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D 000	Initial Comments The Adult Care Licensure Section and the Caldwell County Department of Social Services conducted a complaint investigation and follow up survey 01/29/26 - 01/30/26, 02/05/26 - 02/06/26, and 02/09/26 - 02/11/26.	D 000		
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 A1 VIOLATION Based on interviews and record reviews the facility failed to ensure referral and follow-up to meet the acute health care needs for 6 of 6 sampled residents (# 1, #2, #3, #6, #8, #14) related to a facial injury sustained from an assault (#8 & #2), a change in behavior (#14), an alleged sexual assault (#1 & #3) and an unwitnessed fall (#6). The findings are: 1. Review of Resident #8's current FL2 dated 10/28/25 revealed: -Diagnoses included schizoaffective disorder. -There was documentation she was intermittently disoriented and had wandering behaviors. Review of Resident #8's Resident Register dated 06/08/20 revealed: -She was admitted to the facility on 06/08/20. -A family member was documented as her Power of Attorney (POA).	D 273		

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D 273	Continued From page 1 Review of Resident #8's care plan dated 10/28/25 revealed: -The care plan was updated due to decline in health necessitating transfer to the SCU. -She required supervision with ambulation due to an unsteady gait. -She required limited assistance with dressing and grooming. -She required extensive assistance with bathing. Review of a local Hospice providers Notice of Admission dated 10/16/25 revealed Resident #8 was admitted to hospice services due to a terminal diagnosis of senile degeneration of the brain (age related loss of mental capacities). Review of Resident #8's care notes revealed: -On 08/24/25 Resident #8 got into an altercation with another resident. Resident #8 was grabbed by her hair and flung from a chair. The other resident told Resident #8 to "sit down and stay there"; witnessed by a medication aide (MA). -On 08/25/25 Resident #8 was moved to a different bedroom. Review of Resident #8's Incident Report dated 08/24/25 revealed: -The report was completed by a MA. -Resident #8 was in the dining room and another resident grabbed her hair told her to sit there and stay and then flipped over the chair Resident #8 was sitting in. -The incident occurred at 3:00pm and was witnessed by the MA. -There was documentation Resident #8's Nurse Practitioner (NP) was notified by telephone by the MA but the documented number was invalid. -The Administration group was notified of the incident on the facility's group chat application.	D 273		

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-Additional intervention documented at the bottom of the report included Resident #8 was moved to a different hallway and the other resident was to have meals in his room until further notice.
-Resident #8's NP signed the incident report on 08/26/25.

Review of Resident #8's NP's progress note dated 08/26/25 revealed:
-Resident #8 was seen due to facial bruising.
-Resident #8 had an encounter with another resident and suffered injury and trauma to her face.
-Resident #8 had extensive swelling and bruising on the left side of her face and eye and there was a large amount of bruising around the eye and the eye was swollen almost shut.

Review of Resident #8's NP's progress note dated 09/01/25 revealed:
-Resident #8 was seen for a follow-up visit due to facial bruising.
-The swelling had improved but there was still a large amount of bruising around the left eye.

Telephone interview with Resident #8's POA on 02/06/26 at 2:17pm and 3:01pm revealed:
-She was notified of the 08/24/25 incident.
-She was told Resident #8 and another resident "got into a fuss" and the other resident either pulled the chair out from under Resident #8 or tipped the chair over.
-Resident #8 had facial bruising from hitting either the floor or the wall when she fell out of the chair.
-She did not remember if she was told Resident #8 had her hair pulled during the altercation.

Interview with Resident #8's Primary Care Provider (PCP) on 02/09/26 at 9:09am revealed:
-The facility usually notified the NP that worked

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for him about injuries sustained by residents.
-The NP was currently away from the office and unavailable.
-He expected the facility to contact the NP directly via telephone during business hours and the on-call number if it was after business hours.

Interview with a MA on 02/09/26 at 9:55am and 11:22am revealed:
-She was the MA who observed the incident between Resident #8 and another resident on 08/24/25.
-She saw the other resident pull Resident #8's hair, flip her chair and throw her to the floor and said he was tired of her asking for coffee.
-She was not sure if Resident #8 hit her head when she was thrown to the floor.
-She did not send Resident #8 to the hospital because she did an evaluation, checked for range of motion and altered mental status and she determined Resident #8 appeared to be at her baseline.
-Resident #8 was placed on 30-minute checks for 24 hours after the incident.
-She called the telephone number documented on the incident report and had to leave a message.
-The telephone number she documented on the incident report was the number she always called to report an accident or incident.
-She never spoke to anyone at the office when she was reporting an incident and always had to leave a message.
-She did not know the telephone number documented on the incident report was no longer a valid telephone number.
-She did not attempt to contact the NP at her direct number or at the after-hours on call number.
-The NP was informed about the 08/24/25

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incident on 08/26/25 when she came to the facility for her weekly visit.

Telephone interview with another MA on 02/11/26 at 9:36 am revealed:
-She was the MA on-call when the altercation occurred between Resident #8 and another resident.
-She received a telephone call that day, and it was reported to her that a resident grabbed Resident #8 by the hair, used his foot to kick the chair over, knocking her out of it.
-The other resident "drop kicked her" and slammed her face into the floor.
-Earlier in the day it was reported to her that the other resident pushed down Resident #8 and then later he pulled her hair when she was walking down the hall.
-A few weeks prior to the 08/24/25 incident Resident #8 was "punched in the face" by the same resident.
-He told Resident #8 around that same time that he was going to "[expletive] her up", "beat her [expletive]" and "punch her in the face" because he did not like Resident #8.

Interview with the facility's Consulting Registered Nurse (RN) on 02/10/26 at 3:32pm and 02/11/26 at 8:56am revealed:
-When an accident or incident occurred the MAs checked the resident for bruising and provided any basic medical needs.
-If a resident was known to hit their head they were sent out for evaluation per facility policy.
-She was informed about the incident between Resident #8 and another resident by the group chat application that staff used to communicate with each other.
-She was told there was an altercation between Resident #8 and another resident and the other

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resident "slammed her face on the table".
-She "assumed" the NP knew about the incident.

Interview with the Administrator's Assistant on 02/09/26 at 10:18am and 02/10/26 at 9:12am revealed:
-He became aware of the 08/24/25 incident when he read the Incident Report because he was not at the facility when the incident occurred.
-He could not remember any details other than a resident pulled Resident #8 from her chair onto the floor.
-He thought the MA who witnessed the incident completed a physical assessment on Resident #8 which included obtaining vital signs, conducting a skin check and checking for mental status changes.
-He expected the MA to call the NP immediately when there was an incident or an accident during regular business hours and the on-call number if it was after business hours.
-The MAs had the NP's direct telephone number to call her.
-He expected staff to contact the NP after the bruising became evident and not wait until the NP came to the facility on 08/26/25 for her regularly scheduled visit.
-Residents who hit their head during an incident were to be sent out for evaluation according to the facility policy.
-Resident #8 was not sent out because they did not know she hit her head until the next day when the bruising became visible.

Interview with the Administrator on 02/09/26 at 10:22am and 02/11/26 at 10:48am revealed:
-He expected the staff to call the NP and inform her of any accidents or incidents between residents.
-A MA should use the direct telephone number to

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contact the NP if it was during regular business hours.
-If the incident happened after business hours the on-call telephone number for the NP should be used.
-If staff were calling and had to leave a message he would expect them to continue to try reaching the NP at either her daytime or on-call number.
-He was informed of the 08/24/26 incident at the Monday morning stand-up meeting on 08/25/25.
-He thought the incident involved a verbal altercation not a physical altercation.
-Local Law Enforcement (LLE) and Emergency Medical Services (EMS) should have been contacted if the incident was physical.
-He did not recall the incident so he can not recall what happened afterward.
-If there was an altercation resulting in an injury the consulting RN or the NP should be contacted.

2. Review of Resident #1's current FL2 dated 01/24/2025 revealed:
-Diagnoses included Alzheimer's dementia and cognitive impairment.
-He was constantly disoriented.
-He was ambulatory and had a history of wandering.
-His level of care was special care unit (SCU).

Review of Resident #1's Resident Register revealed an admission date of 01/24/25.

Review of Resident #1's record revealed he passed away on 01/10/26.

Review or Resident #1's care plan dated 02/01/25 revealed:
-He had a history of wandering, becoming physically abusive and resisting care.
-He ambulated throughout the SCU.

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D 273	Continued From page 7 -He resisted care and was aggressive at times. -He required supervision with eating, ambulation and transferring. -He required extensive assistance with toileting, bathing, dressing and grooming. Review of a local Hospice provider's Notice of Admission dated 11/18/25 revealed Resident #1 was admitted under Hospice services due to Alzheimer's dementia. a. Review of Resident #1's Hospice Registered Nurse's (RN) progress note dated 11/26/25 revealed: -Facility staff reported to the Hospice certified nursing assistant (CNA) that Resident #1 was involved in a sexual incident where his roommate was allegedly performing a sexual act on him. -He and the Nurse Practitioner's (NP) completed a physical evaluation with no evident or apparent injuries. -Reported findings to facility staff and reported alleged incident to the unit manager and Administrator's Assistant. Review of Resident #1's Hospice NP progress note dated 11/26/25 revealed: -Facility staff reported to Resident #1's Hospice CNA he was involved in a sexual incident with another resident where the other resident had Resident #1 bent over the bed was observed to be performing a sexual activity. -Facility staff reported after this incident, Resident #1 had loose stool and blood in his stool. -She and the RN reported incident to the MA and to the Administrator's Assistant. -She was told by the MA the incident apparently occurred yesterday (11/25/26) and the other resident had been sent to the hospital and discharged from the facility.	D 273		

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-Resident #1 was nonverbal, unable to engage in conversation or answer questions.

Review of Resident #1's care notes revealed there was no documentation of the alleged sexual assault.

Review of an undated written statement by a former MA revealed:
-Two PCAs walked into Resident #1 and his roommate's room where they saw Resident #1, face down lying in the bed.
-His roommate was standing at Resident #1's bed with his pants down to his ankles.
-His roommate pulled his pants up when the PCAs walked into the room.
-She took Resident #1 to the dayroom for the rest of the night.
-She asked Resident #1 if anything happened and he stated no.
-She asked Resident #1 if he was okay and he stated yes.
-She completed a physical assessment and did not observe Resident #1 to have any areas of redness or bruising.
-Nothing was "wrong" with Resident #1.
-There was a towel lying on the floor that looked like it had feces on it.
-She put the towel in a plastic bag and put it in the medication room.

Review of a statement dated "11/20/26" written by the Administrator's Assistant revealed:
-He received a call from a MA who reported two PCAs walked into Resident #1's room, observed his roommate adjusting his pants beside Resident #1 who was lying on his side crossways with his legs bent.
-The PCAs had concerns about the roommate.
-Per the MA, there were no signs of any type of

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abuse.
-Per the MA, details per the MA of statements did not match.
-He instructed the MA to move Resident #1 and another resident.
-He would speak to Resident #1 in the morning.

