not appear afraid, upset, or apprehensive regarding the male resident's holding her hand or sitting together. -There was no increased supervision after the 11/12/20 incident when the residents were found undressed sitting on Resident #2's bed because staff did not consider the occurrence as an incident. -The occurrence on 11/13/20 was not reported to the MCUC or the Senior RCD. -Staff redirected the residents from either bedroom but there was no documentation of	D 270			

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D 270	Continued From page 31 increased supervision. -Resident #2 was not placed on 30 minutes supervision until 11/20/20 when the Senior RCD became aware of the 11/13/20 event reported to the MCUC during a staff meeting on 11/19/20. -The MCUC and the Senior RCD and/or ED could authorize increase supervision for residents. -The Senior RCD, or Wellness Nurses would be responsible to contact a resident's PCP on case by case basis regarding if residents needed increased supervision for behaviors related to right to consensual relationships. 2. Review of Resident #1's current FL2 dated 08/14/20 revealed: -Diagnoses included encephalopathy, history of falling, unsteadiness on feet, other abnormalities of gait and mobility, muscle weakness, communication deficit, other lack of coordination, and repeated falls. -Resident #1 was semi-ambulatory. -Resident #1 was intermittently disoriented. Review of Resident #1's record revealed she was admitted to the facility on 08/17/20. Review of Resident #1's service plan/care plan dated 08/17/20 revealed: -Resident #1 had impaired cognitive function related to communication deficit and required simple cues, prompts, and step by step direction to assist. -Resident #1 had a history of falls. -Resident #1 had fall risk factors and required safety reminders and information on what to do if a fall occurred. -Resident #1 had a fall without injury on 08/19/20, 08/21/20, 10/04/20, and 12/02/20. -There was an intervention initiated on 08/19/20 to place Resident #1's bed in a lower position.	D 270		

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D 270	Continued From page 32 -There was an intervention initiated on 09/11/20 to evaluate and monitor Resident #1 post fall, observe for and report changes in vital signs and mental status; and immediately report any new onset of confusion, sleepiness, inability to maintain posture, and agitation. -There was an intervention initiated on 10/05/20 to evaluate Resident #1's environment at the time and location of the fall and attempt to identify any factors that may have contributed to her fall and report findings to the supervisor. -Effective 07/31/20, Resident #1 needed physical assist of 1 person with mobility. - Effective 08/17/20, Resident #1 was independent with mobility, needed a walker to assist with mobility and staff was to observe and report any changes in mobility. -Effective 07/31/20, Resident #1 needed assistance with 1 person transferring. -Effective 08/17/20, Resident #1 was independent with transferring and staff were to observe for and report changes in her level of independence, and ensure her assistive device was available for use, clean and in good condition. Review of the facilities fall policy dated January 2019 revealed there was no documentation of how the facility would increase supervision according to residents needs after a fall. Review of Resident #1's Incident Report Notification dated 08/19/20 at 2:45am revealed: -Resident #1 had an unwitnessed fall. -Resident #1 stated she fell in the bedroom and crept to the bathroom and was unable to stand on her feet to use the bathroom. -There was no injury noticed. -Resident #1's vital signs were taken. -Resident #1's Primary Care Physician (PCP) signed the notification on 08/25/20.	D 270		

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D 270	Continued From page 33 -There was no documentation of any increase in supervision after Resident #1's fall on 08/19/20. Review of Resident #1's progress notes dated 08/19/20 revealed: -Resident #1 fell around 2:45am. -Resident #1 was sitting on the side of the bed and slid down to the floor and then crawled to the bathroom. -The action/intervention after the fall was Resident #1 was assisted off the floor by staff and helped back to bed. -Resident #1's responsible party and PCP were notified and Resident #1's family member was to come to lower the bed. -There were no injuries noted. -There was no documentation of any increase in supervision for Resident #1 after her fall on 08/19/20. Review of Resident #1's Incident Report Notification dated 08/21/20 at 1:30 (time of day was not indicated) revealed: -Resident #1 had an unwitnessed fall. -Resident #1 was found by staff on the floor in the bathroom -There was no injury noticed and Resident #1 did not complain of pain. -Resident #1's vital signs were taken. -Resident #1's PCP signed off on the notification on 08/25/20. -There was no documentation of any increase in supervision after Resident #1's fall on 08/21/20. Review of Resident #1's progress notes dated 08/19/20 revealed: -Resident #1 fell around 1:30am and was found on the floor in the bathroom. -Resident #1 was going to use the bathroom when she fell.	D 270			

