STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008029	A. BUILDING: _____ B. WING _____	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA'S PLACE	1517 GOVERNOR'S ROAD WINDSOR, NC 27983

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey, and complaint investigations from June 17, 2024, to June 18, 2024. The complaint investigations were initiated by the Bertie County Department of Social Services on May 9, 2024, and June 6, 2024.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews, and record reviews the facility failed to ensure referral and follow-up to meet the routine health care needs of 1 of 3 sampled residents (#2) related to failing to ensure the resident was seen by his psychiatrist. The findings are: Review of Resident #2's current FL-2 dated 11/08/23 revealed: -Diagnoses included autism, and obsessive-compulsive disorder. -The resident was intermittently disoriented and verbally abusive. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 11/06/19. Review of Resident #2's current care plan dated 11/08/23 revealed: -The resident received mental health services. -The resident had disruptive and socially inappropriate behaviors.	C 246		

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C 246	Continued From page 1 -The resident was sometimes disoriented. -The resident required extensive assistance with bathing, dressing and grooming. -Resident #2 resisted care at times. Interview with Resident #2 on 06/17/24 at 10:20am revealed: -Sometimes he refused to go to his appointments with his psychiatrist. -He preferred to go to his day program rather than go to his appointment. -If he did not feel like attending an appointment with his psychiatrist he refused to go to the appointment. Telephone interview with the nurse from Resident #2's psychiatrist on 06/18/24 at 11:19am revealed: -Resident #2 was seen by the psychiatrist for impulse control and sexual obsession. -Resident #2 was seen by the psychiatrist on 03/20/24 for touching himself in his private area in front of a female staff at the facility. -The resident was confrontational with the psychiatrist and had a difficult time explaining his actions. -The psychiatrist documented on 03/20/24 that the resident had cognitive limitations and poor impulse control. -The psychiatrist also provided counseling to Resident #2 reinforcing that it was not appropriate for the resident to approach women and it could be unsafe for him to approach women. -The psychiatrist documented that baseline counseling was limited due to the resident's cognitive limitations. Telephone interview with the Clinical Manager with Resident #2's psychiatrist on 06/18/24 at 11:23am revealed:	C 246		

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-Resident #2's plan of treatment included visits with the psychiatrist one time a month, and as needed.
-The resident had a scheduled appointment with the psychiatrist on 01/17/24, however staff from the facility called and cancelled the resident's appointment.
-The resident was rescheduled to be seen on 01/24/24 and the resident attended the appointment.
-The resident had a scheduled appointment on 03/11/24 but was a no show for the appointment.
-The receptionist called staff at the facility to reschedule the resident's appointment to 03/20/24 which the resident attended.
-The resident had a scheduled appointment with the psychiatrist on 05/01/24 but was a no show for the appointment.
-She called the Administrator after the resident was a no show for his appointment on 05/01/24 to review the providers no show policy; after a resident had three no shows, they would not be seen by the provider due to the number of no shows.
-A new appointment was scheduled for Resident #2 for 06/05/24 and the resident attended the appointment.

Interview with the Administrator on 06/18/24 at 2:04pm revealed:
-Resident #2 was observed by a female staff person touching himself in his private area when she entered his room to sweep.
-She and staff had provided education to the resident to keep his bedroom door shut if he chose to touch himself in his private area.
-She was not aware of any other incidents when the resident behaved inappropriately sexually.
-Resident #2 refused to attend some of his appointments with his psychiatrist, which caused