Review of the Administrator's Assistant's interview with a PCA dated 11/20/25 revealed:
-The PCA walked into Resident #1 and his roommate's room.
-Resident #1's brief was pulled to the side.
-There was a towel under the roommate's bed.
-The PCA did not observe any contact between the residents.
-His roommate's pants were around his ankles.

Review of a statement dated 11/27/25, titled "investigation", written by the Administrator revealed:
-Staff reported concerns regarding Resident #1 and his roommate.
-Statements were obtained by the shift supervisor and eyewitness staff.
- "Admin and Admin" completed a physical assessment of Resident #1.
- "Assessed for trauma both physical and mental and resident was at baseline, no issues to note."
-He investigated towel that was in residents' room and "feces on the towel was detected."

Telephone interview with Resident #1's Guardian on 01/30/26 at 10:20am revealed:
-Resident #1's Hospice agency notified her on 11/26/25 that facility staff had reported Resident #1 and his roommate were witnessed engaging in alleged sexual activity.
-The facility should have notified her immediately of the incident but did not.
-She reported incident to the local county

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department of social services.

Interview with Resident #1's Hospice CNA on 01/29/25 at 12:50pm revealed:
-Upon arrival to the facility on 11/26/25, facility staff reported Resident #1 had been allegedly sexually assaulted by his roommate.
-She did not know when the incident occurred.
-Facility staff stated the roommate was observed standing behind Resident #1 who was lying in the bed, on his side, facing the wall.
-The roommate was holding two towels with feces and blood on them.
-She notified Resident #1's Hospice RN and Hospice NP of what had been reported to her by the facility staff.
-Resident #1 had loose stools on 11/26/25.

Telephone interview with a PCA on 02/03/26 at 12:29pm revealed:
-She and another PCA worked the night of the alleged sexual assault involving Resident #1 and his roommate.
-She could not recall the date the of the alleged sexual assault.
-She walked into Resident #1's room behind another PCA and witnessed the roommate standing behind Resident #1 who was in the fetal position.
-She witnessed his roommate let go of Resident #1's brief, quickly pull up his pants that were down to his ankles and then the roommate ran to his side of the room.
-She or the other PCA reported the incident to the lead MA but could not recall who that was.
-She did not remember if the police were called.
-The roommate was sent out to the hospital, "maybe the next day" when he became aggressive towards staff and other residents, but she could not remember what date.

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D 273	Continued From page 11 Interview with a second PCA on 02/05/26 at 3:00pm revealed: -She walked into Resident #1's room behind another PCA and witnessed his roommate standing behind Resident #1 who was in the fetal position, facing the wall, and hanging off the bed. -This roommate was "fixing himself" when she walked in. -There were signs of sexual activity because Resident #1 had feces on his buttocks but not on his brief. -When she went to change Resident #1's brief immediately after walking into the room, he acted like he was trying to have a bowel movement. Telephone interview with a former MA on 02/09/26 at 4:05pm revealed: -A PCA who was working the night of the incident reported she suspected an alleged sexual assault had occurred. -The PCA reported the roommate had been seen pulling up his pants that were down at his ankles when she walked into the room while Resident #1 was lying in his bed. -The PCA later reported she witnessed the roommate "adjusting himself." -She reported the incident to the Administrator's Assistant via telephone who told her to separate Resident #1 and his roommate and place them on 30-minute checks. -She notified Resident #1's Guardian but did not recall or remember when. -She observed the roommate assisting Resident #1 with brief changes. -The Administrator's Assistant asked her about Resident #1's brief being pulled down to the side and she notified the Administrator's Assistant the PCA suspected, "something sexual" had happened.	D 273		

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-She completed an Accident and Incident Report later that night.

Interview with the Special Care Coordinator (SCC) on 02/09/26 at 2:28pm revealed:
-She had witnessed the roommate attempting to provide incontinence care to Resident #1 but could not recall the date.
-She asked other staff if they had witnessed his roommate change Resident #1's brief and staff told her yes.
-No staff had reported to her they had witnessed the roommate change Resident #1's brief.
-She was told by a PCA and MA that staff had walked into Resident #1 and his roommate's room and found the roommate adjusting his pants.
-Staff reported Resident #1 may have been "sexually abused".
-She did not recall what date the incident occurred.

Interview with Resident #1's Hospice RN on 01/29/26 at 3:29pm revealed:
-He learned from the Hospice CNA facility staff stated Resident #1 was involved in an alleged sexual incident involving his roommate.
-The facility did not notify or report the incident to Hospice.
-He and the Hospice NP completed an evaluation of Resident #1.
-He was uncertain when the incident happened.

Telephone interview with Resident #1's Hospice NP on 02/03/26 at 11:42am revealed:
-On 11/26/25, she and the Hospice RN were notified by Resident #1's Hospice CNA that facility staff reported they had walked in on Resident #1 and his roommate, "in the act".
-The CNA reported that Resident #1 had rectal

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bleeding and loose stools.
-Resident #1 was non-verbal.
-She and the Hospice RN completed an evaluation of Resident #1, did not see any trauma but she was uncertain of when the alleged sexual assault occurred.
-She did not know if Resident #1 had any type of evaluation completed after the incident.
-She expected the facility to notify Hospice immediately in order to send Resident #1 out for an alleged sexual assault kit.
-Resident #1 should have had an evaluation completed immediately after knowledge of the incident so he could have been assessed for rectal tears, internal bleeding, and tested for sexually transmitted diseases which was standard procedure.

Telephone interview with Resident #1's PCP on 02/05/26 at 11:07am revealed:
-She was not notified of the incident between Resident #1 and his roommate when it allegedly occurred.
-She was notified of the allegation by the Administrator's Assistant and the Administrator but could not remember the date.
-She would have expected the facility to notify Hospice who was primarily seeing Resident #1.
-If there was a suspected sexual assault, the facility should have notified the residents provider, sent the resident to the emergency department for an evaluation or to assess if there was any injury or trauma, and to determine if a sexual assault had occurred.

Interview with facility's Consulting RN on 02/11/26 at 8:56am and 9:35am revealed.
-She did not know about the alleged sexual assault allegation involving Resident #1 and his roommate.

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-She was not aware the roommate was providing care to other residents.
-She should have been notified of alleged sexual assault.
-She should be notified of increased aggression, sexual behaviors or any mental status changes.
-Resident #1 should have been sent to a hospital for a professional evaluation.

Interview with the Administrator's Assistant on 02/10/26 at 11:00am revealed:
-He received a call from a MA that two PCAs had reported walking into Resident #1 and his roommate's room, where they witnessed Resident #1's brief pulled down and his roommate pulling his pants back up.
-The PCA reported the roommate then running to his side of the room.
-He was told after MA had completed an assessment of Resident #1 that she did not see anything.
-He does not recall the date of when the incident occurred but thought it was on the night of 11/20/25 and the morning of 11/21/25.
-He instructed the MA to move room Resident #1 to a different bedroom.
-If an alleged sexual assault had been witnessed by staff, staff should have contacted local law enforcement and sent the resident to the emergency department.
-He knew the alleged sexual assault did not happen because, "he knew Resident #1 and the resident would not let that happen."
-The facility staff did not notify Resident #1's PCP.
-He was not sure if Resident #1's Hospice provider was made aware of the alleged incident, so he reported the incident to Resident #1's Hospice RN but did not recall when.
-If the alleged sexual assault had been

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witnessed, EMS should have been contacted to transport to the hospital, the PCP should have been notified, and report to LLE.

Interview with the Administrator on 02/11/26 at 10:48am revealed:
-He expected staff to contact the after-hours phone number to inform administration and medical staff of any incidents or accidents involving residents.
-He is part of the facility's group chat application used to inform the administration of issues or problems.
-He was also informed of issues or problems during a daily 10:00am stand up meeting and review with RCC, SCC, Nurse, and Administrator's Assistant.
-A determination was made after the stand-up meetings if any additional actions are needed.
-He and the Administrator's Assistant assessed Resident #1 themselves and determined no sexual assault had occurred.
-He was a North Carolina Emergency Medical Technician (EMT) and had sexual abuse training through his EMT training.
-He did not complete an assessment on the roommate.
-He did not send Resident #1 or his roommate to the hospital for an evaluation.
-The RCC should notify the residents' PCP and responsible party if an injury was confirmed by staff.
-If there was evidence of abuse, he would contact the resident's PCP and send the resident to the hospital for an evaluation.

Attempted telephone interview with Resident #1's Behavioral Health NP on 02/05/26 at 2:50pm was unsuccessful.

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b. Review of Resident #1's Incident Report dated 12/08/25 revealed:
-The Accident and Incident Report was completed by a MA.
-The incident occurred at 3:45pm.
-The resident was found in hall by a MA with two black eyes.
-The PCP was notified.
-The incident had not been witnessed.
-Resident #1 was sent to the local hospital on 12/09/25 for a follow-up and no additional injuries were noted.

Review of Resident #1's emergency medical services (EMS) report dated 12/08/25 revealed:
-EMS was dispatched to the facility on 12/08/25 at arrived at 7:24pm.
-Under the section titled "Primary impression" was documented as suspected abuse/neglect.
-Under the section titled "Chief complaint" was documented as assault with head injury.
-Under the section titled "Injury", there was documentation of assault with bodily force.
-Under the section titled" Additional Information", there was documentation of sexual assault.
-There was documentation Resident #1 had injuries to his eye, face, forearm, hand, wrist and finger(s).
-There was documentation Resident #1 had an abrasion to his left ear and face.
-There was documentation Resident #1 had contusions (soft tissue injuries caused by blunt force trauma) to both eyes, two contusions to left forearm, left third finger and swelling to his left middle finger.
-Under the sections titled "Narrative", there was documentation EMS was dispatched to the facility in reference to Resident #1 who was potentially assaulted and had sustained bilateral black eyes.
-When EMS arrived on the scene, there were two

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workers from the local Department of Social Services who were there in reference to a previous incident where the resident was sexually assaulted by another resident.
-There was documentation Resident #1 sustained significant bruising around both eye sockets, in addition to abrasions to his face.
-Facility staff reported that Resident #1, "likely got into an altercation" with another resident.
-The Medication Aide (MA) reported she noticed Resident #1's facial bruising at the start of her shift at 3:15pm but did not observe bruising on the resident while on shift over the weekend.
-Another staff member reported she did not see any bruising when she left the facility at 3pm on 12/08/25, but when she arrived back at the facility at 6:30pm on 12/08/25, she noticed Resident #1's facial bruising which prompted her to then call EMS.
-A MA reported EMS was not called sooner when Resident #1 was observed to have facial trauma because she had to follow protocol which was to notify the facility's PCP and a report was made.
-The MA reported to EMS Resident #1's facial abrasions could have been self-inflicted while showering.

Review of Resident #1's local Emergency Department (ED) note dated 12/08/25 revealed:
-There was documentation EMS was called because Resident #1 had bruising around bilateral eyes.
-Facility staff stated possible alteration with another resident at 3:15pm.
-EMS did not know how the resident sustained the injuries to his face.
-There was documentation of periorbital contusion (bilateral, dark, purplish bruising around the eyes) under section titled "Assessment".

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-Resident #1 was discharged back to the facility.

