

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER SOUNDVIEW FAMILY CARE HOMES - UNIT I	STREET ADDRESS, CITY, STATE, ZIP CODE 136 CENTER AVENUE BLACK MOUNTAIN, NC 28711
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C 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an annual survey 2/25/16-3/1/16. A phone exit was completed on 3/4/16.	C 000		
C 033	<p>10A NCAC 13G .0302 (m) Design And Construction</p> <p>10A NCAC 13G .0302 Design And Construction</p> <p>(m) The building shall meet sanitation requirements as determined by the North Carolina Department of Environment and Natural Resources; Division of Environmental Health.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews the facility failed to assure the building met sanitation requirements as determined by the North Carolina Department of Environment and Natural Resources: Division of Environmental Health.</p> <p>The findings are:</p> <p>On 2/25/16 during the initial tour 3 of 6 residents revealed: -Concerns about the dog being in the dining room during meals begging for food or in the kitchen. -Enjoyed having the dog in the house.</p> <p>Observation on 2/25/16 at 10:00am revealed a black dog walked through the dining room from staff quarters to living room with the kitchen door open.</p> <p>Observation on 2/25/16 at 11:25am revealed:</p>	C 033		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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C 033	<p>Continued From page 1</p> <ul style="list-style-type: none"> - The dog went into the kitchen where the Supervisor-in-Charge (SIC) was preparing the noon meal. - The SIC spoke to the dog but did not remove the dog from the kitchen. - The dog followed the SIC out of the kitchen as she was bringing a residents plate out to the dining room table. <p>Interview with Supervisor-in-Charge (SIC) and the Property Manager on 2/25/16 at 1:45pm revealed:</p> <ul style="list-style-type: none"> -The Department of Social Services had previously spoken with SIC about her dog and that he could not be in areas where food is being prepared and eaten. - "I just didn't think about it." -Property Manager explained to SIC that the dog could not be in the kitchen where food is prepared and in the dining room when the residents were eating. <p>Observation on 2/26/16 at 11:45am revealed the Supervisor-in-Charge placed the dog in the staff quarters during lunch meal.</p> <p>Observation on 2/29/16 at 11:32am revealed:</p> <ul style="list-style-type: none"> -The dog standing underneath table beside Resident #3 as she was eating her lunch. -Resident #3 revealed "he always stands there and begs." <p>Observation during survey revealed the dog went into and out of the kitchen, the dining area, living room and office where charts and meds are kept.</p>	C 033		
C 185	<p>10A NCAC 13G .0601(a) Management and Other Staff</p> <p>10A NCAC 13G .0601Mangement and Other</p>	C 185		

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C 185	<p>Continued From page 2</p> <p>Staff</p> <p>(a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.</p> <p>This Rule is not met as evidenced by: Type A2 Violation</p> <p>Based on interviews and record reviews, the administrator failed to be responsible for the operation of the home as evidenced by the continued employment of a staff (Staff B) after reported allegations of sexual assault and exploitation by one staff (Staff B), with no investigation by the facility of the allegations or reporting of the allegations to the Health Care Personnel Registry; and failed to investigate additional allegations of sexual abuse and exploitation reported by residents or report the allegations to the Health Care Personnel Registry until investigation by the local county Department of Social Services.</p> <p>The findings are:</p> <p>The administrator failed to ensure residents were free of neglect, abuse and exploitation as</p>	C 185		