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D 270	Continued From page 34 -The action/intervention after the fall was Resident #1 was checked for injuries and assisted back to bed, and staff reminded Resident #1 to use the call pendant for assistance to the bathroom. -There was no documentation of any increase in supervision for Resident #1 after her fall on 08/19/20. Review of Resident #1's PCP consultation note dated 08/25/20 revealed: -Resident #1 had a history of falling. -The PCP recommended physical therapy (PT) and occupational therapy (OT). -Resident #1 had 2 falls since being admitted to the facility. Review of Resident #1's progress notes dated 10/04/20 revealed: -Resident #1 fell around 3:30pm and had pressed her call pendant. -Resident #1 was observed on the floor in the bathroom sitting on her buttocks. -Resident #1 stated she fell out of her bed and crawled to the bathroom. -Resident #1 was assisted off the floor and back into her bedroom. -There were no apparent injuries. -Resident #1's PCP and responsible party were notified. -There was no documentation of any increase in supervision after Resident #1's fall on 10/04/20. Review of Resident #1's PCP consultation note dated 10/13/20 revealed: -Resident #1 had a history of falling. -The PCP recommended PT evaluation for balance and strength training. Review of Resident #1's Incident Report	D 270			

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D 270	Continued From page 35 Notification dated 12/2/20 at 4:45 (time of day was not indicated) revealed: -Staff went to Resident #1's room and Resident #1 fell while trying to open the door. -Resident #1 was observed on the floor in her room. -Resident #1's vital signs were taken. -Resident #1's PCP signed off on the notification on 12/08/20. -There was no documentation of any increase in supervision. Review of Resident #1's progress notes dated 12/02/20 revealed: -Staff was knocking on Resident #1's door and heard a noise. -Once Resident #1's door was opened, Resident #1 was observed on her bottom behind the door. -Resident #1's walker was not being used. -The action/intervention after the fall was Resident #1 was checked for injury and was able to move all extremities. -Resident #1 was assessed for pain and there were no complaints of pain or discomfort. -Resident #1 was assisted off the floor and to the sofa, and Resident #1's walker was placed within her reach and staff reminded her to use the walker at all times. -Resident #1's responsible party was notified. -There was no documentation of any increase in supervision for Resident #1 after her fall on 12/02/20. Review of Resident #1's progress notes dated 12/05/20 revealed: -Resident #1 was observed on the floor by her couch around 12:30pm. -Resident #1 stated she was trying to sit down on the couch. -The action/intervention after the fall was	D 270		

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D 270	Continued From page 36 Resident #1's vitals were taken, staff assisted Resident #1 to the couch, and Resident #1 was assessed for injuries with no apparent injuries noted. -There was no documentation of any increase in supervision after Resident #1's fall on 12/05/20. Review of Resident #1's Incident Report Notification dated 12/06/20 at 8:30am revealed: -Resident #1 was found sitting on the floor with her legs crisscrossed. -Resident #1 could not stand up and a fall was suspected. -Resident #1 was assessed for injuries and none were found. -Resident #1's PCP had not signed off on the Incident Report Notification dated 12/06/20. -There was no documentation of documentation of any increase in supervision for Resident #1 after her fall on 12/06/20. Review of Resident #1's progress notes dated 12/06/20 at 2:36pm revealed: -Resident #1 fell around 8:30am. -Resident #1 was observed sitting on her bottom in her room. -Resident #1 stated she was walking around her room. -The action/intervention after the fall was Resident #1 was assisted to her couch and checked for injuries with no apparent injuries noted. -There was no documentation of any increase in supervision. Review of Resident #1's Incident Report Notification dated 12/06/20 at 2:00 (time of day was not indicated) revealed: -Resident #1 was found in her room sitting on her bottom.	D 270			

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D 270	Continued From page 37 -Resident #1 was going to her table when she fell. -Resident #1 was sent to the emergency room. -There was no documentation of any increase in supervision for Resident #1 after her fall on 012/06/2. Review of Resident #1's progress notes dated 12/06/20 at 3:00pm revealed: -Resident #1 was observed sitting on her bottom around 1:00pm. -Resident #1 stated she was walking to the dining room table. -The action/intervention after the fall was Resident #1 was assisted back to bed assessed for injuries and with no apparent injuries, and emergency medical services were called and Resident #1 was sent to a local hospital. -Resident #1's responsible party and PCP were notified. Review of Resident #1's local hospital admission summary dated 12/06/20 revealed: -Resident #1 was seen in the emergency room and admitted to the hospital on 12/06/20. -Resident presented to the emergency room with falls. -There was a healing abrasion on Resident #1's right elbow. Telephone interview with the Wellness Nurse on 12/21/20 at 1:56pm revealed: -She wrote the progress notes for Resident #1 dated 08/19/20, 08/21/20, 12/05/20, and both progress notes on 12/06/20. -When a resident fell, the nurse staff visited the resident for the following 3 days to check the resident for bruising, injuries and increased confusion. -Resident #1 did not have any injuries after any of her falls.	D 270			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/23/2020
NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF GREENSBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 1208 NEW GARDEN ROAD GREENSBORO, NC 27410		
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D 270	Continued From page 38 -Resident #1 had 3 falls between 12/05/20 and 12/06/20. -Resident #1 was sent out to the hospital for evaluation after her second fall on 12/06/20 due to having 3 falls in 2 days. -There was no increased supervision for Resident #1 after her falls on 08/19/20, 08/21/20, 12/05/20, and 12/06/20. -She did not know why there was no increased supervision. Telephone interview with the Wellness Coordinator on 12/21/20 at 2:37pm revealed: -She wrote the progress notes for Resident #1 dated 10/04/20 and 12/02/20. -After a resident fell, the resident's PCP was notified and was seen by the PCP when he visited the facility. -Residents received a 3 day follow up where they were checked on by the nurses for 3 days following a fall to assess for any new injuries and pain. -Resident #1 had no injuries after any of her falls. -Interventions included: Resident #1's bed was lowered after her fall on 08/19/20; Resident #1 started PT and OT and was reminded to use the call bell after her fall on 08/21/20; Staff evaluated Resident #1's environment after her fall on 10/04/20; Staff reminded Resident #1 to use her walker after her fall on 12/02/20; There were no interventions put in place after Resident #1's falls on 12/05/20 and 12/06/20. -Resident #1 did not return to the facility after her hospitalization on 12/06/20. -She was not sure if there was any increase in supervision for Resident #1 after any of her falls. -If there had been an increase in supervision for Resident #1, it would have been documented in Resident #1's service plan. -All residents were checked on at least every 2	D 270		