Review of Resident #1's PCP visit note dated 12/16/25 revealed:
-He was sent to the ED on 12/08/25 because Resident #1 had bruising around both eyes.
-The bruising was possibly caused by an altercation with another resident.
-Information was obtained by staff and chart.

Review of a written PCA statement dated 12/08/25 revealed:
-On 12/06/25, the MA yelled for assistance because two residents got into an altercation.
-She observed one of the resident's right eyes was a little red and reported to the MA.
-The MA checked on both residents before assisting them to bed.

Review of written statement by a former MA dated 12/05/25 revealed:
-On 12/05/25 during dinner, Resident #1 and another resident were getting agitated with each other, nudging each other with their walker and wheelchair.
-She called for assistance from a PCA to help redirect the residents.
-She did not observe the resident's engage in a physical altercation at that time.
-The residents were separated and placed on 30-minute checks.

Review of a text message sent via the facility's group chat application dated 12/07/25 at 9:59am revealed an unknown staff member asking if anyone knew why Resident #1 had two black eyes.

Telephone interview with Resident #1's Guardian on 01/30/26 at 10:20am revealed:

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-The facility notified her on 12/09/25 at 8:00pm that Resident #1 had walked out of his room with two black eyes and was sent to the local Hospital for an evaluation.
-On 12/10/25, Adult Protective Services notified her they were onsite at the facility on 12/08/25, observed Resident #1 had two black eyes, and requested Resident #1 to be sent to the hospital for an evaluation.

Telephone interview with Resident #1's PCP on 02/05/26 at 11:07am revealed:
-She was not notified Resident #1 was observed by staff to have two black eyes.
-She expected the facility to notify Resident #1's Hospice provider in order for Hospice to determine if Resident #1 should have been sent to the hospital.
-Depending on the severity, she expected the facility to monitor for any change in mental status and to notify the provider.

Interview with Resident #1's Hospice CNA on 01/29/25 at 12:50pm revealed:
-She observed Resident #1 had two black eyes but could not recall the date.
-She asked the staff why Resident #1 had two black eyes, however staff did not tell her.

Interview with Resident #1's Hospice RN on 01/29/26 at 3:29pm revealed:
-The facility did not notify or report Resident #1's black eyes to Hospice.
-Facility staff notified him the local Department of Social Services had discovered Resident #1's back eyes while visiting the facility but he could not recall the date.
-He expected the facility to report to Hospice so Hospice could complete an evaluation of the resident to determine if the resident needed to be

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sent to the hospital.

Telephone interview with Resident #1's Hospice NP on 02/03/26 at 11:42am revealed:
-Resident #1's Hospice RN was notified the local Department of Social Services had found Resident #1 with two black eyes, but she could not recall the date.
-The facility did not notify or report Resident #1's black eyes to Hospice.
-Hospice should have been notified in order to assess the resident or the facility should have sent the resident to the hospital for evaluation if emergent.

Interview with the facility's Consulting RN on 02/11/26 at 5:56am revealed:
-She learned about an altercation between another resident and Resident #1 from facility staff, after Resident #1 had been sent to the local hospital for an evaluation.
-Resident #1 should have been sent to the hospital for evaluation when the incident occurred or if not witness, upon the onset of bruising.

Interview with a MA Supervisor on 02/09/26 at 10:34am revealed:
-She was working on 12/08/25 when the local County Department of Social Services reported to her that Resident #1 had two black eyes.
-She noticed that Resident #1 had a bluish color to both eyes and on his nose.
-Staff reported to her that Resident #1 had got into an altercation with another resident but could not recall the date.
-The 3rd shift MA Supervisor reported Resident #1 did not have black eyes when she left her shift earlier the morning of 12/08/25.
-She sent Resident #1 to the local hospital due to him having a head injury which was part of the

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facility's head injury protocol.
-No one had witnessed what had happened.

Interview with the SCC on 02/09/26 at 2:28pm revealed:
-Staff reported to her that Resident #2 hit Resident #1 but could not recall when the incident happened.
-She expected staff to complete an Accident and Incident Report and skin assessment.
-She expected staff to notify the residents' providers and responsible parties.

Interview with the Administrator on 02/11/26 at 10:48am revealed:
-He expected staff to contact the after-hours phone number to inform administration and medical staff of any incidents or accidents involving residents.
-He, the Administrator's Assistant, the RCC and SCC had a stand-up meeting daily at 10:00am and anything that occurred since the last meeting was discussed.
-He was informed about all accidents and incidents at that meeting.
-A determination would be made after the stand-up meetings for any additional action needed.
-Protocol for a physical altercation, injury or event was to contact EMS and LLE.
-If there was a change in baseline, staff should call RN, PCP or EMS depending on the urgency of the issue.
-It was not considered an assault because both residents had a mental diagnosis.
-Someone needed to be of sound mind for an altercation to be considered an assault.
-Staff had reported Resident #1's black eyes.
-He expected the staff to call the PCP and to inform them of any accidents or incidents

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between residents.
-LLE and EMS would be contacted if the incident was physical.

Attempted telephone interview with Resident #1's Behavioral Health NP on 02/05/26 at 2:50pm was unsuccessful.

3. Review of Resident #14's current FL2 dated 10/31/25 revealed:
-Diagnoses included stroke, dementia, history of alcohol abuse, and mood disorder.
-There was documentation he was intermittently disoriented.
-There was documentation he was rest home level of care.

Review of Resident #14's record revealed he was discharged from the facility in November 2025.

Review of Resident #14's Resident Register dated 11/01/24 revealed:
-He was admitted to the facility on 11/01/24.
-A family member was documented as his Health Care Power of Attorney (HCPOA).
-There was documentation he had significant memory loss.

Review of Resident #14's care plan dated 12/12/24 revealed:
-He required supervision with ambulation and transfers.
-He required extensive assistance with bathing and grooming.

Review of Resident #14's care notes revealed:
-On 08/24/25, Resident #14 grabbed another resident by the hair and told her, "sit down, stay there", then she was "flung from chair onto the floor" by Resident #14.

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-The incident was witnessed by the medication aide (MA).

Interview with the Special Care Coordinator (SCC) on 02/09/26 at 11:23am revealed:
-On 08/24/25, she heard Resident #14 yelling from the dining room.
-When she went immediately to the dining room, she observed Resident #14 grab another resident by the hair, yell at her, and flip the dining room chair she was sitting in over with her in it.
-She ran between Resident #14 and the other resident and told Resident #14 to back away while she checked on the other resident.
-She called out for a personal care aide (PCA) to escort Resident #14 to his room.
-She was working as a MA when this incident occurred and either the Resident Care Coordinator (RCC) or the SCC should have contacted the mental health provider regarding Resident #14.
-She did not contact Resident #14's mental health provider on 08/24/25.
-Resident #14 was not sent out for a mental health evaluation on 08/24/25 after this incident occurred.

Interview with the Administrator's Assistant on 02/10/26 at 9:12am revealed:
-MAs were supposed to inform the supervisor if a physical altercation took place between residents.
-The RCC and the SCC were responsible for reviewing the incident accident reports and to ensure any follow-through that needed to be done.
-The Behavioral Health Nurse Practitioner (NP) did not see Resident #14 until his next scheduled monthly visit.
-He was unsure what the Behavioral Health NP could have done since both residents had

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significant psychiatric issues.
-It never occurred to him that this could be considered assault.

Interview with the facility consulting Registered Nurse (RN) on 02/10/26 at 3:32pm revealed:
-She was not notified about the incident between Resident #14 and the other resident that occurred on 08/24/25 until several days after it occurred.
-Resident #14 should have been sent out for a psychiatric evaluation.

Interview with the Administrator on 02/11/26 at 10:48am revealed:
-The RCC was responsible to actively seek out incident accident reports to ensure all follow up was done.
-The RCC was responsible for determining if there was something else that needed to be done that had not been and to follow through with correcting it.
-Mental Health services should have been contacted for Resident #14.

Attempted telephone interview with Resident #14's Behavioral Health Nurse Practitioner on 02/05/26 at 2:50pm was unsuccessful.

4. Review of the undated facility "Fall Policy and Procedure" revealed "In the event of a fall, if the resident refuses treatment call emergency medical services (EMS) and let them refuse to EMS personnel and document in the resident's medical record."

Review of Resident #6's current FL2 dated 07/16/25 revealed:
-Diagnoses included vascular dementia, history of stroke, epilepsy after stroke, Todd's paralysis (a neurological condition in which a seizure is

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followed by a brief period of temporary paralysis usually occurring on one side of the body) and depression with suicidal ideations.
-She was intermittently disoriented.
-She required rest home level of care.

Review of the mental health progress note dated 10/01/25 revealed Resident #6 had a documented history of dementia, but her last mental assessment score was 15, which indicated no cognitive impairment.

Review of Resident #6's care plan dated 11/15/25 revealed:
-She was alert and oriented.
-She could become anxious and agitated at times but was easily redirected.
-She was at risk for falls.

Telephone interview with a representative from the local Department of Social Services on 01/29/26 at 4:00pm revealed:
-Resident #6 reported she had a fall in November 2025 and hit her head.
-Resident #6 requested to be sent to the emergency room.
-Resident #6 was not sent to the emergency room for an evaluation and treatment.

Telephone interview with a personal care aide (PCA) on 01/30/26 at 9:17am revealed:
-She was working the morning after Resident #6 had an unwitnessed fall on 11/22/25.
-The PCA observed Resident #6 had a cut on her forehead, but it was not bleeding.
-She later observed the medication aide (MA) applying some type of ointment to Resident #6's forehead and placed a bandage over the cut.
-She observed Resident #6 every 30 minutes during her shift to ensure her well-being.

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D 273	Continued From page 26 Interview with a medication aide (MA) on 01/30/26 at 9:36am revealed: -She was not present when Resident #6 had her fall on 11/22/25 but worked the following morning. -Resident #6 had a "bump in her hairline with a bruise" and "the skin was torn and had been bleeding." -She applied triple antibiotic ointment to the wound to prevent an infection. Review of the accident/incident report for Resident #6 dated 11/22/25 at 2:53am revealed: -The MA observed Resident #6 laying at her door in her room. -Resident #6 stated she fell going to the bathroom. -Resident #6 reported she had a headache. -There was documentation that an injury occurred. -There was no documentation treatment was given. -The primary care provider (PCP) was not contacted. -Resident #6 was put on 30-minute checks for 24 hours. -Resident #6 was told by the MA to ring her bell if she needed anything for the rest of the morning and to put non-skid socks on if she was going to be walking with no shoes on. Review of Resident #6's care note dated 11/22/25 at 5:00am revealed: -The MA documented Resident #6 had been coming out of her bathroom and fell. -Resident #6 had a "small knot on forehead but was lying on her back where she fell." -She was put on "checks", and they would "keep an eye out on her."	D 273		

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Interview with Resident #6 on 01/30/26 at 10:51am revealed:
-She fell in November 2025 and hit her head.
-She wanted to go to the hospital to be assessed, but the MA told her she was "okay."
-She had a headache after her fall.

