Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(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 and the Caldwell County Department of Social Services conducted an annual survey and complaint investigation on 04/16/24-04/19/24. Two complaint investigations were initiated on 03/28//24 and a third complaint investigation was initiated on 04/02/24 by the Caldwell County Department of Social Services.	D 000	**Disclaimer** The provider submits this Plan of Action (POA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that the stated deficiencies are accurate. The Provider submits this POA with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings if at any time the Provider determines that the findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider's policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.	
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Type A1 Violation Based on observation, interviews and record reviews, the facility failed to provide supervision for 2 of 2 sampled residents (#2 and #5) who had a history of falls with no additional safety interventions ordered or implemented to minimize future falls. The findings are: Review of the facility's undated policy and procedures for falls management revealed: -Each resident would be assessed upon admission/readmission by the Supervisor using the Fall Risk Worksheet. -The completed assessment would be reviewed	D270	**Action Plan** To minimize the incidence of falls within our facility through proactive measures and efforts among staff. We plan to provide and protect our residents by having continuous staff trainings on falls prevention and interventions. **Corrective Measures-** • Facility has updated fall/incident report form to include a tracking tool for interventions. • Facility has held in-services on fall prevention and interventions. • Facility started a weekly fall/incident meeting with Executive Director, Resident care director, Memory Care Director, Physical Therapy, Occupational Therapy. • Nursing staff has assed each current resident with a Falls Assessment. **Preventative Measures-** • Nursing staff will complete a fall assessment of each resident upon admission and then again quarterly. • Those scoring a higher level will be placed on a falls risk list and this will be noted in the resident's chart, as well as requesting a PT/OT eval. • Residents who score as a high fall risk will be seen by their PCP to address reason(s) for fall/high score.	05/15/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Executive Director

TITLE

(X6) DATE: 5/24/24

Reviewed and Acknowledged Julie Grooms 07/17/24

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D 270	Continued From page 1 by the Resident Care Coordinator (RCC) and discussed with the supervisor. -If the resident is assessed to be at risk for falls, has experienced a recent fall, or has a history of falls, interventions will be identified and implemented. -The residents, responsible party, family members, would participate in/review the interventions. 1. Review of Resident #5's current FL2 dated 04/18/24 revealed: -Diagnoses included Alzheimer's Disease, hypertension, atrial fibrillation, dementia without behaviors. -There was documentation she was semi-ambulatory. -There was documentation she was incontinent of bowel and bladder. Review of Resident #5's Resident Register dated 12/01/22 revealed an admission date of 12/05/22. Review of Resident #5's Care Plan dated 11/28/23 revealed: -There was documentation she was constantly confused. -There was documentation she was incontinent of bowel and bladder. -There was documentation she required extensive assistance for ambulation. -There was no documentation of falls documented during the last three months. -There was no documentation of any fall interventions for Resident #5. Review of hospice physician note for Resident #5 on 02/27/24 revealed: -She was admitted to hospice on 02/12/24. -She received chronic anticoagulation therapy (blood thinner treatment).	D 270	**Monitoring/Frequency**- • Incidents will be monitored daily as incidents happen and placed into falls folder for tracking. • If any interventions are put into place, facility recommends the resident be seen by their PCP within 14 days • Fall/Incident meeting will take place weekly with the ED, RCD, MCD, and OT/PT in attendance to review incidents and interventions. • Falls assessments will happen upon move in and once a quarter thereafter.	

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D 270	Continued From page 2 -There was documentation she was totally dependent on staff for dressing, bathing, toileting, and mobility. -There was documentation of "falls" (no specifics), equipment required for transfers (but equipment not listed) impaired mobility, limited range of motion, muscle wasting, unsteady gait, and weakness. -There was no documentation of any fall interventions. Review of Resident #5's Incident and Accident (I&A) Reports dated 09/13/23 through 04/16/24 revealed: -On 09/13/23 with no time specified, there was documentation Resident #5 had an unwitnessed fall in her room, found on the floor, no injuries were found and there were no interventions to minimize fall reoccurrence documented. -On 09/18/23 at 6:30pm there was documentation Resident #5 had an unwitnessed fall in the hallway, found on the floor, no injuries were found and there were no interventions to minimize fall reoccurrence documented. -On 10/05/23 at 2:40pm there was documentation Resident #5 had an unwitnessed fall in the hallway, found on the floor, "head injury" (with "bump" documented), and sent to local emergency room (ER) for evaluation for altered level of consciousness and there were no interventions to minimize fall reoccurrence documented. -There was not an incident report for a fall that occurred on 10/18/23, resulting in Resident #5 being sent to the ER with a scalp hematoma, urinary tract infection (UTI) and no interventions to minimize fall reoccurrence documented. -There was not an incident report for a fall that occurred on 10/19/23 resulting in Resident #5 being sent to the ER with a finger fracture on her	D 270		

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D 270	Continued From page 3 left hand and no interventions to minimize fall reoccurrence documented. -On 10/21/23 at 8:29pm there was documentation Resident #5 had an unwitnessed fall in her room where she was found on the floor with a "head injury" (with "bump" documented) and sent to local ER for evaluation for altered level of consciousness and there were no interventions to minimize fall reoccurrence documented. -On 11/04/23 at 8:55pm there was documentation Resident #5 had an unwitnessed fall in the hallway, found on the floor, no injuries were found and there were no interventions to minimize fall reoccurrence documented. -On 11/08/23 with no time specified, there was documentation Resident #5 had an unwitnessed fall in the hallway, found on the floor, no injuries were found and there were no interventions to minimize fall reoccurrence documented. -On 11/10/23 at 3:58pm there was documentation Resident #5 had an unwitnessed fall in her room where she was found on the floor tangled up in her blankets, no injuries were found and there were no interventions to minimize fall reoccurrence documented. -On 11/20/23 at 2:00am there was documentation Resident #5 had an unwitnessed fall in the hallway where she was found on the floor, no injuries were found and there were no interventions to minimize fall reoccurrence documented. -On 12/15/23 at 8:00pm there was documentation Resident #5 was backing up to use the commode and fell against the handrail, no injuries were found and there were no interventions to minimize fall reoccurrence documented. -On 12/26/23 at 4:30pm there was documentation Resident #5 had an unwitnessed fall in the hallway just outside her room on her side, with no	D 270		