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D 270	Continued From page 39 hours. Telephone interview with Resident #1's responsible party on 12/18/20 at 10:45am revealed: -She was contacted by the facility regarding Resident #1's falls. -She was not told staff increased supervision or did anything differently for Resident #1 after her falls. -Resident #1 received PT multiple times a week. -Resident #1 was admitted to the hospital on 12/06/20 and was discharged from the hospital to another facility on 12/14/20. Interview with a personal care aide (PCA) on 12/17/20 at 2:20pm revealed: -PCAs were not told to do anything differently for Resident #1 after her falls. -If a resident fell, PCAs checked on the resident every 2 hours after the fall. -He had not been told to increase supervision for Resident #1 after her falls. Interview with the AL Coordinator on 12/17/20 at 2:38pm revealed: -Resident #1 has had multiple falls. -After falls, residents were assessed for increased supervision of 30-minute checks or 15-minute checks and interventions such as a floor mat, PT for strength and conditioning, and hydration. -Thirty-minute checks or 15-minute checks were not implemented for Resident #1. -There was an interdisciplinary team that worked to determine whether residents received 30-minute and 15-minute checks. -She did not know why increased supervision was not implemented for Resident #1.	D 270		

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D 270	Continued From page 40 Telephone interview with a PCA on 12/22/20 at 2:43pm revealed he had never been told to increase supervision for Resident #1 after any of her falls. Telephone interview with the AL Coordinator on 12/22/20 at 3:11pm revealed: -Residents who had falls were followed by the nursing staff for 3 days post fall to assess for bruises and pain. -PCA's checked on residents more often after a fall, but it was not documented. -PCAs typically checked on resident every hour after a fall unless there was some other form of intervention put in place after the fall. -There was no documentation of when residents were checked on every hour after a fall. Telephone interview with the Senior Resident Care Coordinator on 12/23/20 at 12:06pm revealed: -She was aware of Resident #1's falls and had instructed staff to send Resident #1 out to the hospital on 12/06/20 due to Resident #1 having 3 falls within 2 days. -There had been no increase in supervision for Resident #1 after her falls. -Resident's service plan/care plans were updated within 24 hours after a fall, but supervision was not included in the service plan/care plan. -Standard checks for residents were every 2 hours and if a resident required checks more often than every 2 hours, the resident's family would have to consult with a sitter. -The facility used to provide 30-minute checks for residents after a fall, but currently did not. -To have a resident on 30-minute checks was unrealistic because staff could not promise to check on residents every 30 minutes.	D 270			

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D 270	Continued From page 41 Telephone interview with Resident #1's PCP on 12/22/20 at 10:58am revealed: -Resident #1 had a history of falls and he knew about all of Resident #1's falls since admission. -He ordered PT and OT for Resident #1, but he had not ordered any other interventions. -He would have expected the facility to discuss increased safety checks with Resident #1's family as the increase in safety checks would increase Resident #1's cost of care. Telephone interview with Executive Director (ED) on 12/22/20 at 2:35pm revealed: -If a resident had a fall, the residents' vital signs were checked and the resident was followed for 72 hours by the nurse staff. -Resident #1 was sent to the emergency room on 12/06/20 due to having had multiple falls. -She did not know what interventions were put in place for Resident #1 after each of her falls except for PT and OT. -All residents were checked on every 2 hours. -There were increased supervision logs used for residents who had behaviors, but not for residents who had falls. -She did not know if Resident #1 was checked on more frequently after her falls. The facility failed to supervise two residents in the Memory Care Unit that were involved in a relationship, resulting in the residents being undressed on three occasions and one incident when the residents were engaged in a sexual encounter (Residents #2 and #3). This failure resulted in substantial risk of physical harm and neglect and constitutes a Type A2 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/23/20 for this violation.	D 270		