Interview with the Resident Care Coordinator (RCC) on 01/30/26 at 11:35am revealed:
-MAs were supposed to assess residents after a fall.
-If a resident had a fall and hit their head, they should always call Emergency Medical Services (EMS) to be sent to the emergency department (ED).
-Resident #6 refused to go to the ED after her fall.
-The MA must have forgotten to document that.

Interview with the Special Care Coordinator (SCC) on 02/06/26 at 2:05pm revealed:
-The MA informed her that Resident #6 had a fall and refused EMS services.
-There was no documentation EMS had been called by the MA.
-The MAs are trained to take vital signs, perform a head to toe skin check and to call EMS for any head injuries.

Interview with Resident #6's PCP on 02/09/26 at 9:10am revealed:
-Staff should use their nursing judgement whether to send a resident to the ED for an evaluation.
-If a resident had a fall with a head injury, the PCP should be contacted, and the resident should be sent out to be evaluated and treated at the ED.

Interview with the Administrator's Assistant on 02/10/26 at 9:54am revealed:
-The fall policy indicated the facility staff were to

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call EMS and let them assess the resident after a head injury.
-If a resident refused to go to the hospital, EMS would have provided additional support in assessing the resident to determine if the resident needed to go to the ED.
-Resident #6 refused to go to the ED for an evaluation on 11/22/25 after her fall with a head injury.

Interview with the Administrator on 02/11/26 at 10:48am revealed anytime there was a head injury, the MAs were supposed to follow policy and contact EMS to make the determination if a resident needed to go to the ER for evaluation and treatment.

5. Review of Resident #3's record revealed a discharge date of 11/25/25.

Review of Resident #3's current FL-2 dated 12/13/24 revealed:
-Diagnoses included unspecified dementia, edema and hypertension.
-Resident #3's level of care was special care unit (SCU).

Review of Resident #3's Resident Register dated 12/01/22 revealed an admission date of 12/01/22.

Review of Resident #3's care plan dated 01/10/25 revealed:
-He had a history of wandering and confusion.
-He ambulated independently throughout the SCU.
-He required supervision with eating, toileting, ambulation, bathing, dressing, grooming and transfers.

Review of an undated written statement by a

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former MA revealed:
-Two PCAs walked into Resident #3 and his roommate's room where they saw his roommate face down lying in the bed.
-Resident #3 was standing at his roommate's bed with his pants down to his ankles.
-Resident #3 pulled his pants up when the PCAs walked into the room.
-She took Resident #3's roommate to the dayroom for the rest of the night.
-She asked Resident #3's roommate if anything happened and he stated no.
-She asked Resident #3's roommate if he was okay and he stated yes.
-She completed a physical assessment and did not observe the roommate to have any areas of redness or bruising.
-Nothing was "wrong" with Resident #3's roommate.

Review of a statement dated "11/20/26" written by the Administrator's Assistant revealed:
-He received a call from a MA who reported two PCAs walked into Resident #3's room, observed Resident #3 adjusting his pants beside his roommate who was lying on his side crossways with his legs bent.
-The PCAs had concerns about Resident #3.
-Per the MA, there were no signs of any type of abuse.
-Per the MA, details of statements did not match.
-He instructed the MA to move Resident #3's roommate and another resident.
-He would speak to Resident #3's roommate in the morning.

Review of a statement dated 11/27/25, titled "investigation", written by the Administrator revealed:
-Staff reported concerns regarding Resident #3

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and his roommate.
-Statements were obtained by the shift supervisor and eyewitness staff.
- "Admin and Admin" completed a physical assessment of Resident #3's roommate.
-He investigated a towel that was in residents' room and "feces on the towel was detected."

Review of Resident #3's record revealed there was no documentation that an Accident and Incident Report had been completed.

Review of Resident #3's record revealed there was no documentation he was sent to the emergency department related to alleged sexual assault.

Review of Resident #3's care notes revealed there was no documentation of the alleged sexual assault.

Interview with Resident #3's Guardian on 02/05/26 at 2:35pm revealed:
-She was notified by the Administrator's Assistant on 11/25/25 that Resident #3 was at the emergency room and was being discharged from the facility due to aggressive behaviors toward other male residents.
-She was not aware of any incidents or accidents prior to his discharge on 11/25/25.
-She was not notified on 11/22/25 regarding an alleged sexual assault investigation.

Telephone interview with Resident #3's Palliative Care RN on 02/10/26 at 11:09am revealed:
-She was not notified by the facility of the alleged sexual assault allegations involving Resident #3.
-She expected the facility to notify her of all accidents or incidents.

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Interview with a second PCA on 02/05/26 at 3:00pm revealed:
-She and another PCA worked the night of the alleged sexual assault involving Resident #3 and his roommate.
-She and the other PCA walked into Resident #3's bedroom where he was standing behind his roommate and adjusting his brief.
-She did not know the exact date or time.
-She walked into Resident #3's room behind another PCA and witnessed Resident #3 standing behind roommate who was in the fetal position, facing the wall, and hanging off the bed.
-Resident #3 had a history of helping his roommate with changing clothes and his brief but stated "something was weird."
-She and the other PCA reported their findings to the MA.

Interview with the Special Care Coordinator (SCC) on 02/09/26 at 2:28pm revealed:
-She had witnessed Resident #3 changing his roommate's brief and removed Resident #3 from the room but could not remember the date.
-She asked other staff if they had witnessed Resident #3 changing his roommate's brief and staff told her yes.
-She was told by a PCA and MA that staff walked into Resident #3's room and found Resident #3 adjusting his pants.
-Staff reported that Resident #3 allegedly sexually assaulted his roommate.
-She did not recall what date the incident occurred.
-The Administrator's Assistant and Administrator were notified before she was notified.
-She did not know if either resident's PCP or Guardian were notified.

Telephone interview with a former MA on

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D 273	Continued From page 32 02/09/26 at 4:05pm revealed: -A PCA told her she suspected a sexual assault had occurred. -A PCA reported to her that Resident #3 had been seen pulling up his pants that were down at his ankles when she walked into the room while Resident #3's roommate was lying in his bed. -The PCA later reported she had witnessed Resident #3 adjusting himself. -She reported the incident to the Administrator's Assistant via phone who told her to separate Resident #3 and his roommate and place them on 30-minute checks. -She knew Resident #3 helped his roommate with brief changes. -The Administrator's Assistant asked her about Resident #3 roommate's brief being pulled down to the side and she notified the Administrator's Assistant the PCA suspected, "something sexual" had happened. Telephone interview with Resident #3's Primary Care Provider (PCP) on 02/05/26 at 11:07am revealed: -She was not notified of the incident between Resident #3 and his roommate. -She was notified of the allegation by the Administrator's Assistant and the Administrator but could not remember the date. -If there was a suspected sexual assault, the facility should have notified the residents provider, sent the resident to the emergency department for an evaluation or to assess if there was any injury or trauma, and to determine if a sexual assault had occurred. Interview with facility's consulting RN on 02/11/26 at 8:56am and 9:35am revealed. -She did not know about the sexual assault allegation involving Resident #3 and his	D 273		

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roommate.
-She was not aware that Resident #3 assisted his roommate with changing his briefs.
-She should have been notified of alleged sexual assault.
-She should be notified of increased aggression, sexual behaviors or any mental status changes.

Interview with the Administrator's Assistant on 02/10/26 at 9:13am and 11:00am revealed:
-He received a call from a MA that two PCAs reported walking into Resident #3 room, where they witnessed Resident #3 pulling his pants back up and his roommate's brief pulled down.
-The PCA reported Resident #3 then running to his side of the room.
-The MA contacted him by telephone.
-The MA completed an assessment, and nothing was noted.
-There were no mental health or medical evaluations completed on Resident #3 or his roommate.
-He doesn't recall contacting Providers or residents Guardians.
-The facility's consulting RN should have been contacted by SCC or the RCC.
-If the alleged sexual assault had been witnessed, emergency medical services (EMS) should have been contacted to transport residents to the hospital, the PCP should have been notified, possibly seek involuntary commitment (IVC) and report to local law enforcement (LLE).

Interview with the Administrator on 02/11/26 at 10:48am revealed:
-He expected staff to contact after-hours telephone number to inform administration and medical staff of any incidents or accidents involving residents.

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D 273	Continued From page 34 -He was part of the group chat application that informed the administration of issues or problems. -He was also informed of issues or problems during a daily 10:00am stand up meeting and review with RCC, SCC, Nurse, and Administrator's Assistant. -A determination was made after the stand-up meetings if any additional actions are needed. -He and the Administrator's Assistant assessed Resident #3's roommate themselves and determined no sexual assault had occurred. -He did not complete an assessment on Resident #3. -He did not send Resident #3 or his roommate to the hospital for an evaluation. -Staff reported Resident #1's brief had been pulled to the side. -He did not find any evidence of a sexual assault. -The RCC should notify the residents' PCP and responsible party if an injury was confirmed by staff. -If a resident had an increase in sexual behaviors, he would contact the resident's mental health provider. -If there was evidence of abuse, he would contact the resident's PCP and send the resident to the hospital for an evaluation. Attempted telephone interview with Resident #3's Behavioral Health NP on 02/05/26 at 2:50pm was unsuccessful. 6. Review or Resident #2's current FL2 dated 03/27/25 revealed: -Diagnoses included Alzheimer's dementia and dementia with agitation. -He was constantly disorientated. -His level of care for SCU. -He had a history of wandering.	D 273		

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D 273	Continued From page 35 Review of Resident #2's Resident Register revealed and admission date of 03/27/25. Review of Resident #2's Care Plan dated 04/28/25 revealed: -There was documentation he had a history of resisting care. -There was documentation he required supervision with eating, ambulation and transferring. -There was documentation he required extensive assistance with toileting, bathing, dressing and grooming. Review of written statement from a former MA dated 12/05/25 revealed: -On 12/05/25 during dinner, another resident and Resident #2 were getting agitated with each other, nudging each other with their walker and wheelchair. -She called for assistance from a PCA to help redirect the residents. -Neither resident at that time physically hit one another, that she had seen. -The residents were separated and placed on 30-minute checks. Review of a written PCA statement dated 12/08/25 revealed: -On 12/06/25, the MA yelled for assistance because two residents got into an altercation. -She notified one of the resident's right eye was a little red and reported to the MA. -The MA checked on both residents before assisting them to bed. Interview with Resident #2's Hospice RN on 02/09/26 at 11:42am revealed: -She was not notified of Resident #2 being	D 273		

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involved in an altercation with another resident, until a week after the altercation occurred.
-Hospice should have been notified of the altercation in order to evaluate Resident #2.
-Resident #2 and the other resident were aggressive towards one another.

Interview with a PCA on 02/05/26 at 3:00pm revealed:
-She heard another resident and Resident #2 get into an altercation in the hallway.
-She did not witness the altercation but assisted the MA with redirecting the residents.
-The MA did assess both residents.
-She could not recall if anyone was notified.

Interview with a MA Supervisor on 02/09/26 at 10:34am revealed:
-Staff reported to her that another resident had got into an altercation with Resident #2.
-No one had witnessed what had happened.
-She did not complete an Accident or Incident report for Resident #2 or notify his PCP or Guardian of the incident.
-She expected the MA that worked when the altercation occurred to have reported the incident to the residents' PCP's and their Responsible Parties.