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D 270	Continued From page 4 injuries found and there were no interventions to minimize fall reoccurrence documented. -On 12/30/23 at 5:15pm there was documentation of an unwitnessed fall where Resident #5 was found in the floor in the hallway near the dining room, with head bruising and a "little cut" on the right side of her forehead, she was not sent to the ER for evaluation and there were no interventions to minimize fall reoccurrence documented. -On 01/03/24 at 11:30am there was documentation Resident #5 fell from a standing position, hitting her head and complaining of left hip pain, she was sent to the local ER for evaluation. -On 02/23/24 at 5:30am there was documentation Resident #5 was found on the floor in her room with an abrasion and pressure applied, bruising, laceration redness and swelling to her left eye. -On 03/19/24 at 11:20am there was documentation Resident #5 had an unwitnessed fall and was found on the floor in her room with abrasions to both sides of her head, was evaluated at the local ER and there were no interventions to minimize fall reoccurrence documented. -On 04/04/24 there was documentation Resident #5 had an unwitnessed fall in the hallway where she was found on the floor, no injuries were found and there were no interventions to minimize fall reoccurrence documented. Review of the progress notes for Resident #5 revealed: -On 10/19/23 at 12:56pm staff reported hearing a loud noise, ran to resident #5's room and found her sitting in the floor leaning to her left side holding her head. -Resident #5 stated she hit her head and her head hurt and she was sent to local ER for evaluation.	D 270		

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D 270	Continued From page 5 -On 10/20/23 at 4:08am Resident #5 was found on the floor and sent to the local ER for evaluation, and she returned with no new orders. Review of the orthopedic surgeons' notes dated 01/09/24 for Resident #5 revealed there was documentation of a follow up x-ray on 01/09/24 of the residents left foot and ankle as she continued to have pain and swelling resulting in an ankle fracture that required surgery on 01/25/24. Review of Resident #5's ER reports revealed: -On 10/05/23 at 6:37pm, there was documentation Resident #5 had been evaluated for a head injury (a "bump") from an unwitnessed fall, a computed tomography scan (CT scan- shows detailed internal images of the body) was obtained, and Resident was returned to the facility with no new orders. -On 10/18/23 there was documentation Resident #5 was evaluated in the ER for a fall resulting in a scalp hematoma and a UTI. -On 10/19/23 at 8:00pm there was documentation Resident #5 was evaluated for a fall resulting in a fracture of her finger on her left hand. -There was no documentation of Resident being sent to the ER for evaluation in Resident #5's record. -On 12/10/23 there was documentation Resident #5 was evaluated in the ER after a fall and no new orders were received. -On 01/03/24 at 2:35pm there was documentation Resident #5 was evaluated at the ER after a fall that resulted in resulting in an acute compression fracture of the lumbar spine a scalp contusion and a contusion of the hip. -On 02/23/24 at 11:26am there was documentation Resident #5 was evaluated at the ER and admitted to the hospital for a three-night hospital stay due to a "staff finding her on the	D 270		

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D 270	Continued From page 6 floor for an unknown amount of time" with swelling and bleeding around the left eye orbit, with a diagnosis of severe left eye retinal hemorrhage (bleeding in the retina). -On 03/19/24 at 11:20am there was documentation Resident #5 was evaluated in the ER for a fall and treated for an unsutured laceration care to the scalp. Interview with the Special Care Coordinator (SCC) on 04/17/24 at 8:40am revealed: -The only fall prevention interventions implemented for Resident #5's falls was an order for hospice. -The facility staff were not instructed by management to do anything else to prevent Resident #5 from future falls. Interview with a medication aide (MA) on 04/17/24 at 8:41am revealed: -Resident #5 fell "a lot". -She could not say why Resident #5 fell so often. -The PCAs were supposed to round on the residents every 2 hours. -Management did not instruct her to do anything for Resident #5 to prevent Resident #5 from falling in the future. Interview with a personal care aide (PCA) on 04/17/24 at 9:11am revealed: -Resident #5 was a hospice patient and needed total assistance from staff. -Resident #5 fell a "a bunch" of times trying to "do things on her own". -She just "kept an eye out" on Resident #5 to try to prevent falls. Interview with a second shift PCA on 04/17/24 at 4:40pm revealed: -Resident #5 had many falls.	D 270		

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D 270	Continued From page 7 -Resident #5 had been sent to the ER several times due to injuries from falls. -She was not aware of any interventions that had been put in place to prevent falls for Resident #5. -Staff just tried to keep an eye on Resident #5 because she did fall a lot. -She was not instructed by other staff or management to do anything else to prevent Resident #5 from falling. Interview with another second shift PCA on 04/17/24 at 4:55pm revealed: -Resident #5 was a dependent for all ADL's. -She had a ½ rail that should keep her from falling out of bed. -She was not aware of any interventions put in place to prevent falls for Resident #5. -Staff just tried to keep an eye on Resident #5 because she did fall a lot. -She was not instructed by other staff or management to do anything else to prevent Resident #5 from falling. Interview with the Administrator on 04/17/24 at 5:10pm revealed: -He was aware of Resident #5's falls had required visits to the ER after some falls. -He was not aware she had 17 falls since 09/13/23. -He was only aware of the falls that had required Resident #5 going to the ER. -He took responsibility for letting the falls meeting fall by the wayside. -The RCC and the SCC were responsible for informing him when a resident had a fall. -The facility had no interventions for falls at this time. Interview with Resident #5's family member on 04/18/24 at 8:43am revealed:	D 270		