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D 270	Continued From page 42 THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 22, 2021.	D 270			
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident 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. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to protect residents by not requesting a consent from the residents' legal guardians for 2 of 2 sampled residents (#2 and #3) who resided in the memory care unit and were engaged in a sexual relationship. The findings are: 1. Review of Resident #2's current FL2 dated 04/04/20 revealed: -Diagnoses included dementia without behavioral disturbances, amnesia, diverticulosis of intestine, and anxiety. -Resident #2 recommended level of care was memory care or special care unit (SCU). -Resident #2 was intermittently disoriented. -Resident #2 did not have documentation for ambulatory status. Review of Resident #3's current FL2 dated 09/15/20 revealed: -Diagnoses included dementia, diabetes mellitus,	D 338			

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D 338	Continued From page 43 hypothyroid and gastroesophageal reflux disease. -Resident #3 recommended level of care was the special care unit (SCU). -Resident #3 was ambulatory, constantly disoriented and wandered. a. Observation of Resident #2 on 12/17/20 at 11:30am revealed Resident #2 was walking with the Lead Personal Care Manager who was touching her arm and coaching her through the common sitting area of the memory care unit (MCU). Review of Resident #2's annual physical examination encounter documentation for 07/31/17, 09/05/18, 09/30/19 and revealed: -Orientation was documented as "oriented to self only". -Memory was documented as "abnormal". -Recall was documented as "poor recent recall". -Comprehension was documented as "normal" for 2017 and 2018, and "abnormal" for 2019. Review of Resident #2's latest annual physical examination encounter documentation dated 10/26/20 revealed documentation for mental status exam as follows: -Judgement, insight was "poor". -Orientation was "oriented to person, only". -Mentation was "alert but disoriented". Review of Resident #2's service plan/care plan dated 11/09/20 revealed: -Resident #2 was independent with ambulation and transferring. -Resident #2 needed supervision with bathing. -Resident #2 needed step-by-step cueing for dining. -Resident #2 needed 1 person assistance with washing hair, grooming, and dressing.	D 338		

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D 338	Continued From page 44 Review of the Resident #2's current service plan/care plan revealed: -On 11/23/20 the service plan was updated with the focus on "behavioral expression." -The intervention system was for staff to assess and anticipate needs, comfort level, body positioning, security and affection, self-expression; identify recent changes in level of alertness, and lack of sleep. "... known needs are sexual at times." -The staff were to "observe for and monitor behavioral expression episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, possible triggers and situations. Report findings to the nurse/ medication care manager/Supervisor." (Medication aides (MA) were identified as medication care managers if the MA was also designated as the Supervisor for a shift). Review of Resident #2's accident/incident report completed by the Executive Director (ED) on 11/20/20 revealed: -On 11/13/20 at 7:15am, team member reported to the Supervisor on 11/18/20 staff had walked in on a male resident with his face between Resident #2's legs. -The place of incident was Resident #2's room. Review of Resident #2's electronic safety checks documentation log revealed: -Resident #2 had documented 30-minute safety checks that started on 11/20/20. -The resident was checked on every 30 minutes from 11/20/20 at 3:00pm to 11/23/20 at 10:00pm except for 12/22/20 from 6:00am to 2:30pm. Review of Resident #2's progress notes revealed: -On 11/16/20 at 12:47pm, the Memory Care Unit	D 338		

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D 338	Continued From page 45 Coordinator (MCUC) documented "family was made aware of other resident's fondness of his family member and that they were observed in her room with their clothing off over the weekend." -On 11/19/20 at 2:47pm, the Senior Resident Care Director (RCD) spoke with Resident #2's Power of Attorney/responsible person (POA/RP) regarding another resident observed in resident's room with his face between her legs last week. (According to the facility incident report the incident occurred on 11/13/20 at 7:15am). The POA/RP would rather follow-up through PCP than emergency department. Resident #2 had potential room change. Staff was to continue to monitor. -On 11/21/20 at 12:42pm, the MCUC documented the POA/RP contacted the facility for an update and was told Resident #2's room had been switched (for easier observation from the medication room). -On 11/23/20 at 2:21pm, the Senior RCD documented she was notified "Resident #2 was up all night looking for another resident that was previously observed in her room." Staff redirected Resident #2, would continue to monitor. -On 12/01/20 at 4:29pm, the Senior RCD documented she had lengthy conversation with POA/RP about expression of intimacy related to Resident #2 "sometimes seeks out another resident (#3)." The POA/RP would like to think about giving consent for sexual activity and talk with the RCD later. Interview on 12/17/20 at 11:43am with the activity assistant revealed Resident #2 called the male resident (#3) by her spouse's name last week (around 12/11/20). Telephone interview with Resident #2's Power of	D 338		