Interview with the SCC on 02/09/26 at 2:28pm revealed:
-Staff reported to her that Resident #2 hit another resident but could not recall when the incident happened.
-She expected staff to complete an Accident and Incident Report and skin assessment.
-She expected staff to notify the residents' providers and responsible parties.

Telephone interview with Resident #2's PCP on

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D 273	Continued From page 37 02/05/26 at 11:07am revealed she was not notified of Resident #2 assaulting another resident. Interview with the Administrator on 02/11/26 at 10:48am revealed: -He expected staff to contact the after-hours phone number to inform administration and medical staff of any incidents or accidents involving residents. -He, the Administrator's Assistant, the RCC and SCC had a stand-up meeting daily at 10:00am and anything that occurred since the last meeting was discussed. -He was informed about all accidents and incidents at that meeting. -A determination would be made after the stand-up meetings for any additional action needed. -Protocol for a physical altercation, injury or event is to contact EMS and LLE. -If there was a change in baseline, staff should call RN, PCP or EMS depending on the urgency of the issue. -It was not considered an assault because both residents had a mental diagnosis. -Someone needed to be of sound mind for an altercation to be considered an assault. -He expected the staff to call the PCP and to inform them of any accidents or incidents between residents. -He, the Administrator's Assistant, the RCC and SCC had a stand-up meeting daily at 10:00am and anything that occurred since the last meeting was discussed. -LLE and EMS would be contacted if the incident was physical. -Someone needed to be of sound mind for an altercation to be considered an assault.	D 273		

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D 273	Continued From page 38 Attempted telephone interview with a PCA on 02/03/26 at 12:21pm was unsuccessful. Attempted telephone interview with a former MA on 02/05/26 at 1:18pm and on 02/09/26 at 10:07am were unsuccessful. Attempted telephone interview with Resident #2's Behavioral Health NP on 02/05/26 at 2:50pm was unsuccessful. _____ The facility failed to contact the Primary Care Provider (PCP) related to an altercation between Resident #8 and Resident #14 resulting in Resident #8 having her hair pulled, chair knocked out from under her and thrown to the floor, sustaining severe facial trauma including bruising to her left eye with extensive swelling; an alleged sexual assault between Resident #1 and Resident #3; an altercation between Resident #1 and Resident #2 resulting in Resident #1 sustaining two black eyes; after Resident #14 had a change in mental status and assaulted Resident #8, and after Resident #6 hit her head during a fall. This failure resulted in serious physical harm and serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/05/26 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 13, 2026.	D 273		
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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 interviews and record reviews, the facility failed to ensure 2 of 7 sampled residents (#8, and #14) were free from neglect and treated with dignity and respect, related to Resident #8 who was physically assaulted by Resident #14 after a prior assault had occurred and a resident who was confined to his room after physically assaulting another resident (#14).

The findings are:

1. Review of Resident #8's current FL2 dated 10/28/25 revealed:
-Diagnoses included schizoaffective disorder.
-She was intermittently disoriented and had wandering behaviors.
-Her level of care was documented as Special Care Unit (SCU).

Review of Resident #8's Resident Register dated 06/08/20 revealed:
-She was admitted to the facility on 06/08/20.
-A family member was documented as her Power of Attorney (POA).

Review of Resident #8's care plan dated 10/28/25 revealed:
-The care plan was updated due to decline in health resulting in a move to the SCU.
-She required supervision with ambulation due to an unsteady gait.

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-She required limited assistance with dressing and grooming.
-She required extensive assistance with bathing.

Review of a local Hospice providers Notice of Admission dated 10/16/25 revealed Resident #8 was admitted to hospice services due to a terminal diagnosis of senile degeneration of the brain (age related loss of mental capacities).

Review of Resident #8's Incident Report dated 08/24/25 revealed:
-The report was completed by a medication aide (MA).
-The incident occurred at 3:00pm and was witnessed by the MA.
-The Administration group was notified of incident on the facility's group chat application.
-Resident #8 was in the dining room, and another Resident grabbed her hair, told her to sit there and stay and then flipped over the chair Resident #8 was sitting in.
-Additional intervention documented at the bottom of the report included Resident #8 was moved to a different hallway and the other Resident was to have meals in his room until further notice.

Review of Resident #8's care notes revealed:
-There was an entry dated 08/24/25 that documented Resident #8 "got into an altercation with another resident. Resident #8 was grabbed by her hair and flung from a chair. The other resident stated, "sit down and stay there"; witnessed by a MA.
-There was an entry dated 08/25/25 documenting Resident #8 was moved to a different room.

Review of Resident #8's NP's progress note dated 08/26/25 revealed:
-Resident #8 was seen due to facial bruising.

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-Resident #8 had an encounter with another resident and suffered injury and trauma to her face.
-Resident #8 had extensive swelling and bruising on the left side of her face and eye and there was a large amount of bruising around the eye and the eye was swollen almost shut.

Interview with a MA on 02/09/26 at 9:55am and 11:22am revealed:
-She was the MA who observed the incident with Resident #8 and another resident on 08/24/25.
-She saw a male resident pull Resident #8's hair, flip her chair and throw her to the floor and said he was tired of her asking for coffee.
-She was not sure if Resident #8 hit her head when she was thrown to the floor.
-She did not have Resident #8 sent out for an evaluation because she did an evaluation that checked for range of motion and altered mental status.
-Resident #8 was placed on 30-minute checks for 24 hours after the incident.
-She would consider what happened to Resident #8 during the altercation abuse or an assault.

Telephone interview with another MA on 02/11/26 at 9:36 am revealed:
-She was the MA on-call when the altercation occurred between Resident #8 and a male resident.
-It was reported to her that another resident grabbed Resident #8 by the hair, used his foot to kick the chair over, knocking her out of it.
-He slammed her face into the floor.
-Earlier in the day it was reported to her that the same resident pushed her down and then later he pulled her hair when she was walking down the hall.
-She attempted to contact the Administrator's

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Assistant and the RCC but neither answered their phones.
-A few weeks prior to the 08/24/25 the same resident walked up to Resident #8 and she was "punched in the face".
-He told me around that same time that he was going to "[expletive] her up", "beat her [expletive]" and "punch her in the face" because he did not like Resident #8.

Interview with the facility's Consulting Registered Nurse (RN) on 02/10/26 at 3:32pm and 02/11/26 at 8:56am revealed:
-She was informed about the incident between Resident #8 and another resident by the APP that staff used to communicate with each other.
-She was told there was an altercation involving Resident #8 where another resident "slammed her face on the table".
-As an RN she had seen many injuries when someone's head was slammed against a hard surface and Resident #8's injury was consistent with that type of hit.
-Resident #8's head and face injury was consistent with a "face to broad surface contact" injury and not a hit on the face when she fell to the floor.
-Because the residents both have dementia diagnoses law enforcement would not probably consider it an assault but she thought the resident who attached Resident #8 should have been removed from the facility immediately because he was a danger to everyone in the facility.

Interview with the Administrator's Assistant on 02/09/26 at 10:18am and 02/10/26 at 9:12am revealed:
-He became aware of the 08/24/25 incident when he read the Incident report.
-He could not remember any details other than

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Resident #8 was pulled from her chair onto the floor.
-It did not occur to him that the incident could be considered abuse or assault.

Interview with the Administrator on 02/09/26 at 10:22am and 02/11/26 at 10:48am revealed:
-The incident involving Resident #8 was not considered an assault because both residents had a mental diagnosis.
-Someone needed to be of sound mind for an altercation like that to be considered an assault.
-Resident #8, to his knowledge, never had any other incidents with the other resident prior to the 08/24/25 altercation.

2. Review of Resident #14's current FL2 dated 10/31/25 revealed:
-Diagnoses included stroke, vascular dementia, history of alcohol abuse, diabetes, mood disorder, hearing loss and vision loss.
-He was intermittently disoriented.

Review of Resident #14's record revealed he was discharged from the facility in November 2025.

Review of Resident #14's care notes dated 08/24/25 revealed:
-He grabbed another resident by the hair and told her to "sit down, stay there".
-He "flung" the other resident from the chair onto the floor.
-He was placed on 15-minute checks.

Review of care notes dated 08/25/25 revealed Resident #14 came out of his room once around midnight and was redirected back to his room by staff after being given a snack and a beverage.

Review of care notes dated 09/11/25 revealed:

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D 338	Continued From page 44 -Resident #14 was "constantly getting up and down" at night every 30 minutes. -Resident #14 had been getting up and down at night every 30 minutes for "almost a week now." -The MA and PCA redirected him back to his room each time he came out. Review of Resident #14's mental health provider (MHP) notes dated 10/01/25 revealed: -Resident #14 was "now eating in his room due to physical altercations with residents in the lunchroom." -There was no documentation addressing staff were directed to keep Resident #14 in his room or that he was disallowed out of his room without a staff member present following an altercation or if she was made aware of the decision. -There was no documentation addressing when the decision was made to serve Resident #14 meals in his room or if she was aware of the decision. -There was no documentation addressing the length of time Resident #14 had been receiving meals in his room. Review of Resident #14's MHP notes dated 10/29/25 revealed: -Resident #14 had appeared more depressed lately per staff report. -There was no documentation if the MHP questioned facility staff about Resident #14's increased depression. -Resident #14 would be "having one on one activities starting" which hopefully would improve his mood. -There was no documentation addressing why Resident #14 needed "one-on-one activities." -There was no documentation addressing if Resident #14 was still confined to his room for meals.	D 338		

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D 338	Continued From page 45 Interview with the special care coordinator (SCC) on 02/09/26 at 11:23am revealed: -On 08/24/25, she observed a physical altercation between Resident #14 and another resident in the dining room. -Resident #14 grabbed the other resident by the hair and told her to sit down and stay there as he flipped the dining room chair over with her in it. -There had been no issues between Resident #14 and the other resident prior to this incident on 08/24/25. -She called out for a personal care aide (PCA) to come and take Resident #14 to his room and placed him on 15-minute checks for 24 hours. -She was told by administrative staff to keep him in his room. -For at least 4 days, if Resident #14 came out of his room he was redirected back to his room by staff. Interview with a medication aide (MA) on 02/09/26 at 1:31pm revealed: -Several weeks prior to the incident between Resident #14 and another resident on 08/24/25, Resident #14 elbowed the same resident in the face and knocked her down to the floor. -Resident #14 was only allowed to come out of his room if another staff person was present with him. Interview with a personal care aide (PCA) on 02/09/26 at 2:27pm revealed: -After the incident on 08/24/25 between Resident #14 and another resident, the Administrator's Assistant ordered staff to keep Resident #14 in his room. -Resident #14 would try to come out about once an hour but was redirected by staff back to his room.	D 338		

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-Resident #14 had all his meals in his room and continued to be redirected back to his room when he came out into the hallway
-Resident #14 was redirected back to his room for several weeks when he would come out into the hallway.
-Resident #14 had all his meals in his room and continued to be redirected back to his room when he came out into the hallway.