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C 246	Continued From page 3 the resident to be a no show for a few scheduled appointments. -When the resident was a no show for an appointment, she would call the provider to reschedule the resident's appointment. -Staff documented when the resident refused, but the Administrator was unable to provide any progress notes for Resident #2. Attempted telephone interview with Resident #2's primary care provider (PCP) on 06/17/24 at 3:45pm and on 06/18/24 at 10:17am were unsuccessful.	C 246		
C 320	10A NCAC 13G .1002 (f) Medication Orders 10A NCAC 13G .1002 Medication Orders (f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration, are reviewed and signed by the resident's physician or prescribing practitioner at least every six months This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure all current orders for medications and treatments were reviewed and signed by the resident's physician or prescribing practitioner at least every six months for 3 of 3 sampled residents (#1, #2 and #3). The findings are: 1. Review of Resident #1's current FL-2 dated 11/08/23 revealed: -Diagnoses included schizoaffective disorder,	C 320		

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C 320	Continued From page 4	C 320		

hypertension, congestive heart failure, and diabetes.
-He was constantly disoriented.
-There were physician's orders for 16 medications.

Review of Resident #1's resident record revealed there were physician's order sheets printed each month from December 2023 through June 2024 available which listed the same 16 medications but had not been signed by a physician.

Attempted interview with Resident #1's primary care provider (PCP) on 06/17/24 at 3:45 and on 06/18/24 at 10:17am was unsuccessful.

Refer to interview with the Administrator on 06/17/24 at 3:30pm.

2. Review of Resident #2's current FL-2 dated 11/08/23 revealed:
-Diagnoses included autism, and obsessive-compulsive disorder.
-The resident was intermittently disoriented and verbally abusive.
-There were physician orders for 5 medications.

Review of Resident #2's resident record revealed there were physician's order sheets printed each month from December 2023 through June 2024 available which listed the same 5 medications but had not been signed by a physician.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 06/17/24 at 3:45 and on 06/18/24 at 10:17am were unsuccessful.

Refer to interview with the Administrator on 06/17/24 at 3:30pm.

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C 320	Continued From page 5 3. Review of Resident #3's current FL-2 dated 11/08/23 revealed: -Diagnoses included diabetes, insomnia, and autism. -There was no information documented about the resident's orientation status. -There were physician orders for 9 medications. Review of Resident #3's resident record revealed there were physician's order sheets printed each month from December 2023 through June 2024 available which listed the same 9 medications but had not been signed by a physician. Attempted telephone interview with Resident #3's primary care provider (PCP) on 06/17/24 at 3:45 and on 06/18/24 at 10:17am were unsuccessful. Refer to interview with the Administrator on 06/17/24 at 3:30pm. _____ Interview with the Administrator on 06/17/24 at 3:30pm revealed: -Physician order sheets were sent to the facility each month from the pharmacy. -Physician orders were not reviewed and signed by the physician every 6 months because she was not aware orders were required to be reviewed and signed at least every six months by the prescribing physician.	C 320		
C 428	10A NCAC 13G .1206 Health Care Personnel Registry 10A NCAC 13G .1206 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and	C 428		

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C 428	Continued From page 6 .0102.	C 428		

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on interviews and record reviews, the facility failed to complete the Health Care Personnel Registry (HCPR) 24 Hour Initial and 5 Working Day Investigation Report after a resident's (#4) family member reported an allegation that Staff A sexually abused Resideint #4 to the Administrator.

The findings are:

Review of the facility's Policy and Procedure Manual dated 04/01/20 revealed:
-In the event of allegations of physical abuse, the Administrator would complete the 24-hour report and send it to the Health Care Personnel Registry (HCPR).
-The facility would conduct an investigation and send findings documented on the five-day report to the HCPR.
-A report would be sent to Department of Social Services (DSS), Adult Home Specialist (AHS).

Review of Resident #4's current FL-2 dated 11/08/23 revealed:
-Diagnoses included schizoaffective disorder, mental retardation, hypertension and allergies.
-There was no documentation regarding orientation status.

Telephone interview with Resident #4 on 06/17/24 at 9:01am revealed:
-Resident #4 did not have a roommate when he

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was at the facility.
-Staff A came into his room at night when other residents were asleep.
-Staff A wanted Resident #4 to have sex with her.
-Staff A climbed on top of him and had sex with Resident #4.
-Resident #4 asked the staff to stop but Staff A would not stop.
-He was scared during the incident, but Staff A did not threaten him or tell him not to tell anyone the incident occurred.
-He did not report the incident to anyone at the facility.
-He did not know when or what month the incident occurred.