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D 270	Continued From page 8 -Resident #5 had fallen 15-20 times over the past 6 months and he had brought her back from the hospital each time related to injuries from her falls. -He visited Resident #5 one to two times a week. -He was very "frustrated with a system that allows her to fall". -He was not aware of any interventions the facility had put in place for Resident #5 regarding her multiple falls. -The facility had not reached out to him regarding any possible interventions or fall precautions for Resident #5. Telephone interview with Resident #5's hospice medical director on 04/18/24 at 9:34am revealed: -Resident #5 was admitted to hospice services on 02/12/24. -She was aware Resident #5 had 18 falls in the last 5 months. -Resident #5 experienced dementia and poor safety awareness and atrial fibrillation. -The facility had not reached out to her for any fall interventions for Resident #5. -They could coordinate with the facility in ordering a specialized chair, wedge cushion, bed alarm to assist with fall prevention. -She had not suggested fall preventions interventions regarding Resident #5 with the facility. -She had ordered Resident #5 a low dose of Ativan (for anxiety) and a partial side rail as she slid out of the bed on 04/12/24. Telephone interview with Resident #3's hospice registered nurse (RN) on 04/18/24 at 11:45pm revealed: -She had been the nurse for Resident #5 since she was admitted to hospice on 02/12/24. -Resident #5 had experienced multiple falls with	D 270		

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D 270	Continued From page 9 significant injuries. -Resident #5 had a compression fracture, broken ankle, left retinal hemorrhage. -Resident #5 tried to transfer on her own and she was not able to. -The facility had not reached out to her for any fall interventions for Resident #5. -She was concerned Resident #5 would fall and sustain severe head trauma. -After the 02/23/24 fall, Resident #5 became more agitated and really did not want to be bothered and began sleeping more. -She could not confirm if the changes Resident #5 was experiencing were from the fall or disease progression or both. Refer to Interview with the Administrator on 04/17/24 at 5:15pm. Based on observations, interviews, and record review it was determined Resident #5 was not interviewable. 2. Review of Resident #2's current FL2 dated 03/12/24 revealed: -She was semi-ambulatory with the use of a wheelchair. -Diagnoses included history of falls, osteoarthritis, unsteady gait, and dementia. Review of Resident #2's physician's order dated 02/12/24 revealed an order for a referral for hospice. Review of Resident #2's Care Plan dated 04/02/24 revealed: -Resident #2's functional status related to falling more than two times in the last month was documented as yes. -The box indicating Resident #2 required more	D 270		

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assistance than previously required was documented as yes.
-Resident #2 required limited assistance from the facility staff with ambulation, dressing, grooming and personal hygiene, transferring, and toileting.

Observation of Resident #2 during the initial tour on 04/16/24 at 10:17am revealed:
-Resident #2 was sitting in a reclining wheelchair in her room.
-She had purple, blue, and red bruising to the left side of her face.
-There was a circular, scabbed wound to the center of Resident #2's forehead the size of a 50-cent piece.

Interview with Resident #2 on 04/16/24 at 10:17am revealed:
-She had experienced multiple falls in the past couple of months.
-She did not know the last date she fell but was hospitalized for a couple of days for the fall.
-She required the assistance from the facility staff with completing activities of daily living (ADLs) including transfers from her bed to the wheelchair and toileting.
-She did not know how often staff checked on her.

Review of Resident #2's local hospital discharge instructions dated 03/12/24 revealed:
-Resident #2 was admitted to the hospital on 03/10/24 at 11:10am for a fall sustaining head trauma with a left frontal scalp hematoma (pooling of mostly clotted blood that is caused by a broken blood vessel from an injury), and a forehead laceration requiring sutures.
-Resident #2's family member reported to the hospital provider that the skin tear to Resident #2's right shoulder and trauma to Resident #2's

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D 270	Continued From page 11 left eye was caused by a fall occurring on 03/07/24 or 03/08/24 at the facility where Resident #2 resided. Review of Resident #2's hospice notes revealed: -Resident #2 was admitted to hospice on 02/13/24 with a diagnosis of senile degeneration of the brain. -On 03/12/24, there was documentation Resident #2 had a dressing on the forehead that was clean, dry, and intact with bruising to the left side of the forehead and face. Review of Resident #2's Incident and Accident (I&A) Reports dated 01/01/24-04/16/24 revealed: -On 01/11/24 at 4:00pm, there was documentation Resident #2 had an unwitnessed fall out of her bed and onto the floor, first aid was not administered, and she was not sent to the local hospital emergency room (ER) for an evaluation. -On 02/20/24 at 2:15pm, there was documentation Resident #2 had an unwitnessed fall and was found on the floor in her room with no injuries, first aid was not administered, and she was not sent to the ER for an evaluation. -On 03/15/24 at 5:00pm, there was documentation Resident #2 had an unwitnessed fall and was found on the floor in her room with no injuries, a mild pain medication was administered, no first aid was administered, and she was not sent to the ER for an evaluation. -On 03/29/24 at 5:45am, there was documentation Resident #2 had an unwitnessed fall from her bed onto the floor obtaining an abrasion on her back and nose, first aid was not administered, and she was transported to the local hospital ER for an evaluation. -On 04/09/24 at 1:30am, there was documentation Resident #2 had an unwitnessed	D 270		

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GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

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fall and found on the floor in her room, no injuries occurred, first aid was not administered, and she was not sent to the ER for an evaluation.
-There was no I&A Report dated 03/07/24 or 03/08/24 provided.
-There was no I&A Report dated 03/10/24 provided for the fall requiring hospitalization from 03/10/24-03/12/24.