Interview with the Administrator's Assistant on 02/10/26 at 9:12am revealed:
-After the incident occurred on 08/24/25 with Resident #14 and the other resident, Resident #14 was kept in his room.
-He was unsure how long Resident #14 was confined to his room, but it was less than a week.
-Resident #14 was increasingly inappropriate toward staff and he was discharged to a local hospital sometime in November 2025 and did not return to the facility.

Interview with a second PCA on 02/11/26 at 7:38am revealed:
-Resident #14 was very agitated because he was not allowed to wander the halls after the incident with the other resident in August 2025.
-Re-direction was rarely successful with Resident #14.

Telephone interview with a former Resident Care Coordinator (RCC) on 02/11/25 at 9:36am revealed:
-She was on call when the incident occurred between Resident #14 and the other resident in August 2025.
-The Assistant Administrator ordered staff to keep Resident #14 in his room.
-He had no activities and had all meals in his room for several weeks.

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D 338	Continued From page 47 -She thought this was excessive and would let Resident #14 out of his room and into the hall when the administration was not in the building. _____ The facility failed to ensure Resident #8 was free of physical assault from another resident related to Resident #14 assaulting Resident #8. Staff reported Resident #14 had previously punched Resident #8 in the face and had verbalized intent to beat her up. Staff reported Resident #14 did not like Resident #8. The facility confined Resident #14 to his room without a mental health evaluation after assaulting another resident (#8). The failure to protect Resident #8 and the confinement of Resident #14 resulted in serious physical harm and serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/05/26 for this violation. CORRECTION DATE FOR THIS VIOLATION SHALL NOT EXCEED MARCH 13, 2026.	D 338		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of	D 367		

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D 367	Continued From page 48 medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 1 Resident (#6) related to documentation for wound care treatment given for a head injury. The findings are: Review of an incident accident report dated 11/22/25 revealed: -Resident #6 had a fall with injury at 2:53am. -The location of the injury was not documented. -There was no documentation first aide was administered. -Resident #6 had no treatment given. Review of Resident #6's current FL2 dated 07/16/25 revealed: -Diagnoses included vascular dementia, Todd's paralysis (a neurological condition in which a seizure is followed by a brief period of temporary paralysis usually occurring on one side of the body), epilepsy after stroke, atrial fibrillation, high blood pressure and depression.	D 367		

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-Resident #6 was intermittently disoriented.

Review of Resident #6's November 2025 eMAR revealed:
-There was no entry for wound care.
-There was no documentation of administration of wound cleanser, Neosporin, or bandaging of the wound.

Review of Resident #6's physician's orders for November 2025 revealed there were no wound care orders after Resident #6's fall on 11/22/25.

Telephone interview with a personal care aide (PCA) on 01/30/26 at 9:17am revealed:
-She came in for her morning shift and saw that Resident #6 had a cut on her head, but it was not bleeding.
-She saw the medication aide (MA) put some type of cream over the cut and placed a bandage over the wound.

Interview with a MA on 01/30/26 at 9:36am revealed:
-Resident #6 fell and sustained a wound to her head in November 2025.
-Resident #6 had a bump at her hairline with a bruise and the "skin was torn and bleeding."
-She used wound cleanser to clean the area, then covered it with triple antibiotic ointment.
-She did not call the primary care provider for instructions for treatment of the wound.
-She did not document on the eMAR she provided a treatment.

Interview with a second PCA on 01/30/26 at 10:21am revealed:
-Resident #6 fell and sustained a head injury in November 2025.
-Resident #6 asked for a medicated cream

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several times for her head wound and she would tell the MA.

Interview with Resident #6 on 01/30/26 at 10:51am revealed:
-She had a fall and hit her head on or before Christmas Day of 2025.
-She had a gash on her forehead and wanted to go to the hospital.
-The staff told her she would be okay.
-She was unsure if she received any treatment for her head injury.

Interview with the PCP on 02/05/26 at 11:06am revealed:
-She had no way to know for sure if her office was contacted in November about Resident #6's fall since it was during night shift and they have over 30 providers on-call.
-There was not a record kept that far back.
-She was unable to remember if she was notified about the fall with a head injury.
-She was unsure how soon after Resident #6's fall with head injury that she had seen Resident #6.
-The staff should be letting the on-call PCP know on 3rd shift so treatment orders can be given.

Interview with a third PCA on 02/06/26 at 1:30pm revealed:
-She saw the MAs cleaning Resident #6's head wound and administering some type of cream on it.
-The area on her forehead looked like a scrape at the hairline.

Interview with a second MA on 02/06/26 at 1:53pm revealed:
-When she saw Resident #6's forehead in November, she observed the area had already

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D 367	Continued From page 51 scabbed over and was not bleeding. -She used wound cleanser then applied triple antibiotic ointment over the area every day for at least a week. -She did not follow any specific PCP guidance for the treatment. -She did not document on the eMAR she performed a treatment every day for at least a week. Interview with the Special Care Coordinator (SCC) on 02/06/26 at 2:05pm revealed: -The MA reported to her on 11/22/25 Resident #6 was found in the floor and had hit her head. -She cleaned Resident #6's head wound and bandaged it. -There was no documentation on the eMAR that any treatment orders were given by the PCP. -There was no documentation on the eMAR of treatments that were administered by staff to Resident #6 after her head wound on 11/22/25. Interview with the Administrator on 02/11/26 at 10:48am revealed staff should always document each wound care treatment given to residents on the eMAR.	D 367		
D 456	10A NCAC 13F .1212(g) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (g) In the case of physical assault by a resident or whenever there is a risk that death or physical harm will occur due to the actions or behavior of a resident, the facility shall immediately: (1) seek the assistance of the local law enforcement authority; (2) provide additional supervision of the	D 456		

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threatening resident to protect others from harm;
(3) seek any needed emergency medical treatment;
(4) make a referral to the Local Management Entity for Mental Health Services or mental health provider for emergency treatment of the threatening resident; and
(5) cooperate with assessment personnel assigned to the case by the Local Management Entity for Mental Health Services or mental health provider to enable them to provide their earliest possible assessment.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on interviews and record reviews, the facility failed to immediately seek emergency medical treatment, provide additional supervision of the threatening residents, contact local law enforcement and make referrals to mental health services for 5 of 5 sampled residents (#1, #3, #2, #14, and #8) related to an allegation of sexual assault between two residents (#1, #3), related to a physical assault between two residents (#2, #1) and related to a resident (#14) physically assaulting another resident (#8).

The findings are:

1. Review of Resident #1's current FL2 dated 01/24/2025 revealed:
-Diagnoses included Alzheimer's dementia and cognitive impairment.
-He was constantly disoriented.
-He was ambulatory and had a history of wandering.
-His level of care was special care unit (SCU).

Review of Resident #1's Resident Register

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BROCKFORD INN	56 N HIGHLAND AVENUE 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
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revealed an admission date of 01/24/25.

Review of Resident #1's record revealed he passed away on 01/10/26.

Review or Resident #1's care plan dated 02/01/25 revealed:
-He had a history of wandering, becoming physically abusive and resisting care.
-He ambulated throughout the SCU.
-He resisted care and was aggressive at times.
-He required supervision with eating, ambulation and transferring.
-He required extensive assistance with toileting, bathing, dressing and grooming.

Review of a local Hospice provider's Notice of Admission dated 11/18/25 revealed Resident #1 was admitted under Hospice services due to Alzheimer's dementia.

a. Review of Resident #1's Hospice Registered Nurse's (RN) progress note dated 11/26/25 revealed facility staff reported to the Hospice certified nursing assistant (CNA) Resident #1 was involved in a sexual incident with another resident where the other resident was doing penetrative sexual things to him.

Review of Resident #1's record revealed there was no documentation that an Accident and Incident Report had been completed.

Review of Resident #1's record revealed there was no documentation Local Law Enforcement (LLE) was notified of the alleged sexual assault.

Review of Resident #1's nursing notes revealed there was no documentation of the alleged sexual assault.

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D 456	Continued From page 54 Review of a statement written by a former MA that was not dated revealed: -Two PCA's walked into Resident #1 and Resident #3's room where they saw Resident #1, face down lying in the bed. -Resident #3 was "at" Resident #1's bed, with his pants down to his ankles. -Resident #3 pulled his pants up when the PCAs walked into the room. -She took Resident #1 to the dayroom for the rest of the night. -She asked Resident #1 if anything happened and he stated no. -She asked Resident #1 if he was okay and he stated yes. -She completed a physical assessment and did not observe Resident #1 to have any areas of redness or bruising. -Nothing was "wrong" with Resident #1. -She did not complete a report because nothing physical happened. Review of a written statement dated "11/20/26" from the Administrator's Assistant revealed: -He received a call from a MA stating two PCAs walked into Resident #1's room, saw his roommate (Resident #3) adjusting his pants beside Resident #1 who was lying on his side crossways with his legs bent. -The PCA's had concerns about Resident #3. Review of a written interview with a PCA dated 11/20/25, written by the Administrator's Assistant revealed: -The PCA walked into Resident #1 and Resident #3's room. -Resident #1's brief was pulled to the side. -Towel under Resident #3's bed. -Did not see any contact between the residents.	D 456		

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D 456	Continued From page 55 -Resident #3's pants were around his ankles. Review of a written interview with a second PCA dated 11/20/25, written by the Administrator's Assistant revealed: -The PCA walked into Resident #1 and Resident #3's room. -Resident #1's brief was pulled to the side. -Did not see any contact between the residents. -Did not see Resident #3's pants down. Review of a statement dated 11/27/25, titled "investigation", written by the Administrator revealed: -Staff reported concerns regarding Resident #1 and his roommate. -Statements were obtained by the shift supervisor and eyewitness staff. - "Admin and Admin" completed a physical assessment of Resident #1. - "Assessed for trauma both physical and mental and resident was at baseline, no issues to note." Telephone interview with Resident #1's Hospice NP on 02/03/26 at 11:42am revealed: -On 11/26/25, she and the Hospice RN were notified by Resident #1's Hospice CNA that facility staff reported, staff had walked in on Resident #1 and Resident #3, "in the act". -She did not know if Resident #1 had any type of evaluation completed after the incident. Telephone interview with Resident #1's Primary Care Practitioner (PCP) on 02/05/26 at 11:07am revealed: -She was not notified of the alleged incident between Resident #1 and Resident #3. -She was notified of the allegation by the Administrator's Assistant and the Administrator but could not remember the date.	D 456		

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-She would have expected the facility to notify Hospice who was primarily seeing Resident #1.
-If there was a suspected sexual assault, the facility should have notified the residents provider, sent the resident to the emergency department for an evaluation or to assess if there was any injury or trauma, and to prove if a sexual assault had occurred.

Interview with a MA on 02/09/26 at 10:34am revealed she did not know if medical treatment was provided.

Interview with the Administrator's Assistant on 02/10/26 at 9:13am and 11:00am revealed:
-An initial assessment of abuse or injury should include physical viewing of injury and assessment of the residents mental health.
-Staff should assess the resident's mental status and determine if they are not at baseline and note abnormalities.
-He told MA to move Resident #1 to a different room.
-He completed an investigation and found interviews were not credible and there were no visible signs of injury to Resident #1.
-There were no mental health or medical evaluations completed on either Resident #1 or Resident #3.