Telephone interview with Resident #4's family member on 06/17/24 at 8:52am revealed:
-She picked up Resident #4 from the facility in April 2024 and he had not returned to the facility since that time.
-Resident #4 told her Staff A made Resident #4 have sex with her.
-She reported the allegation to the Administrator and to law enforcement in the facility's home county.
-She did not know when the incident occurred.

Second telephone interview with Resident #4's family member on 06/18/24 at 5:23pm revealed:
-She reported the incident to law enforcement in the facility's home county on or around 05/01/24.
-She went to law enforcement to make the report but was made to wait approximately thirty minutes, so she left the station and called from her car.
-She was asked to return to the station, but she did not return because she did not want to be bothered by the incident anymore because she did not think law enforcement would do anything

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C 428	Continued From page 8	C 428		

about the allegation.
-She sent the law enforcement officer a private message on social media about Resident #4's allegation on or around 05/01/24.
-Resident #4 had not been evaluated by a doctor for the alleged incident.

Review of 24 Hour Initial Report Notification of Facility Allegation To HCPR dated 06/10/24 revealed:
-There was documentation of an allegation of sexual abuse to Resident #4.
-Date of the incident was documented as 04/23/24.

Review of email from HCPR Investigations to the Administrator dated 06/13/24 revealed:
-An Initial Allegations Report (formerly referred to as 24-Hour Initial Report) for Resident #4 was sent on 06/10/24.
-The Investigation Report (formerly referred to as the 5-Day Report) and supporting documents and information was requested to be submitted.

Review of the 5-Working Day Report Result of Facility Allegation Investigation to HCPR (undated) revealed:
-Allegation type was marked as resident abuse with date of incident documented as 04/23/24.
-In the Resident information section, Resident #4's ability to be interviewed is marked "No".
-There was documentation there was no physical injury/harm and there was no mental anguish lasting 5 days or more.
-There was no documentation of the incident being reported to law enforcement.
-There was documentation the incident was reported to DSS on 04/24/24.

Interview with Staff A who was a medication aide

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C 428	Continued From page 9 (MA) 06/17/24 at 3:00pm revealed: -She was working as the MA at the facility on 04/23/24 when the Administrator came to the facility. -The Administrator informed Staff A that Resident #4 had reported to his family member that Staff A had sexually abused the resident in his bedroom at night. -She was questioned by the Administrator about allegations of sexual abuse made by Resident #4. -She completed a written statement about the alleged sexual abuse and provided it to the Administrator. -The Administrator sent her home without pay for two weeks until the Administrator completed her investigation. -She was shocked by Resident #4's allegations because he had never had any problems with the resident; the resident enjoyed going to his day program and got along well with the other residents at the home. Interview with the Administrator on 06/17/24 at 12:35pm revealed: -Resident #4 left the facility with a family member on 04/19/24 for a visit and never returned to the facility. -Resident #4 called her on 04/23/24 at approximately 6:00pm to say they would not be returning until 04/25/24. -At approximately 6:30pm on 04/23/24, the family member called and reported the allegation of sexual abuse by Staff A. -She asked to speak with Resident #4 regarding the allegation but was denied by the family member. -There was no report of abuse prior to 04/23/24. -She went to the facility on 04/23/24 following the report and sent Staff A home and began her investigation.	C 428		