Review of Resident #2's progress notes from 01/01/24-04/16/24 revealed:
-There was a total of 3 progress notes provided dated 01/17/24, 02/03/24, and 04/09/24.
-On 04/09/24 at 2:04am, there was documentation Resident #2 slid out of bed onto the floor and landed on a pillow on her bottom, no injuries occurred, and Resident #2 told the medication aide (MA) that someone told Resident #2 to "get up that she was going to be late".
-There were no other progress notes with documentation regarding Resident #2's falls.
-There were no interventions documented to prevent Resident #3 from falling again.

Interview with a personal care aide (PCA) on 04/16/24 at 4:50pm revealed:
-Resident #2 did not use to fall as often but had experienced multiple falls in the past few months.
-She did not know when Resident #2 fell last.
-She tried to make rounds every 2 hours to check on the residents.
-She did not document when she checked on the residents.
-She was not instructed to check on Resident #2 more frequently to try to prevent falls.
-She was not instructed to do anything else to try to prevent Resident #2 from falling.

Interview with the Resident Care Coordinator (RCC) on 04/17/24 at 8:34am revealed:

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D 270	Continued From page 13 -Fall prevention interventions were not documented by the facility staff. -Hospice started seeing Resident #2 as a new patient in February 2024 due to a decline in health. -Resident #2's hospice provider ordered Resident #2 a reclining wheelchair on 03/18/24 to help prevent Resident #2 from falling because most of Resident #2's falls occurred because of leaning forward in the wheelchair. -No other interventions were ordered for Resident #2 to prevent falls. -She was responsible for contacting a resident's provider to obtain new orders including interventions requiring orders. -She did not contact Resident #2's hospice provider to see if any other interventions could be ordered to prevent Resident #2 from falling. Interview with a MA on 04/18/24 at 8:10am revealed: -Resident #2 had multiple falls over the last few months. -Resident #2 was not sent to the ER with most of her falls because she was a hospice patient. -The MAs were responsible for notifying hospice when Resident #2 fell to see if Resident #2 was supposed to be sent to the ER for an evaluation. -She worked on at least 2 different occasions when Resident #2 fell but could not remember the dates. -She did not know if Resident #2 experienced any falls since hospice ordered a reclining wheelchair. -The hospice RN told her she wanted Resident #2's room moved closer to the nurse's station and main offices due to falls. -She asked the RCC if Resident #2's room could be moved since her room was so far away towards the end of the building due to Resident #2 falling and the RCC told her there were no	D 270		

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closer rooms available.
-The PCAs were supposed to round on the residents every 2 hours.
-The facility staff did not document the rounds for supervision checks on the residents.
-She was not told by management to do anything differently to prevent Resident #2 from falling.

Interview with a second PCA on 04/18/24 at 8:20am revealed:
-She knew Resident #2 fell multiple times because the facility's staff were informed of the residents' falls during the daily shift report meetings.
-She was not instructed by anyone to do any specific interventions to prevent residents from falling but just told by management to "keep an eye" on the residents who had experienced falls.
-Resident #2 used her call light to call for assistance from staff.
-When Resident #2 did not call for assistance within 2 hours she would go check on Resident #2.
-She checked on the residents every 2 hours but did not document the supervision checks anywhere.
-She was not told to complete any interventions for fall prevention for Resident #2.

Interview with the hospice RN on 04/18/24 at 8:28am revealed:
-Resident #2 was admitted to hospice with a diagnoses of senile degeneration of the brain on 02/13/24.
-She was informed Resident #2 fell on 6 different occasions since admission to hospice.
-The facility did not contact her to see if any interventions could be ordered to try to prevent Resident #2 from falling.
-She spoke with the Administrator and informed

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D 270	Continued From page 15 him that an order for a reclining wheelchair was obtained from the hospice provider on 03/18/24 to try to prevent Resident #2 from falling again. -Resident #2 could experience more trauma or break a bone if falls were not prevented. Interview with Resident #2's family member on 04/18/24 at 8:47am revealed: -Resident #2 had experienced 8 falls since January 2024 that he was aware of because Resident #2 had a decline in her mobility status. -Resident #2 became a patient of hospice in February 2024 due to a decline in Resident #2's health. -A couple of Resident #2's falls were "bad" with a laceration to Resident #2's forehead requiring sutures and a lot of bruising to the face. -He did not know how often the facility staff checked on Resident #2. -He did not know if any interventions were ordered for Resident #2 to try and prevent Resident #2 from falling. Interview with the Administrator on 04/17/24 at 5:15pm revealed: -The facility used to keep a log of resident falls but had stopped logging the falls around May 2023. -He was not aware Resident #2 had experienced 7 or 8 falls since 01/01/24. -He talked to Resident #2's hospice registered nurse (RN) in March 2024 and asked if the hospice provider could order a chair alarm or a Velcro strap to keep Resident #2 from falling out of the wheelchair but hospice told him no and ordered Resident #2 a reclining wheelchair instead. -He did not know Resident #2 had 2 falls after the reclining wheelchair was ordered. -No other interventions were ordered for fall	D 270		

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D 270	Continued From page 16 prevention for Resident #2. -He did not instruct staff to increase supervision for Resident #2. -He did not contact Resident #2's primary care provider (PCP) for a significant change in Resident #2's mobility with increased falls. -The facility staff were not required to document rounds to check on the residents. -Staff were instructed to try to round on the residents every 2 hours. Refer to the interview with the Administrator on 04/18/24 at 1:01pm. Attempted telephone interview with Resident #2's hospice provider on 04/18/24 at 8:28am was unsuccessful Interview with the Administrator on 04/18/24 at 1:01pm revealed: -He was not informed of all the residents who experienced falls. -The RCC was responsible for making sure all falls were documented, I&A reports were filled out, residents' primary care providers and families were notified, and obtaining orders from providers for any fall prevention interventions that were needed to be implemented. The facility failed to provide supervision to minimize additional falls for Resident #5, who experienced 17 falls from 09/13/23-04/04/24 with 7 ER evaluations, one hospitalization from 02/23/24-02/25/24, 6 falls with injuries including a L4 compression fracture, broken ankle, broken finger, severe left eye hemorrhage, scalp and head lacerations with bruising while taking an anticoagulant medication and Resident #2, who experienced at least 7 falls from 01/01/24-04/16/24 and was hospitalized from	D 270		