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D 338	Continued From page 46 Attorney/Responsible Party (POA/RP) on 12/17/20 at 1:00pm revealed: -He was notified on 11/19/20 about an incident that occurred on 11/13/20 between Resident #2 and a male resident (#3) involving the residents being undressed in Resident #2's room. -He had not been notified that Resident #2 was involved in any physical or emotional type relationship with a male resident prior to 11/19/20. -He had not been contacted to inform him of Resident #2's interest in Resident #3. -He did not think Resident #2 was able to make decisions regarding relationships. -He had not given consent regarding Resident #2 to be in a physical relationship with a male resident (#3). -Going forward, he requested to be informed regarding ongoing or increasing relationship with another resident. Telephone interview with the Senior Resident Care Director (RCD) on 12/21/20 at 2:03pm revealed: -Resident #2's POA/RP was contacted on 11/19/20 by the Senior RCD regarding the 11/13/20 encounter between Resident #2 and a male resident (#3). -The POA/RP needed some time to process the information and did not give consent for Resident #2 to have anything but a friendly relationship with Resident #3. Telephone interview with Resident #2's POA/RP on 12/22/20 at 1:21pm revealed: -He did not know Resident #2 was showing physical interest with a male resident (#3) until 11/16/20. -On 11/16/20, the MCUC called him to say Resident #2 was fond of Resident #3 and the two had been observed in Resident #2's room	D 338		

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D 338	Continued From page 47 partially clothed. -On 11/19/20, a Nurse from the facility called to tell him about an incident on 11/13/20 involving Resident #2 and Resident #3. -He had no prior knowledge that Resident #2 had interest in Resident #3. -He did not think Resident #2 had the ability to make her sound decisions regarding relationships. -He felt he should have been consulted or informed as the POA regarding Resident #2's interest in Resident #3. -He believed the POA/RP should give consent for sexual relationships since Resident #2 was in the MCU and not able to make good relationship choices on her own. -He requested information or documentation regarding the facility's plan for monitoring Resident #2's physical relationship with the male resident (#3), but had not received any written information. -He was asked to give consent for Resident #2 to have physical relationship with Resident #2 was not comfortable giving consent for Resident #2 to be involved sexually with a male resident without some kind of documentation for the extent Resident #2 would be supervised and boundaries for sexual safety. Telephone interview with Resident #2's Primary Care Provider (PCP) on 12/23/20 at 12:07pm revealed: -He had been the PCP for Resident #2 for several years, long before she transitioned to the MCU at the facility in 2017 due to loss of her spouse and daughter. -Resident #2's memory had been in steady decline over the last 10 or more years. -She had scored low on a Mini Mental State Exam (MMSE) taken in 2016. [According to the	D 338		

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D 338	Continued From page 48 Alzheimer's Association, Scores on the MMSE range from 0 to 30, with scores of 26 or higher being traditionally considered normal. Scores less than 9 generally indicate severe impairment, while scores between 10 and 20 indicate moderate dementia.) -The facility had not made any contact with the PCP regarding sexual behavior until the notification of the incident on 11/13/20. -The facility had not requested an assessment for Resident #2's ability to consent to sexual activity. -Resident #2 was not capable of making good judgement and insightful decisions regarding relationships including sexual activity due to her loss of cognitive function and progression of her Alzheimer's disease. -If making decisions about Resident #2's ability to have consensual relations involving sexual acts, he would expect the facility staff to consult him for his professional opinion. -The POA/RP should be consulted to make that decision. -The facility would be responsible to supervise residents to keep them safe. Based on observation, interviews and record review, it was determined Resident #2 was not interviewable. Refer to the interview on 12/17/20 at 11:43am with the activity assistant. Refer to the interview with the MCU first shift medication aide (MA) on 12/17/20 at 1:50pm. Refer to the interview with a second shift MA on 12/17/20 at 3:00pm. Refer to the telephone interview with the Memory Care Unit Coordinator (MCUC) on 12/17/20 at	D 338			

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D 338	Continued From page 49 12:30pm. Refer to the telephone interview with the personal care aide on 12/23/20 at 6:19pm. Refer to the telephone interview with the Executive Director (ED) on 12/23/20 at 1:22pm. b. Review of Resident #3's service plan/care plan dated 09/24/20 revealed: -Resident #3 was independent with eating, ambulation, transferring, toileting, and grooming. -Resident #3 needed supervision with dressing. -Resident #3 needed hands on assistance with bathing. -On 11/11/20 the service plan was updated with the focus on "behavioral expression." -The intervention system was for staff to intervene to protect the rights and safety of others. -The direction given was for staff to remove Resident #3 and suggest an alternate and relationship based redirection. Review of Resident #3's accident/incident report completed on 11/20/20 revealed on 11/13/20 at 7:15am a MA reported she observed Resident #3 in a female resident's bed (Resident #2) with his head between her legs. Review of Resident #3's progress notes revealed: -On 11/16/20 at 12:53pm, "family made aware Resident #3 was with a female resident (#2) and both were observed having taken their clothes off." -On 11/19/20 at 2:53pm, spoke with Resident #3's family regarding an incident that occurred on 11/13/20 at 7:15am, when Resident #3 was observed in a female resident (#2) room with his face between her legs.	D 338		