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C 428	Continued From page 10 -She was responsible for notification to the HCPR and conducting investigations of alleged abuse. -She did not complete or send a 24-hour Initial report or a 5 day report to the HCPR until 06/10/24 and more information was sent on 06/13/24 per request from HCPR. -She forgot that she was supposed to send the 24-hour Initial report and 5-day report to HCPR. Second interview with the Administrator on 06/18/24 at 2:04pm revealed: -She first heard of the allegation regarding Resident #4 when she received a call from his family member on 04/23/24. -It was the facility's policy to complete a 24-hour Initial report and send it to the HCPR when allegations of abuse were made. -The facility's policy was also to conduct an investigation and send a 5-day report to the HCPR for the allegation of abuse. -She learned that these reports were required in 2013 when she took the class for her administrator license. -She did not send a 24-hour Initial or 5-day report when she completed her investigation because it just did not cross her mind. _____ The Administrator failed to report allegations of physical abuse by staff to the health care personnel registry (HCPR) despite receiving a direct report from a family member. This failure to report allegations of physical abuse to the HCPR was detrimental to the safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/17/24 for this violation.	C 428		

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C 428	Continued From page 11 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 2, 2024.	C 428		
C 447	10A NCAC 13G .1213 (d) Reporting Of Accidents And Incidents 0A NCAC 13G .1213 Reporting Of Accidents And Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to immediately notify law enforcement and the Department of Social Services (DSS) for 1 of 1 sampled resident (#4) after the resident's family member reported to the Administrator that the resident told her a Staff A at the facility had sexually abused him. The findings are: Review of the facility's Policy and Procedure Manual dated 04/01/20 revealed: -Observation or report of inappropriate behavior toward others requires notification to the facility's Administrator, the resident's physician, responsible party, mental health provider, and authorities if warranted.	C 447		

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-Staff should ensure resident and staff safety, use behavior interventions, and follow physician orders.
-In case of physical assault by a resident or whenever there is a risk that physical harm will occur due to the actions or behaviors of a resident, the staff should immediately contact law enforcement, provide additional supervision to protect others from harm, seek emergency treatment if needed, and contact local mental health services for emergency treatment.
-In the event of physical or verbal abuse a report should be sent to DSS.
-There was no policy available for allegations of sexual abuse.

Review of Resident #4's current FL-2 dated 11/08/23 revealed:
-Diagnoses included schizoaffective disorder, mental retardation, hypertension and allergies.
-There was no documentation regarding orientation status.

Telephone interview with Resident #4 on 06/17/24 at 9:01am revealed:
-He enjoyed visiting with his family some weekends.
-He had not returned to the facility because he told his family member he did not want to go back to the facility.
-He told his family member that Staff A came into his bedroom at night after the other residents had gone to sleep.
-Staff A wanted Resident #4 to have sex with her.
-Staff A climbed on top of him and had sex with Resident #4.
-Resident #4 asked Staff A to stop but the staff would not stop.
-He was scared and upset when he asked the staff to stop, and Staff A did not stop.

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C 447	Continued From page 13 -The resident did not have a roommate at the facility when the incident occurred with staff. Telephone interview with Resident #4's family member on 06/17/24 at 8:52am revealed: -She picked up Resident #4 most weekends to come stay with her at her home. -She picked up Resident #4 from the facility in April 2024 and he had not returned the resident to the facility since that time. -Resident #4 was usually excited to return to the facility when she took him back to the facility after his weekend visit, however one weekend in April 2024 the resident did not want to go back to the facility. -She asked Resident #4 what was wrong and why did he not want to go back to the facility. -Resident #4 told her Staff A made Resident #4 have sex with her. -She did not know when the incident occurred. -She called the Administrator of the facility and reported Resident #4's allegation of sexual abuse. -The Administrator accused Resident #4 of lying during the telephone call when she reported the incident to the Administrator. -She went to law enforcement to make the report but had to wait approximately thirty minutes, so she left the station and called from her car. -She was asked to return to the station, but she did not return because she did not want to be bothered by the incident anymore because she did not think the law enforcement would do anything about the allegation. -She sent the law enforcement officer a private message on social media about Resident #4's allegation on or around 05/01/24. Review of Resident #4's resident record revealed there were no Incident and Accident reports	C 447		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008029	A. BUILDING: _____ B. WING _____	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA'S PLACE	1517 GOVERNOR'S ROAD WINDSOR, NC 27983

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C 447	Continued From page 14	C 447		

completed for the alleged sexual assault.