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D 270	Continued From page 17 03/10/24-03/12/24 due to a laceration on the forehead requiring sutures, a hematoma on the scalp, and large amount of bruising to the face. This failure resulted in serious physical harm and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/17/24. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 19, 2024.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure the primary care provider (PCP) was notified for 2 of 5 sampled residents (Resident #1 and #4) related to multiple incidents of physical and verbal sexual assault (#1) resulting in delayed care to assist with behaviors (#4). The findings are: Review of the facility's incident and accident reporting policy revealed: -An incident/accident report will be filled out when any unusual happenings such as, but not limited to, injuries, sudden illness, medication errors, hospitalizations, etc. occur.	D 273	**Action Plan** To ensure resident safety by timely and effective communication and follow-up and with staff, resident PCP, and any other necessary providers to address issues/concerns. **Corrective Measures-** • Facility began morning and afternoon daily meetings with nursing staff to create better communication between shifts and employees. • Facility held in-services with all staff to address signs and symptoms of assault/abuse, and what to do and who to notify when/if they believe assault occurred. • The facility implemented a 24-hour report for both units that the RCD reviews daily. Incidents such as falls, sickness, and hospitalizations, etc., are to be reported in the 24-hour report. RCD to review with ED and notify residents PCP and RP if needed.	05/15/2024

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D 273	Continued From page 18 -An incident/accident form will be completed for every incident involving a resident, visitor, or employee. -If the incident happens to a resident, the form will be completed immediately. -Report incident to the charge nurse for the next shift. -Attendants will give the completed form and a copy to the resident care coordinator (RCC). -The RCC will send to Department of Social Services (DSS) when resulting in injury. 1. Review of Resident #1's FL2 dated 03/10/24 revealed: -Resident #1's diagnoses included dementia, hypertension, transient ischemic attack, and history of traumatic brain injury. -Resident #1 was constantly disoriented. -Resident #1 was ambulatory. -The recommended level of care was documented as Special Care Unit (SCU). Review of Resident #1's Resident Register dated 05/18/23 revealed: -An admission date of 05/18/23. -Resident #1 had a Power of Attorney (POA). Review of Resident #1's Incident and Accident Report dated 03/14/24 revealed: -A male resident had Resident #1 up against the railing on the wall [simulating sexual intercourse]. -All clothes were on both parties. -No skin was exposed. -Staff broke it up immediately and reported to supervisor. Interview with Resident #1's POA on 04/16/24 at 10:35am and on 04/17/24 at 9:25am revealed: -She visited the facility on 03/18/24 and noticed a change in Resident #1's behavior.	D 273	**Preventative Measures-** • The ED, RCD, and MCD will meet once a week to review all incidents and interventions. • If any interventions are put into place, facility recommends the resident be seen by their PCP within 14 days. **Monitoring/Frequency-** • Regularly review the effectiveness of follow-up and referral processes through internal audits and resident/PCP feedback. • ED, RCD, MCD will meet once a week to review all falls. • ED, RCD and MCD will meet quarterly to review effectiveness of interventions put into place.	

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D 273	Continued From page 19 -Resident #1 was sitting in a fetal like position with her head down in the dining room. -She had never seen Resident #1 exhibit behaviors such as having head down and sitting in fetal like position. -A family member who visited the facility a week prior to 03/18/24 notified her that staff had told the family member Resident #1 had been pushed up against the wall by a male resident who began [simulating sexual intercourse with] her. -Resident #1 was placed on hydroxyzine 25 mg on 03/26/24 and Ativan 1 mg on 03/29/24 due to increased anxiety and agitation. -Resident #1's PCP was not notified and the only protective measure implemented by the facility was to "keep a close eye on" both of the residents. -Resident #1's POA felt like Resident #1 was having flashbacks of the incidents due to increased anxiety and agitation at times. Interview with the facility's contracted Nurse Practioner (NP) on 04/17/24 at 12:47pm revealed: -His last visit with Resident #1 was on 03/19/24. -He was aware of one incident that occurred on 03/14/24 when a male resident [simulated sexual intercourse with] Resident #2 and was notified by the RCC the next day. -He was not aware of any other incidents that had taken place. -He did not know a male resident had [simulated sexual intercourse with] Resident #1 multiple times. -He did not know a male resident called Resident #1 a prostitute or said he was going to rape her. -He was told by staff Resident #1 was exhibiting behaviors of increased agitation and anxiety as a result of what the male resident did to her. -He also was told she would walk with her head	D 273		

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D 273	Continued From page 20 down at times. -She was mostly agitated when staff would try and do staff care tasks like bathing. -The resident lying in a fetal position with head down and exhibiting anxiety and depression could result from trauma. Refer to interview with a personal care aide (PCA) on 04/16/24 at 3:53pm. Refer to interview with a second PCA on 04/17/24 at 8:57am. Refer to interview with SCC on 04/16/24 at 4:21pm. Refer to interview with the RCC on 04/18/24 at 9:23am. Refer to interview with Administrator on 04/18/24 at 10:16am. 2. Review of Resident #4's current FL2 dated 03/06/24 revealed: -Diagnoses included dementia, asymptomatic microscopic hematuria (urinary tract malignancy). -Orientation was documented as constantly disoriented. -He was ambulatory with no assistive devices. -The recommended level of care was documented SCU. Review of Resident #4's Resident Register dated 01/15/24 revealed: -An admission date of 01/15/24. -Resident #4 had a POA. Revlew of Resident #4's Incident Report dated 03/14/24 revealed: -Resident #4 had a female resident up against	D 273		

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the railing on the wall [simulating sexual intercourse with] her.
-All clothes were on both parties.
-No skin was exposed.
-Staff intervened and separated both residents.