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NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF GREENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1208 NEW GARDEN ROAD GREENSBORO, NC 27410		
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D 338	Continued From page 50 -There was no documentation Resident #3's guardian had been contacted prior to 11/16/20 regarding obtaining permission to engage in a relationship and/or sexual activity. Review of Resident #3's "behavioral tracking log" revealed: -On 11/16/20 at 2:15pm, Resident #3 was observed in a female resident's (Resident #2) room with his clothes off sitting on the bed. -On 11/22/20 at 4:00am, Resident #3 was wandering the hall trying to go in a female resident's (Resident #2) room. Review of Resident #3's documented reports (progress notes, accident/incident reports and behavioral tracking log) revealed there was no documentation related to obtaining Resident #3's guardian's consent for the resident to engage in a relationship and/or sexual activity. Based on record review, observation and attempted interview on 12/17/20 at 10:50am, it was determined that Resident #3 was not interviewable. Attempted interview with Resident #3's Primary Care Provider (PCP) on 12/22/20 at 9:05am was unsuccessful. Attempted interviews with Resident #3's legal power of attorney (POA) on 12/18/20 at 1:34pm, 12/21/20 at 8:48am, and 12/22/20 at 9:25am were unsuccessful. Refer to the interview on 12/17/20 at 11:43am with the activity assistant. Refer to the interview with the MCU first shift medication aide (MA) on 12/17/20 at 1:50pm.	D 338			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/23/2020
NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF GREENSBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 1208 NEW GARDEN ROAD GREENSBORO, NC 27410		
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D 338	Continued From page 51 Refer to the interview with a second shift MA on 12/17/20 at 3:00pm. Refer to the telephone interview with the Memory Care Unit Coordinator (MCUC) on 12/17/20 at 12:30pm. Refer to the telephone interview with the personal care aide on 12/23/20 at 6:19pm. Refer to the telephone interview with the Executive Director (ED) on 12/23/20 at 1:22pm. Interview on 12/17/20 at 11:43am with the activity assistant revealed on several occasions she had observed Resident #3 sitting in a chair in Resident #2's room, the two residents were talking, and she did not think anything about the residents being together. Interview with the first shift medication aide (MA) on 12/17/20 at 1:50pm revealed: -She had noticed that Resident #3 was attentive to Resident #2 helping with seating during meals, getting her a blanket if she expressed being cold, walking down the hallway holding hands, and expressing that he loved Resident #2. -The first incident she observed was on 11/12/20 around 3:30pm, and Resident #2 and #3 were sitting on the bed undressed. -The second incident that she observed was on 11/13/20 at 7:15am, Resident #3 was observed in Resident #2's room. -Resident #3 was standing by the railing at the foot of the bed and his pants and underwear were off. -Resident #2 was lying in the bed on her back with her incontinent brief was pulled down to her knees.	D 338		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/23/2020
NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF GREENSBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 1208 NEW GARDEN ROAD GREENSBORO, NC 27410		
(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 338	Continued From page 52 -She did not tell the RCD or the ED because the previous RCD had told her that residents in the memory care unit had the right to engage in sexual activity if desired. -Prior to this incident, no training or instructions had been given regarding supervising residents, documenting incidents of sexual activity, contacting residents' power of attorney or PCP when residents were observed engaged in sexual activity. Interview with a second shift MA on 12/17/20 at 3:00pm revealed: -On 11/12/20, around 2:45pm she observed Resident #3 in Resident #2's room both residents were sitting on the bed with no clothes on. -On 11/16/20, the time was after 2:15pm, she was walking down the hallway in the memory care unit and she observed Residents #2 and #3 in Resident #2's room, -Both residents were sitting on the bed with their clothes off. -Prior to this incident no instructions had been given related to what do when memory care unit residents engaged in sexual activity. -Currently, both residents still followed each other to their individual rooms, but they were redirected. She was shocked to find Resident #2 in a room with her clothes off. Interview with the MCUC on 12/17/20 at 12:30pm revealed he had been told by the ED and Senior RCD that it was against Residents' Rights to deny residents to have relationships if both residents consented. -He had not obtained consent from both Residents #2 and #3's guardians for a relationship. Telephone interview on 12/23/20 at 6:19pm with a	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/23/2020
NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF GREENSBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 1208 NEW GARDEN ROAD GREENSBORO, NC 27410			
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D 338	Continued From page 53 third shift PCA revealed: -She was sure Resident #3 knew what he was doing when he was undressing because when re-directed he got upset and would said "we are adults." -She was sure Resident #2 mentally did not understand the relationship with Resident #3, but Resident #2 mostly liked the attention she received from Resident #3. Also, Resident #2 always did what she was told to do. -She had observed Resident #3 was possessive of Resident #2 and he would get upset if another male showed Resident #2 attention or spent time with Resident #2, even if the male was a PCA or therapy. Telephone interview with the Executive Director (ED) on 12/23/20 at 1:22pm revealed: -Residents have a right to engage in consensual sexual relationships even if they were in a dementia unit provided both parties agree. -Resident #2 seeks Resident #3 whereabouts and did not appear afraid, upset, or apprehensive regarding the male resident's holding her hand or sitting together. -The Senior RCD, or Wellness Nurses would be responsible to contact a resident's PCP on case by case basis regarding if residents needed consent related to the right to consensual relationships. The facility failed to obtain consent from two residents' legal guardians regarding a male resident (#3) and a female resident (#2), who resided in the memory care unit, related to Resident #3 found undressed in Resident #2's room on 3 occasions with one occasion both residents were engaged in sexual activity resulting in Resident #2 being sent to a local emergency department and receiving	D 338			