Interview with the Administrator on 02/11/26 at 10:48am revealed:
-He, the Administrator's Assistant, the RCC and SCC had a stand-up meeting daily at 10:00am and anything that occurred since the last meeting was discussed.
-He was informed about all accidents and incidents at that meeting.
-LLE and EMS would be contacted if the incident was physical.

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-It was not considered an assault if both residents had a mental diagnosis.
-Someone needed to be of sound mind for an altercation to be considered an assault.
-He was informed of the alleged sexual assault but could not recall the date.
-He and the Administrator's Assistant assessed Resident #1 themselves and determined no sexual assault had occurred.
-If the sexual assault had been witnessed, EMS should have been contacted to transport to the hospital, the PCP should have been notified, possibly seek involuntary commitment (IVC) and report to LLE.

Attempted telephone interview with Resident #1's Behavioral Health NP on 02/05/26 at 2:50pm was unsuccessful.

b. Review of Resident #1's Incident Report dated 12/08/25 revealed:
-The report was completed by a MA.
-The incident occurred at 3:45pm.
-Resident#1 was found in hall by a MA with two black eyes.
-There was no documentation the PCP was notified.
-There was no documentation LLE was notified.
-There was documentation that the incident had not been witnessed.
-There was documentation dated 12/09/25 Resident #1 had been sent to the local hospital for a follow-up and no additional injuries noted.

Review of Resident #1's emergency medical services (EMS) report dated 12/08/25 revealed:
-EMS was dispatched to the facility on 12/08/25 at arrived at 7:24pm.
-The Medication Aide (MA) reported she had noticed Resident #1's facial bruising at the start of

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her shift at 3:15pm but was adamant she noticed no bruising on the resident while on shift over the weekend.
-Another staff member reported she did not see any bruising when she first left her shift at 3pm on 12/08/25, but when she arrived back to work at 6:30pm on 12/08/25, she noticed Resident #1's facial bruising which prompted her to then call EMS.

Interview with the Administrator on 02/11/26 at 10:48am revealed:
-He was informed about all accidents and incidents in stand-up meetings.
-A determination would be made after the stand-up meetings for any additional action needed.
-Protocol for a physical altercation, injury or event is to contact EMS and LLE.
-If there was a change in baseline, staff should call RN, PCP or EMS depending on the urgency of the issue.
-It was not considered an assault because both residents had a mental diagnosis.
-Someone needed to be of sound mind for an altercation to be considered an assault.
-LLE and EMS would be contacted if the incident was physical.

Attempted telephone interview with Resident #1's Behavioral Health NP on 02/05/26 at 2:50pm was unsuccessful.

2. Review or Resident #2's current FL2 dated 03/27/25 revealed:
-Diagnoses included Alzheimer's dementia and dementia with agitation.
-He was constantly disorientated.
-His level of care for SCU.
-He had a history of wandering.

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D 456	Continued From page 59 Review of Resident #2's Resident Register revealed and admission date of 03/27/25. Review of Resident #2's Care Plan dated 04/28/25 revealed: -He was resistive to care. -He required supervision with eating, ambulation and transferring. -He required extensive assistance with toileting, bathing, dressing and grooming. Review of a written statement from a PCA dated 12/08/25 revealed: -On 12/06/25, the MA yelled for assistance because two residents got into an altercation. -She observed one of the resident's right eye was a little red and reported to the MA. -The MA checked on both residents before assisting them to bed. Review of written statement by a former MA dated 12/05/25 revealed: -On 12/05/25 during dinner, Resident #1 and Resident #2 were getting agitated with each other, nudging each other with their walker and wheelchair. -She called for assistance from a PCA to help redirect the residents. -Neither resident at that time physically hit one another, that she had seen. -The residents were separated and placed on 30-minute checks. Interview with Resident #2's Hospice RN on 02/09/26 at 11:42am revealed Resident #2 and Resident #1 were aggressive towards one another. Interview with a PCA on 02/05/26 at 3:00pm	D 456		

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revealed she could not recall if anyone was notified.

Interview with a MA Supervisor on 02/09/26 at 10:34am revealed:
-She was working on 12/08/25 when the local County Department of Social Services reported to her that Resident #1 had two black eyes.
-She noticed that Resident #1 had a bluish color to both eyes and on his nose,
-Staff reported to her that Resident #1 had got into an altercation with Resident #2.
-She sent Resident #1 out to the local hospital due to him having a head injury which was part of the facility's head injury protocol.

Interview with the Administrator on 02/11/26 at 10:48am revealed:
-He expected staff to contact the after-hours phone number to inform administration and medical staff of any incidents or accidents involving residents.
-He, the Administrator's Assistant, the RCC and SCC had a stand-up meeting daily at 10:00am and anything that occurred since the last meeting was discussed.
-He was informed about all accidents and incidents at that meeting
-A determination would be made after the stand-up meetings for any additional action needed.
-Protocol for a physical altercation, injury or event was to contact EMS and LLE.
-If there was a change in baseline, staff should call RN, PCP or EMS depending on the urgency of the issue.
-It was not considered an assault because both residents had a mental diagnosis.
-Someone needed to be of sound mind for an altercation to be considered an assault.

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-Staff had reported Resident #1's black eyes.
-He expected the staff to call the PCP and to inform them of any accidents or incidents between residents.
-LLE and EMS would be contacted if the incident was physical.
-It was not considered an assault because both residents had a mental diagnosis.
-Someone needed to be of sound mind for an altercation to be considered an assault.

Attempted telephone interview with Resident #2's Behavioral Health NP on 02/05/26 at 2:50pm was unsuccessful.

3. Review of Resident #3's record revealed a discharge date of 11/25/25.

Review of Resident #3's current FL-2 dated 12/13/24 revealed:
-Diagnoses included unspecified dementia, edema and hypertension.
-Resident #3's level of care was special care unit (SCU).

Review of Resident #3's Resident Register dated 12/01/22 revealed an admission date of 12/01/22.

Review of Resident #3's care plan dated 01/10/25 revealed:
-He had a history of wandering and confusion.
-He ambulated independently throughout the SCU.
-He required supervision with eating, toileting, ambulation, bathing, dressing, grooming and transfers.

Review of an undated written statement by a former MA revealed:

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D 456	Continued From page 62 -Two PCAs walked into Resident #3 and his roommate's room where they saw his roommate face down lying in the bed. -Resident #3 was standing at his roommate's bed with his pants down to his ankles. -Resident #3 pulled his pants up when the PCAs walked into the room. -She took Resident #3's roommate to the dayroom for the rest of the night. -She asked Resident #3's roommate if anything happened and he stated no. -She asked Resident #3's roommate if he was okay and he stated yes. -She completed a physical assessment and did not observe the roommate to have any areas of redness or bruising. -Nothing was "wrong" with Resident #3's roommate. Review of a statement dated "11/20/26" written by the Administrator's Assistant revealed: -He received a call from a MA who reported two PCAs walked into Resident #3's room, observed Resident #3 adjusting his pants beside his roommate who was lying on his side crossways with his legs bent. -The PCAs had concerns about Resident #3. -Per the MA, there were no signs of any type of abuse. -Per the MA, details of statements did not match. -He instructed the MA to move Resident #3's roommate and another resident. -He would speak to Resident #3's roommate in the morning. Review of a statement dated 11/27/25, titled "investigation", written by the Administrator revealed: -Staff reported concerns regarding Resident #3 and his roommate.	D 456		

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-Statements were obtained by the shift supervisor and eyewitness staff.
- "Admin and Admin" completed a physical assessment of Resident #3's roommate.
-He investigated a towel that was in residents' room and "feces on the towel was detected."

Review of Resident #3's record revealed there was no documentation he was sent to the emergency department related to alleged sexual assault.

Review of Resident #3's care notes revealed there was no documentation of the alleged sexual assault.

Telephone interview with Resident #3's Palliative Care RN on 02/10/26 at 11:09am revealed:
-She was not notified by the facility of the alleged sexual assault allegations involving Resident #3.
-She expected the facility to notify her of all accidents or incidents.

Telephone interview with Resident #3's Primary Care Practitioner (PCP) on 02/05/26 at 11:07am revealed:
-She was not notified of the incident between Resident #3 and his roommate.
-She was later notified of the allegation by the Administrator's Assistant and the Administrator but could not remember the date.
-If there was a suspected sexual assault, the facility should have notified the residents provider, sent the resident to the emergency department for an evaluation or to access if there was any injury or trauma, and to determine if a sexual assault had occurred.

Interview with the Administrator's Assistant on 02/10/26 at 9:13am and 11:00am revealed:

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D 456	Continued From page 64 -Incidents should be reported to a supervisor. -He received a call from a MA that two PCAs had reported walking into Resident #3's room, where they witnessed Resident #3 pulling his pants back up and his roommates brief pulled down. -He does not recall the date of when the incident occurred but believes it was on the night of 11/20/25 and the morning of 11/21/25 -He completed an investigation and found interviews were not credible and there were no visible signs of injury to Resident #3's roommate. -There were no mental health or medical evaluations completed on either Resident #3 or his roommate. -He completed an investigation by interviewing staff but stated allegations were unfounded. Interview with the Administrator on 02/11/26 at 10:48am revealed: -He expected staff to contact the after-hours phone number to inform administration and medical staff of any incidents or accidents involving residents. -Protocol for a physical altercation, injury or event is to contact EMS and LLE. -If there was a change in baseline, staff should call the consulting RN, PCP or EMS depending on the urgency of the issue. -It was not considered an assault because both residents had a mental diagnosis. -Someone needed to be of sound mind for an altercation to be considered an assault. -Following policy was always recommended. -He was aware of the alleged sexual assault but could not remember the date. -He did not send Resident #3 or his roommate to the hospital for an evaluation. -If there was evidence of abuse, he would contact the resident's PCP and send the resident to the hospital for an evaluation.	D 456		

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-He would contact Local Law Enforcement (LLE) and the residents responsible party if abuse was substantiated.
-An Accident and Incident report should not have been completed if the sexual assault did not occur.

Attempted telephone interview with Resident #3's Behavioral Health NP on 02/05/26 at 2:50pm was unsuccessful.

4. Review of Resident #14's current FL2 dated 10/31/25 revealed:
-Diagnoses included stroke, dementia, history of alcohol abuse, hypothyroidism, hearing loss, functional vision loss, diabetes, high blood pressure and mood disorder.
-There was documentation he was intermittently disoriented.

Review of Resident #14's record revealed he was discharged from the facility in November 2025.

Review of Resident #14's Resident Register dated 11/01/24 revealed:
-He was admitted to the facility on 11/01/24.
-A family member was documented as his Health Care Power of Attorney (HCPOA).
-There was documentation he had significant memory loss and must be directed.

Review of Resident #14's care plan dated 12/12/24 revealed:
-There was documentation he needed supervision with eating, ambulation, and transfers.
-There was documentation he needed extensive assistance with toileting, bathing, dressing, and grooming.