Telephone interview with Resident #4's POA on 04/18/24 at 12:41pm revealed:
-He was recently admitted to the SCU from the facility's assisted living (AL) unit right before the 03/14/24 incident.
-The SCC notified her that Resident #4 had been witnessed by staff [simulating sexual intercourse with] a female resident.
-The most recent call she received from facility, was them (she was unsure who called her) notifying her Resident #4 called another female resident a slut and he needed a medication change.

Telephone interview with Resident #4's Mental Health Provider (MHP) on 04/18/24 at 11:07am and 11:37am revealed:
-She had only seen Resident #4 twice, but was unsure of exact dates.
-She was not notified of any incidents of Resident #4 [simulating sexual intercourse with] another resident or Resident #4 verbalizing any sexually inappropriate statements.
-She prescribed depakote (an anti-convulsant medication sometimes used for mood stabilization) due to irritability and agitation, but if she would have known about Resident #4's sexual behaviors, she would have prescribed Paxil (an antidepressant that may cause a decrease in libido).
-She expected the facility to notify her of any behaviors.

Interview with the SCC on 04/18/24 at 1:36pm

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D 273	Continued From page 22 revealed: -On 03/14/24, at the time of the initial assault, Resident #4 was not seeing a MHP. -She did not think to notify the MHP after Resident #4 began seeing her at the end of March, 2024. -She did not report to the facility's contracted physician because Resident #4 did not see the facility's contracted physician. -The RCC reported the incident to Resident #4's PCP. Attempted telephone interview with Resident #4's PCP on 04/18/24 at 8:35am was unsuccessful. Refer to interview with a PCA on 04/16/24 at 3:53pm. Refer to interview with a second PCA on 04/17/24 at 8:57am. Refer to interview with SCC on 04/16/24 at 4:21pm. Refer to interview with the RCC on 04/18/24 at 9:23am. Refer to interview with Administrator on 04/18/24 at 10:16am. _____ Interview with a PCA on 04/16/24 at 3:53pm revealed: -She saw Resident #4 push Resident #1 up against the wall and he attempted to [simulate sexual intercourse with] Resident #1 on 03/14/24. -Staff intervened immediately and stopped Resident #4 from continuing to [simulate sexual intercourse with] Resident #1. -Both residents were fully clothed. -On another day, but unsure of exact date, she	D 273		

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D 273	Continued From page 23 witnessed the Resident #4 push Resident #1 into another resident's room and attempted to [simulate sexual intercourse with] Resident #1. -On the same day, she also witnessed Resident #4 pressing up against Resident #1 [simulating sexual intercourse with] her in front of the nurse station. -She reported the incident to the medication aide (MA) who was working that day. -After the initial incident, for about 2 days, she had noticed Resident #1 would put her head down, would get into fetal position at times, which was not her usual behavior. Interview with a second PCA on 04/17/24 at 8:57am revealed: -On 03/19/24, she witnessed Resident #1 get pushed up against the wall by Resident #4 and Resident #4 attempted to [simulate sexual intercourse with] Resident #1. -She immediately separated both residents. -Both residents were fully clothed. -Later that day, she heard Resident #4 say, "There goes that prostitute; I'm going to get that prostitute later." -She also heard Resident #4 say he was going to rape Resident #1. -She informed the Administrator, RCC and SCC through a group text. -After the incident on 03/14/24, she observed Resident #1 walking around with her head down and was not talking. -Resident #1 was not acting like her usual self. -She also noticed Resident #1 was curled in a fetal position in her bed during the day time. -Resident #1 was always up and walking during the day, so for her to be in bed, was not her usual behavior. -Resident #1 had those behaviors where she was not acting like her usual self for around 24-48	D 273		

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D 273	Continued From page 24 hours after the initial incident. Interview with the SCC at 04/16/24 at 4:21pm revealed: -On 03/14/24, around 3:30pm, she witnessed Resident #4 pin Resident #1 up against the wall and he was [simulating sexual intercourse with] her. -Both residents were fully clothed. -She and a PCA intervened and separated both residents. -About 20 minutes later, she heard a commotion again in hallway, and witnessed the Resident #4 [simulating sexual intercourse with] Resident #1. -She separated both residents. -She attempted to call the Administrator and RCC, but was unsuccessful. -The RCC came to the SCU around 4:10pm on 03/14/24 and the RCC was told about the incidents that took place. -The RCC said she did not know what to do and left the facility. -Resident #1 was not acting like her normal self after the incidents. -She was withdrawn, had head down, and in a fetal position. Interview with the RCC on 04/18/24 at 9:23am revealed: -She was aware of two incidents, the initial incident on 03/14/24 when Resident #4 had Resident #1 pinned up against the wall [simulating sexual intercourse with] her, and the verbal assault on 03/19/24, in which Resident #4 called Resident #1 a prostitute and he was going to rape her. -She contacted Resident's PCP about the resident who was initiating the assaults on 03/20/24. -She asked for a medication to help with sexual	D 273		

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	HAL014-017	A. BUILDING: _____ B. WING _____	04/19/2024