Division of Health Service Regulation

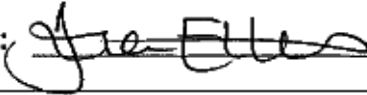
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/23/2020
NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF GREENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1208 NEW GARDEN ROAD GREENSBORO, NC 27410		
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D 338	Continued From page 54 prophylactic treatment for sexually transmitted diseases. This failure resulted in substantial risk of physical harm and neglect which constitutes a Type A2 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/23/20 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 22, 2021.	D 338			
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 interviews and record reviews, the facility failed to ensure residents were free from neglect and treated with respect, consideration, and dignity as related related to supervision and Residents' Rights. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 5 sampled residents (#1, #2 and #3) related to a male resident (Resident #3) found undressed in a female resident's room (Resident #2) on 3 occasions and on one occasion both residents engaged in sexual activity, and a resident who had multiple falls (#1). [Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care	D914			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/23/2020
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D914	Continued From page 55 and Supervision (Type A2 Violation)). 2. Based on observations, interviews, and record reviews, the facility failed to protect residents by not requesting a consent from the residents' legal guardians for 2 of 2 sampled residents (#2 and #3) who resided in the memory care unit and were engaged in a sexual relationship. [Refer to Tag D0338, 10A NCAC 13F .0909 Residents' Rights (Type A2 Violation)].	D914			

Sunrise Senior Living Plan of Correction

Name of Community: Brighton Gardens of Greensboro
Address of Community: 1208 New Garden Rd. Greensboro, NC
License number: HAL 041-084
Inspection date(s): 12/23/2020
Name/Title of Legal Entity Representative Signing the Plan of Correction:
 Fran Etters, Executive Director