Interview with Staff A who was a medication aide (MA) 06/17/24 at 3:00pm revealed:
-She was working as the MA at the facility on 04/23/24 when the Administrator came to the facility and informed her of the allegation of sexual abuse by Resident #4.
-The Administrator questioned her about Resident #4's allegation of sexual abuse.
-She completed a written statement about the alleged sexual abuse and provided it to the Administrator.
-The Administrator sent her home without pay for two weeks until the Administrator completed her investigation.

Interview with the Administrator on 06/17/24 at 12:35pm revealed:
-Resident #4 left the facility with a family member on 04/19/24 for a visit and never returned to the facility.
-Resident #4 called her on 04/23/24 at approximately 6:00pm to inform her that he would not be returning to the facility until 04/25/24.
-At approximately 6:30pm on 04/23/24, Resident #4's family member called and informed the Administrator that Resident #4 told her that Staff A had sex with the resident in his bedroom at night.
-She asked to speak with Resident #4 regarding the allegation of sexual abuse, but the family member did not allow her to speak with Resident #4.
-The Administrator stated that she told Resident #4's family member, "I said that's not possible, it's no way, I've never had any allegations about that staff."
-The staff that Resident #4 accused of having sex with him had worked at the facility for the last

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C 447	Continued From page 15	C 447		

three to four years and there was no report of abuse prior to 04/23/24.
-After she received the telephone call from Resident #4's family member about the allegation of sexual abuse she went to the facility on 04/23/24 to begin her investigation.
-She interviewed Staff A that was working at the facility on 04/23/24 and placed the staff on two weeks of unpaid leave until 5/02/24.
-She interviewed the remainder of staff at the facility and obtained written statements from all staff.
-She interviewed the residents at the facility and obtained written statements from each resident.
-She notified DSS of the allegation of sexual abuse on 04/24/24 by telephone.
-She did not complete an Incident and Accident report to send to DSS or notify DSS immediately of the allegation of sexual abuse.

Second interview with the Administrator on 06/18/24 at 2:04pm revealed:
-She called DSS on 04/24/24 and reported the allegation of sexual abuse to the Supervisor at DSS.
-She called local law enforcement on 04/25/24 and informed an officer about the resident's allegation but law enforcement never came to the facility to investigate.
-She notified local law enforcement that the resident's family member would be coming to the local law enforcement station to report her allegations; she wanted local law enforcement to be aware that they may receive an allegation of abuse from Resident #4's family member.
-A law enforcement office told her that he would be in touch with her once Resident #4's family member made a report of the allegation.
-She was not aware that she needed to immediately notify DSS and local law

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enforcement of the alleged sexual abuse immediately.

Telephone interview with a local law enforcement officer on 06/18/24 at 4:42pm revealed:
-Resident #4's family member came to the local law enforcement station one morning around 6:00am but had to wait for an available officer to take her report but she left before an officer was available.
-He could not remember what date Resident #4's family member came to the law enforcement station.
-The officer spoke with Resident #4's family member after she left the local law enforcement station.
-The family member was asked to come back to the station if she wanted to file a report but to his knowledge the family member never filed a report.
-He could not recall the date the family member came to the station, but he received a call from the Administrator of the facility later that same day to report the allegation.
-There was no report filed and no law enforcement investigation was completed, becasue the agency never received a report from the resident's family member.

_____

The facility failed to immediately notify local law enforcement authorities and DSS for 1 of 1 sampled resident (#4) after the resident's family member reported Staff A sexually abused him. The facility's failure was detrimental to the resident's health, safety, and welfare and constitutes a Type B Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/18/24 for this violation.

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C 447	Continued From page 17 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 2, 2024.	C 447		