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D 273	Continued From page 25 behaviors and asked for a referral to behavioral health. -The PCP only recommended he be sent out to local hospital for possible stroke that could be contributing to those behaviors. Interview with the Administrator on 04/18/24 at 10:16am revealed: -He found out about the initial incident when Resident #4 [simulated sexual intercourse with] Resident #1 by Resident #1's POA on 03/18/24. -He was not sure why Resident #4's MHP was not notified. -The SCC and RCC were responsible for notifying the PCPs. -He did not think the PCP for Resident #1 was notified because no one reported to the RCC, SCC, or himself about multiple instances occurring. The facility failed to notify Resident #1's PCP and Resident #4's PCP and MHP of multiple instances when Resident #1 was sexually and verbally harassed by Resident #4 when he pushed her up against the wall and simulated sexual intercourse and referred to her with sexual slurs which resulted in a behavior change in Resident #1 that included a withdrawn demeanor, lying in a fetal position and preferring to remain in bed during hours when she would otherwise prefer to be out of bed. This failure placed Resident #1 at substantial risk for sexual abuse and constitutes a Type A2 violation. The facility provided a plan of protection in accordance with G.S. 131-D-34 on 04/18/24 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 19,	D 273		

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D 273	Continued From page 26 2024.	D 273		
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 A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure a resident was free from sexual harassment for 1 of 1 sampled resident (Resident #1) who was sexually assaulted by another resident who also made sexually inappropriate comments which caused her to demonstrate signs of emotional trauma as evidenced by resident keeping her head down, presenting in a fetal like position with increased anxiety and agitation. The findings are: Review of Resident #1's current FL2 dated 03/10/24 revealed: -Resident #1's diagnoses included dementia, hypertension, transient ischemic attack, and history of traumatic brain injury. -Resident #1 was constantly disoriented. -Resident #1 was ambulatory. Review of Resident #1's Incident and Accident Report dated 03/14/24 revealed: -A male resident had Resident #1 up against the railing on the wall simulating sexual intercourse.	D 338	**Action Plan** The provider strives to provide and maintain compliance. The provider has policies and procedures in place to maintain residents' rights. Facility continues to provide in-services and trainings for all staff. **Corrective Measures**- • Resident # 1 saw PCP on 03/19/2024. • Resident was referred to hospice per sister request on 3/23/24. • Male resident saw mental health provider on 3/28/24. Mental health prescribed Depakote, however, it was stopped by residents RP on her request. • Depakote restarted on 4/10/24 per VA order. • Facility has monitored female resident for altered behaviors since incident date. • Male resident was assigned 1-on-1 supervision through his discharge date. • Male resident left GVAL on 4/13/2024 to seek mental health eval at VA. **Preventative Measures**- • The RCD, ED, MCD retrained all staff on signs and preventions of elderly abuse. • All staff were given in-services reviewing resident rights. • Facility has reached out to facility ombudsman to schedule staff and resident training for resident rights. **Monitoring/Frequency**- • RCD, MCD, ED will hold annual Residents Rights training for all staff. • The facility will contact resident ombudsman and set up semi-annual training for residents and staff. • Facility ED will ask to join each month's resident council meeting going forward to ensure their rights and concerns are being heard and maintained.	05/15/2024

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D 338	Continued From page 27 -All clothes were on both parties. -No skin was exposed. -Staff broke it up immediately and reported to supervisor. Interview with Resident #1's Power of Attorney (POA) on 04/16/24 at 10:35am and on 04/17/24 at 9:25am revealed: -She visited the facility on 03/18/24 and noticed a change in Resident #1's behavior. -Resident #1 was sitting in a fetal like position with her head down. -She had never seen Resident #1 exhibit behaviors such as having head down and sitting in fetal like position. -A family member who visited the facility a week prior to 03/18/24 notified her that staff had told the family member Resident #1 had been pushed up against the wall by a male resident who began [simulating sexual intercourse with] her. -She was never notified of the incident that happened on 03/14/24 by any staff at the facility. -The Administrator and RCC told her they did not know about it. -On 04/10/24 she found out Adult Protective Services (APS) were involved and had known the male resident referred to Resident #1 as a "prostitute" and was going to "rape" Resident #1. -Resident #1's PCP was not notified and the only protective measure implemented by the facility was to "keep a close eye on" both of the residents. Interview with a personal care aide (PCA) on 04/16/24 at 3:53pm revealed: -She saw a male resident push Resident #1 up against the wall and he attempted to [simulate sexual intercourse with]Resident #1 on 03/14/24. -Staff intervened immediately and stopped resident from continuing to [simulate sexual	D 338		

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D 338	Continued From page 28	D 338		

intercourse with] Resident #1.
-Both residents were fully clothed.
-She was unsure of the exact date, but during a separate incident, she witnessed the same male resident push Resident #1 into another resident's room and attempted to [simulate sexual intercourse with] Resident #1.
-On the same day, she again witnessed the male resident pressing up against Resident #1 and [simulating sexual intercourse with] her in front of the nurse station.
-She reported the incident to the medication aide (MA) who was working that day.
-They all were told by management to keep their eye on both residents.
-After the initial incident, for about 2 days, she had noticed Resident #1 would put her head down, would get into fetal position at times, which was not her usual behavior.

Interview with a second PCA on 04/17/24 at 8:57am revealed:
-On 03/19/24, she witnessed Resident #1 get pushed up against the wall by a male resident and male resident attempted to [simulate sexual intercourse with] Resident #1.
-She immediately separated both residents.
-Both residents were fully clothed.
-Later that day, she heard the same resident who pushed Resident #1 up against the hall say, "There goes that prostitute; I'm going to get that prostitute later."
-She also heard the resident say he was going to rape Resident #1.
-She informed the Administrator, RCC and SCC through a group text.
-The only intervention she was aware of was management telling staff to keep their eye on both of them for the next few weeks.
-After the incident on 03/14/24, she observed