Signature of Sunrise Representative: 
Date of Submission: 2/9/2021

Regulation	Target Date by Which Correction will be completed	Plan of Correction
D 269 10A NCAC 13F .0901(a) Personal Care and Supervision	12/23/2020	A. With respect to the specific resident/situation cited: Resident #1 no longer resides in the community as of 12/23/2020.
	1/22/2021	B. With respect to how the facility will identify residents/situations for the identified concerns: Residents who are listed as Independent and/or one person assist with toileting and bathing had their care plans reviewed to assure they are being assisted, cared for and documented on properly. This was completed by our Resident Care Director (RCD), Reminiscence Coordinator (RC) and Assisted Living Coordinator (ALC). Review in-service completed 12/29/2020 by RCD/RN.
	1/22/2021	C. With respect to what systemic measures have been put into place to address the stated concern: One care plan on AL and one on REM is reviewed weekly by the ALC and RC of Residents who are listed as Independent with toileting and bathing to ensure continuance of quality care reflective of Residents continuous changing needs. This was reviewed with the ALC and RC by the ED on 2/5/2021.
	1/22/2021	D. With respect to how the plan of correction will be monitored: This Plan of Correction will be monitored by weekly for four weeks and monthly audits and reviewed at the Quality Assurance Performance Improvement meetings for three months which are conducted by the ED and QAPI committee.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
D 270 10A NCAC 13F .0901(b) Personal Care and Supervision	12/23/2020	A. With respect to the specific resident/situation cited: Resident #1 no longer resides at the community as of 12/23/2020.
	12/1/2020	Senior RCD had a phone meeting with Resident #2's responsible party to discuss the ongoing relationship with Resident #3, providing information on Resident right to have sexual intimacy, how supervision can promote a safe relationship and evaluation of Resident's verbal and non-verbal expressions and queues of discomfort or pain will be reviewed with staff and added to the ISP.
	12/1/2020	Senior RCD had a phone meeting with Resident #3's responsible party to discuss the ongoing relationship with Resident #3, providing information on Resident right to have sexual intimacy, how supervision can promote a safe relationship and evaluation of Resident's verbal and non-verbal expressions and queues of discomfort or pain will be reviewed with staff and added to the ISP.
	1/22/2021	B. With respect to how the facility will identify residents/situations for the identified concerns: Residents residing in AL and REM who are involved in a relationship beyond friendship will be consulted about consent both by the Resident themselves and/or active POAs/Guargians. Consultation will be made by RCD, ED, or EDs designee. ISPs of the Residents will be updated to reflect the consent, the behaviors and activity of their relationship and their way of verbal and non-verbal expressions of discomfort.
	1/22/2021	Residents that have experienced falls in the last three months had their ISPs reviewed during At-Risk meetings to confirm appropriate interventions were in place and to confirm fall events are documented.
	1/22/2021	The ALC and RC discussed topics of Resident consented sexual activity, behavior expressions and fall interventions with the care managers during cross shift meetings.
	1/14/2021	C. With respect to what systemic measures have been put into place to address the stated concern: Incidents of falls are reported to the RCD and investigated by RCD, ED or EDs designee to determine a root cause analysis for appropriate interventions. Falls are reported promptly to PCPs with orders followed when given. Who is a fall risk will be discussed at At-Risk meeting for planning and implementation of appropriate interventions for prevention.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		Team members complete our training on Intimacy and Reporting of incidents. Resident Rights training is completed upon hire for all Team Members, annually and PRN throughout the year. 12/29/2020 Inservice on Resident Rights completed by our RCD/RN on 12/29/2020. Inservice on Resident Right conducted by our Ombudsman on 1/29/2021. 1/13/2021 Team Members who recognizes relations/signs between Residents beyond friendships must report to their Department Coordinator, RCD and ED. ISPs will reflect the nature of the consented relationships and include the Resident's verbal and non-verbal expressions which will inform care managers of how to provide appropriate supervisor and reporting events. 1/22/2021 <i>D. With respect to how the plan of correction will be monitored:</i> Falls are reviewed initially at daily stand up with planning, interventions and reviews during weekly At-Risk meetings and QAPI meeting conducted by ED and QAPI committee. Any new or current activity between Residents are discussed/monitored at weekly Department Coordinator and At-Risk meetings and action put in place where needed. In-service trainings on Personal Care and Supervision are monitored to ensure timely completion by our BOC, RCD and/or ED. This plan of correction will be monitored for three months through the review of performance indicators and Resident events at the QAPI meeting led by the ED and QAPI committee.
D 338 10A NCAC 13F .0909 Resident Rights	1/22/2021	<i>A. With respect to the specific resident/situation cited:</i> Senior RCD had a phone meeting with Resident #2's responsible party to discuss the ongoing relationship with Resident #3, providing information on Resident right to have sexual intimacy, how supervision can promote a safe relationship and evaluation of Resident's verbal and non-verbal expressions and queues of discomfort or pain will be reviewed with staff and added to the ISP. Senior RCD had a phone meeting with Resident #3's responsible party to discuss the ongoing relationship with Resident #3, providing information on Resident right to have sexual intimacy, how supervision can promote a safe relationship and evaluation of Resident's verbal and non-verbal expressions and queues of discomfort or pain will be reviewed with staff and added to the ISP.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	1/22/2021	B. With respect to how the facility will identify residents/situations for the identified concerns: Residents residing in AL and REM who are involved in a relationship beyond friendship will be consulted about consent both by the Resident themselves and/or active POAs/Guargians. Consultation will be made by RCD, ED, or EDs designee. ISPs of the Residents will be updated to reflect the consent, the behaviors and activity of their relationship and their way of verbal and non-verbal expressions of discomfort.
	1/22/2021	The ALC and RC discussed topics of Resident consented sexual activity, behavior expressions and fall interventions with the care managers during cross shift meetings.
	1/22/2021	C. With respect to what systemic measures have been put into place to address the stated concern: Incidents of falls are reported to the RCD and investigated by RCD, ED or EDs designee to determine a root cause analysis for appropriate interventions. Falls are reported promptly to PCPs with orders followed when given. Who is a fall risk will be discussed at At-Risk meeting for planning and implementation of appropriate interventions for prevention. Team members complete our training on Intimacy and Reporting of incidents. Resident Rights training is completed upon hire for all Team Members, annually and PRN throughout the year. Inservice on Resident Rights completed by our RCD/RN on 12/29/2020. Inservice on Resident Right conducted by our Ombudsman on 1/29/2021. Team Members who recognizes relations/signs between Residents beyond friendships must report to their Department Coordinator, RCD and ED. ISPs will reflect the nature of the consented relationships and include the Resident's verbal and non-verbal expressions which will inform care managers of how to provide appropriate supervisor and reporting events.
	1/22/2021	D. With respect to how the plan of correction will be monitored: Falls are reviewed initially at daily stand up with planning, interventions and reviews during weekly At-Risk meetings and QAPI meeting conducted by ED and QAPI committee. Any new or current activity between Residents are

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		completion by our BOC, RCD and/or ED. This plan of correction will be monitored for three months through the review of performance indicators and Resident events at the QAPI meeting led by the ED and QAPI committee.

Received and Accepted

Keisha Banks

02/23/21