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Review of Resident #14's care notes revealed:
-There was an entry dated 08/24/25 that Resident #14 grabbed another resident by the hair and told her, "sit down, stay there", then she was "flung from chair onto the floor" by Resident 14.
-The incident was witnessed by the medication aide (MA).

Interview with the Special Care Coordinator (SCC) on 02/09/26 at 11:23am revealed:
-On 08/24/25, she heard Resident #14 yelling from the dining room.
-When she went immediately to the dining room, she observed Resident #14 grab a female resident by the hair, yelled at her, and flipped the dining room chair she was sitting in over with her in it.
-She ran between Resident #14 and the other resident and told Resident #14 to back away while she checked on the other resident.
-She called out for a personal care aide (PCA) to escort Resident #14 to his room.
-She was working as a MA when this incident occurred and either the Resident Care Coordinator (RCC) or the SCC should have contacted the mental health provider regarding Resident #14.
-She did not contact Resident #14's mental health provider on 08/24/25.
-Resident #14 was not sent out for a mental health evaluation on 08/24/25 after this incident occurred.

Interview with the Administrator's Assistant on 02/10/26 at 9:12am revealed:
-MAs were supposed to inform the supervisor if a physical altercation took place between residents.
-The Behavioral Health Nurse Practitioner (NP) did not see him until his next scheduled monthly visit.

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-He was unsure what the Behavioral Health NP could have done since both residents had significant psychiatric issues.
-It never occurred to him that this could be considered assault, so law enforcement was not notified.

Interview with the consulting RN on 02/10/26 at 3:32pm revealed:
-She was not notified about the incident between Resident #14 and the other resident that occurred on 08/24/25 until several days after it occurred.
-Resident #14 should have been sent out for a psychiatric evaluation.
-Even if law enforcement (LE) had been contacted, they usually defer to the health care provider since both residents had dementia.

Interview with the Administrator on 02/11/26 at 10:48am revealed Mental Health services should have been contacted for Resident #14.

Attempted telephone interview with Resident #14's Behavioral Health Nurse Practitioner on 02/05/26 at 2:50pm was unsuccessful.

5. Review of Resident #8's current FL2 dated 10/28/25 revealed:
-Diagnoses included schizoaffective disorder.
-She was intermittently disoriented and had wandering behaviors.
-Her level of care was documented as Special Care Unit (SCU).

Review of Resident #8's Resident Register dated 06/08/20 revealed:
-She was admitted to the facility on 06/08/20.
-A family member was documented as her Power of Attorney (POA).

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Review of Resident #8's care plan dated 10/28/25 revealed:
-The care plan was updated due to decline in health resulting in a move to the SCU.
-She required supervision with ambulation due to an unsteady gait.
-She required limited assistance with dressing and grooming.
-She required extensive assistance with bathing.

Review of a local Hospice providers Notice of Admission dated 10/16/25 revealed Resident #8 was admitted to hospice services due to a terminal diagnosis of senile degeneration of the brain (age related loss of mental capacities).

Review of Resident #8's Incident Report dated 08/24/25 revealed:
-The report was completed by a medication aide (MA).
-The incident occurred at 3:00pm and was witnessed by the MA.
-The Administration group was notified of incident on the facility's group chat application.
-Resident #8 was in the dining room, and another Resident grabbed her hair, told her to sit there and stay and then flipped over the chair Resident #8 was sitting in.
-Additional intervention documented at the bottom of the report included Resident #8 was moved to a different hallway and the other Resident was to have meals in his room until further notice.
-There was no documentation law enforcement was notified.

Review of Resident #8's care notes revealed:
-On 08/24/25 Resident #8 got into an altercation with another resident. Resident #8 was grabbed by her hair and flung from a chair. The other resident told Resident #8 to, "sit down and stay

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there"; witnessed by a MA.
-On 08/25/25 Resident #8 was moved to a different room.

Interview with a MA on 02/09/26 at 9:55am and 11:22am revealed:
-She was the MA who observed the incident with Resident #8 and another resident on 08/24/25.
-She saw a male resident pull Resident #8's hair, flip her chair and throw her to the floor and said he was tired of her asking for coffee.
-She was not sure if Resident #8 hit her head when she was thrown to the floor.
-She did not have Resident #8 sent out for an evaluation because she did an evaluation that checked for range of motion and altered mental status.
-She would consider what happened to Resident #8 during the altercation abuse or an assault.
-She did not contact LLE at the time of the incident because at the time she did not think about it being an assault.

Telephone interview with another MA on 02/11/26 at 9:36 am revealed:
-She was the MA on-call when the altercation occurred between Resident #8 and a male resident.
-It was reported to her that another resident grabbed Resident #8 by the hair, used his foot to kick the chair over, knocking her out of it.
-He slammed her face into the floor.
-Earlier in the day it was reported to her that the other resident pushed her down and then later he pulled her hair when she was walking down the hall.
-She attempted to contact the assistant Administrator and the RCC but neither answered their phones.
-A few weeks prior to 08/24/25 the other resident

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walked up to Resident #8 and she was "punched in the face".
-The other resident told her that he was going to "[expletive] her up", "beat her [expletive]" and "punch her in the face" because he did not like Resident #8.

Interview with the facility's Consulting Registered Nurse (RN) on 02/10/26 at 3:32pm and 02/11/26 at 8:56am revealed because the residents both had dementia diagnoses law enforcement would not probably consider it an assault but she thought the resident who attacked Resident #8 should have been removed from the facility immediately because he was a danger to everyone in the facility.

Interview with the Administrator's Assistant on 02/09/26 at 10:18am and 02/10/26 at 9:12am revealed it did not occur to him that the incident could be considered abuse or assault so he did not call law enforcement.

Interview with the Administrator on 02/09/26 at 10:22am and 02/11/26 at 10:48am revealed:
-He was informed of the 08/24/26 incident at the Monday morning stand-up meeting on 08/25/26.
-He thought the incident involved a verbal altercation and was not a physical altercation.
-Local Law Enforcement (LLE)and Emergency Medical Services (EMS) would be contacted if the incident was physical.
-He can not recall the incident so he can not recall what happened afterward.
-He would not consider the altercation an assault or abuse; he considered it an altercation between two confused individuals.
-It was not considered an assault because both residents had a mental diagnosis.
-Someone needed to be of sound mind for an

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D 456	Continued From page 71 altercation like that to be considered an assault. -He would only call LLE if he was seeking an involuntary commitment for a resident. _____ The facility failed to immediately seek emergency medical treatment, provide additional supervision of threatening residents, contact local law enforcement and make referrals to mental health services for 5 of 5 sampled residents related to a suspected sexual assault between Resident #1 who was alleged to have been sexually assaulted by Resident #3; related to Resident #2 who physically assaulted Resident #1 who sustained two black eyes and related to Resident #14 who physically assaulted Resident #8 who sustained facial trauma including extensive bruising and swelling to her left eye. This failure resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/05/26 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 13, 2026.	D 456		
D 610	10A NCAC 13F .1801(a) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement infection prevention and control policies and procedures consistent with the federal Centers for Disease	D 610		

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D 610	Continued From page 72 Control and Prevention (CDC) published guidelines on infection prevention and control. The Department shall approve a set of policies and procedures for infection prevention and control consistent with the federal CDC published guidelines on infection prevention and control that shall be made available on the Division of Health Service Regulation, Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost. The facility shall either: (1) utilize the set of policies and procedures for infection prevention and control approved by the Department; (2) develop policies and procedures for infection prevention and control that are consistent with the set of Department approved policies and procedures; or (3) develop policies and procedures for infection prevention and control that are based on nationally recognized standards in infection prevention and control that are consistent with the federal CDC published guidelines on infection prevention and control. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to implement infection prevention	D 610		

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and control procedures as evidenced by the use of a residents (#12) personal electric razor for other residents.

Review of Resident #12's current FL2 dated 06-10-25 revealed diagnoses included anxiety and psychosis.

Review of Resident #12's current care plan dated 06-19-25 revealed:
-He was currently receiving mental health services.
-He was currently receiving medications for psychosis.
-He was able to verbalize his wants and needs.
-He required limited assistance with dressing, grooming, and hygiene.
-He required extensive assistance with bathing.

Interview with Resident #12 on 02-06-26 at 9:05am revealed:
-Staff came in residents' room on more than one occasion and obtained Resident #12's personal electric razor.
-Staff told him they needed to use his personal electric razor on another resident who did not have a personal electric razor.
-He was unsure of the staff members' name that asked to borrow his personal electric razor for the other resident.
-He did not like it when staff used his personal electric razor for another resident because it was his personal electric razor.
-He was concerned that he could possibly get sick from staff using his personal electric razor on another resident.

Interview with Resident #12's family member on 02-06-26 at 9:51am revealed:
-Resident #12 made her aware that staff had

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been using his personal electric razor on other residents.
-During a visit to the facility, Resident #12 pointed out to his family member the staff that had used his personal electric razor on other residents.
-The family member confronted staff and the staff admitted she had used Resident #12's personal electric razor on other residents.
-The family member notified the Assistant Administrator that Resident #12's personal electric razor was being used by staff on other residents.

Interview with a personal care aide (PCA) on 02-06-26 at 10:30am revealed:
-Several residents had their own personal electric razors.
-If a Resident did not have a personal electric razor, the facility had disposable razors in the supply closet for the other residents use.
-Shaving and beard trimming was completed every Sunday and on other days as needed.
-She had not witnessed any staff member use a resident's personal electric razor on other residents.

Interview with a second PCA on 02-06-26 at 11:00am revealed:
-Some residents had their own personal electric razors provided by a family member.
-Residents who did not have personal electric razors had access to a straight razor provided by the facility for grooming and hygiene needs with staff assistance.
-Shaving residents was an assignment that was scheduled to be completed weekly on Sundays and as needed on other days.
-She did not use any residents' personal razors for anyone except the owner of the razor because of blood borne pathogens.

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-She had not witnessed any staff member use a resident's personal electric razor on other residents.

Interview with a medication aide (MA) on 02/09/26 at 8:21am revealed:
-Sundays were nail, shower, and shave days.
-The PCAs provided all personal care assistance to the residents.
-The PCAs were aware of blood borne pathogens and infectious disease control prevention.
-She had not witnessed or been made aware of any staff using any residents' personal electric razors on another resident.

Interview with the Administrator's Assistant on 02/09/26 at 9:10am revealed:
-Sunday was the assigned day for shaving every week and additional shaving throughout the week as needed.
-Some residents had their own personal electric razors which are kept in residents' rooms.
-The facility provided straight razors for residents requiring staff assistance who did not have their own personal electric razors.
-The PCAs provided shaving and hygiene care to the residents.
-Staff were educated they were not to share electric razors or straight razors between residents.
-Staff attended blood borne pathogens training upon hire.

Interview with the Administrator on 02/11/26 at 3:30pm revealed:
-Sunday was the designated day for shaving although it was also as needed.
-They provided disposable razors if a resident did not have their own.
-He was not aware of any staff using the same

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D 610	Continued From page 76 razors between residents. -Staff were not supposed to share razors between residents.	D 610		