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C 185	<p>Continued From page 3</p> <p>evidenced by the failure continued employment of a staff (Staff B) after the staff acknowledged inappropriately touching and kissing a resident; and failed to investigate additional allegations of sexual assault by Staff B to at least one resident (#4) until an investigation by the local county Department of Social Services.</p> <p>A review of the facility's policy regarding abuse revealed:</p> <ul style="list-style-type: none"> - Abuse, both verbal and physical, or neglect of a client by facility staff will not be tolerated. - Allegations of this nature will result in an immediate investigation by the Administration of the facility as well as immediate notification of such allegations to the Department of Social Services and local law enforcement (if applicable). If the allegation is substantiated the staff position will be terminated and the findings reported to the Health Care Personnel Registry. <p>Review of a facility incident report on 08/07/14 revealed:</p> <ul style="list-style-type: none"> - A former resident stated she was walking to the store and the supervisor-in-charge (Staff B) stopped her and asked her if she wanted a ride. Staff B passed the store and went to the daycare. Staff B pulled his car behind a tree and started to feel on her breast and private area. Staff B kissed her, she tried to pull away and he pulled her back to him, she told him to take her home and Staff B took her to the store and he let her out of the car. The resident walked back to the facility. - The incident report was signed by the resident. - There was no documentation the facility investigated the allegation. - There was no documentation the resident's family was notified. - There was no documentation the County 	C 185		

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C 185	<p>Continued From page 4</p> <p>Department of Social Services was notified.</p> <ul style="list-style-type: none"> - There was no documentation the allegation had been reported to the Health Care Personnel Registry. - Law enforcement was notified. <p>Review of the Incident /Investigation Report provided by Law enforcement dated 08/07/14 revealed:</p> <ul style="list-style-type: none"> - Crime/Incident was noted as Sexual Battery. - Reported to law enforcement at 5:00pm. - Staff B touched the resident inappropriately in front of the child. - The narrative reports Officer interviewed the resident and Staff B. - Both the resident and Staff B wrote voluntary statements. - Staff B denied incident, then recounted and admitted to feeling the resident's breast and asking the resident for a kiss before exiting the car. <p>Review of the Voluntary Statement of Resident #5 on 08/07/14 at 5:00 pm confirmed the information in the law enforcement report.</p> <p>Review of Staff B's Voluntary Statement dated 08/07/14 at 5:45 pm revealed:</p> <ul style="list-style-type: none"> - He went to pick up "the kid" at the care center. - The resident was walking along the road. - He asked the resident if she wanted a ride, resident said "ok". - He saw a red mark on her breast and asked her if her boyfriend did that, the resident said "no". - "I looked at it and I touched her breast to see, on the way back when I dropped her off at the store I asked her for a good-bye kiss and she did." - It was written and signed by Staff B. 	C 185		

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C 185	<p>Continued From page 5</p> <p>Interview on 02/26/16 at 1:00pm with Staff B revealed:</p> <ul style="list-style-type: none"> - He "never heard anything else about it [incident with former resident in 2014]". - "I will regret it (the incident with the former resident) for the rest of my life." <p>A telephone interview on 02/29/16 at to the NC Health Care Personnel Registry revealed no report had been made regarding the incident on 08/07/14.</p> <p>A telephone interview on 02/29/16 at 5:42pm with the Detective assigned to the case.</p> <ul style="list-style-type: none"> - He was assigned to the case as the detective. - He remembered the incident. - It was a misdemeanor assault charge, he had encourage the facility to obtain a warrant on the resident's behalf. - If the warrant had been made "we would have backed her up, it did happen." - They both signed a statement. -The facility filled out the voluntary statement for the resident and the staff member (Staff B) filled his out. - "He [Staff B] admitted to kissing her and touching her breast." - "He knew he had done wrong." - "It was the facility's responsibility to obtain a warrant that is out of the scope of what we do." - "It was my understanding that he would no longer work at the facility permanently from the Administrator." - "I'm surprised he is still there." - "We spoke with the Administrator during the investigation and kept her informed of what had transpired and encouraged them to file for a warrant for sexual battery." <p>Interview on 03/01/16 at 10:50am with Staff C,</p>	C 185		