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D 338	Continued From page 29 Resident #3 walking around with her head down and was not talking. -Resident #1 was not acting like her usual self. -She also noticed Resident #1 was curled in a fetal position in her bed during the day time. -Resident #1 was always up and walking during the day, so for her to be in bed, was not her usual behavior. -She had those behaviors where she was not acting like her usual self for around 24-48 hours after the initial incident. Interview with the SCC at 04/16/24 at 4:21pm revealed: -On 03/14/24, around 3:30pm, she witnessed a resident pin Resident #1 up against the wall and he was [simulating sexual intercourse with] her. -Both residents were fully clothed. -She and a PCA intervened and separated both residents. -About 20 minutes later, she heard a commotion again in hallway, and witnessed the same resident again [simulating sexual intercourse with] Resident #1. -She separated both residents. -The RCC came back to the special care unit (SCU) around 4:10pm on 03/14/24 and was told about the incidents that took place. -The RCC said she did not know what to do and left the facility. -The next day she called the POA for the resident who had been sexually harassing Resident #1 and informed her of the incident. -She attempted to call Resident #1's POA, but she did not answer the call. -On 03/18/24, Resident #1's POA visited the facility. -She called the RCC and asked the RCC to come over while she told Resident #1's POA what had happened so she would have a witness, but the	D 338		

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D 338	Continued From page 30 RCC stated she was not going to tell the POA at that time. -She was told by the RCC to just tell Resident #1's POA that the resident had just placed his hand on Resident #1's shoulder. -Resident #1's POA was standing beside her while on the phone with the RCC. -After the RCC stated to her to just tell Resident #1's POA that the resident had just placed his hand on Resident #1's shoulder, the POA stated she already knew what happened from a family member who had heard about it while visiting the facility a week before. -Almost 4 weeks went by before the 1:1 was put in place. -Resident #1 was not acting like her normal self after the incidents. -She was withdrawn, had head down, and would sit in a fetal position. Interview with the registered nurse (RN) from hospice on 04/18/24 at 11:39am revealed: -She began seeing Resident #1 on 03/23/24. -She was aware of the incident before she started seeing Resident #1. -She was told by a PCA that Resident #1 had been raped. -Resident #1 was very anxious when she first began seeing her. -She was curled up in a fetal position with her head down when she first saw her. -She would get anxious and agitated during personal care with showers. Interview with a PCA on 04/18/24 at 12:28pm revealed: -She was not sure what happened because she did not witness any of the incidents. -Resident #1 became "uncomfortable" with showers.	D 338		

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D 338	Continued From page 31 -There were no interventions or safety measure put into place for approximately 4 weeks until 1:1 supervision was initiated for the male resident. -The PCA observed Resident #1 holding her head down when she would see the male resident who sexually harassed her. Interview with the facility's contracted Nurse Practioner (NP) on 04/17/24 at 12:47pm revealed: -His last visit with Resident #1 was on 03/19/24. -He was aware of one incident that occurred on 03/14/24 when a male resident [simulated sexual intercourse with] Resident #2 and was notified by the RCC the next day. -He was not aware of any other incidents that had taken place. -He did not know a male resident had [simulated sexual intercourse with] Resident #1 multiple times. -He did not know a male resident called Resident #1 a prostitute or said he was going to rape her. -He was told by staff Resident #1 was exhibiting behaviors of increased agitation and anxiety as a result of what the male resident did to her. -He also was told she would walk with her head down at times. -She was mostly agitated when staff would try and do staff care tasks like bathing. -The resident lying in a fetal position with head down and exhibiting anxiety and depression could result from trauma. Interview with RCC on 04/18/24 at 9:23am revealed: -The initial incident on 03/14/24 was posted on the app the facility used to use to communicate with each other. -She did not see it on the app. -She got a call from the SCC on 03/18/24 about	D 338		

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D 338	Continued From page 32 the incident around 10:12am and that is when she first found out about it. -The SCC told her over the phone that a resident pinned Resident #1 up against the wall and [simulated sexual intercourse with] her. -She was told both residents were fully clothed. -She called the Administrator right after she got off the phone and he told her to come straight to his office. -Resident #1's POA was already in the office when she arrived. -The SCC explained both residents were fully clothed and she witnessed a male resident [simulate sexual intercourse with] Resident #1 in hallway. -She and the Administrator began doing an internal investigation. -She was aware of two incidents, the initial incident where the resident had Resident #1 pinned up against the wall [simulating sexual intercourse with] her, and the sexual slurs on 03/19/24, in which the male resident called Resident #1 a prostitute and said he was going to rape her. -She did not report anything to Resident #1's POA. Interview with the Administrator on 04/18/24 at 10:16am revealed: -On 03/18/24, Resident #1's POA informed him about the initial incident when a male resident [simulated sexual intercourse with] Resident #1. -He had staff watch both residents closely on 03/19/24, and then the resident who initiated the assault went to hospital on 03/20/24 for an evaluation for possible stroke. -He was only aware of the initial incident and one incident where the resident verbalized he was going to rape her and he stated she was a prostitute.	D 338		

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D 338	Continued From page 33 -He was unaware of any other incidents in which the male resident [simulated sexual intercourse with] Resident #1. -Medication management was recommended and staff were to keep an eye on both residents. -He thought "everything was going well" since he was not getting any other reports from staff about any incidents. -After talking to AHS, 1:1 was put into place on 04/10/24 with the resident who initiated the assaults. Based on interviews and record reviews, it was determined Resident #1 was not interviewable. The facility failed to protect Resident #1 was free from sexual harassment resulting in Resident #1 enduring multiple incidents of a male resident [simulating sexual intercourse with] her and making inappropriate sexual comments towards her resulting in Resident #1 experiencing trauma from the incidents evidenced by increased anxiety and agitation and presenting with a depressed mood. No safety interventions were put into place for approximately 3 and a half weeks before a 1:1 was put into place to protect Resident #1. This failure resulted in serious neglect of the resident and constitutes a Type A1 violation. The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 04/16/24. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MAY 19, 2024.	D 338		