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C 185	<p>Continued From page 6</p> <p>Supervisor-in-Charge, revealed:</p> <ul style="list-style-type: none"> - She was working here on the day of the incident between the former resident and Staff B. - The former resident was crying. Former resident told me what had happened with Staff B and Staff C called the Administrator." - "(Administrator's name) told me to call the police." - The Police came to the facility and stayed until Staff B left that evening. - "(The Administrator's name) spoke with the Police on the phone." - Staff B had to leave the property for a few days after the incident. - The police told the Administrator and the former resident they should go and file charges at the magistrates office. - The Property Manager offered to take the former resident to the police station. - "There are no other incidents that I know of, I have been at the sister facility for about a year." <p>Interview on 03/02/16 at 2:20 pm with family member revealed:</p> <ul style="list-style-type: none"> -He received a call from the Administrator who stated she was "calling to report her findings". -The call was a few days after the incident, "no one called at time of the incident". - The Administrator also told him that she would be filing a report with the Health Care Personnel Registry and that the staff member would have no contact with the former resident. <p>Interview on 03/02/16 at 3:31pm with Staff B further revealed:</p> <ul style="list-style-type: none"> - There was nothing else to add to earlier conversation. - He denied writing a Voluntary Statement on 08/07/14 at 5:45pm witnessed by a Law Enforcement Officer in which he admitted to 	C 185		

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C 185	<p>Continued From page 7</p> <p>kissing her and touching her. - "I don't know why they (referring to Law Enforcement) would say that."</p> <p>Based on interview and record review, Resident #4 was sexually assaulted by Staff B in February 2016.</p> <p>Review of Resident #4's current FL2 dated 10/21/15 revealed: - Diagnoses included traumatic brain injury, schizoaffective disorder, bipolar disorder, schizophrenia-paranoid type. -Orientation was noted as not applicable for constantly disoriented and not applicable for intermittently disoriented.</p> <p>Review of the Resident Register for Resident #4 revealed she was admitted to the facility on 12/01/12.</p> <p>Interview on 02/25/16 at 4:15 pm with Resident #4 revealed: - She moved to her current location in August/September of 2015. - "I'm not crazy, I take my meds so I don't have those problems." - Within last couple of weeks Resident #4 was told not to go to the building where Staff B worked except on the porch to socialize. - Staff B had made passes at 6 different residents and she provided the names of each of the other residents. - Staff B told her to come over at certain times and "gave him oral sex in his bedroom when the doors were locked". -"It happened a lot during the summer and spring." - It had happened several times since she had moved to her current house.</p>	C 185		

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C 185	<p>Continued From page 8</p> <ul style="list-style-type: none"> - "He won't force himself on you, he always asks would you give me a oral sex." - She didn't feel uncomfortable she felt sorry for him as he was lonely and his wife was in another state. -A couple of weeks ago Staff B approached her outside the building when he was walking his dog and ask her to tell the Department of Social Services she "was out of her mind" as he could get into a lot of trouble for what they did. - Staff B came to the house about a month ago and was in Resident #4's room with Resident #1, all three were sitting on the bed, he would kiss one of them on the cheek and then turn his head and kiss the other one. - "I can't say for sure about (Resident #1's name) but he said things to her like "Let's make romantic noises together." - "I don't know if he was paying her or what but she was always asking him when he was getting paid or didn't he get paid today." <p>Confidential interview with a staff members revealed:</p> <ul style="list-style-type: none"> - Staff B may have intimidated Resident #3 because she had made sexual accusations about Staff B. - Resident #3 wanted a cigarette and Staff B would not give her one. - Resident #3 said "It's ok for (named Resident #4) and me to give you oral sex but it's not ok for me to ask you for a cigarette." - "That was back when (called name of staff member) was still here about 3 weeks ago." - "Feels (Staff B's name) is an honest person." - The Property Manager had spoken with the Administrator regarding Staff B and inappropriate behavior after each incident. - "This isn't the first time this has happened." - "Its an ongoing issue" since he has been at Unit 	C 185		

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C 185	<p>Continued From page 9</p> <p>H.</p> <ul style="list-style-type: none"> - "Property Manager hears it all and then she tells Administrator." - " I heard it from the Property Manager and the Administrator." <p>Interview with Staff B on 02/26/16 at 1:00pm.</p> <ul style="list-style-type: none"> - "I don't interact with females and I have no reason to do so." - Resident #4 used to live in Staff D's building (Unit G) but they transferred her to the building where she is now. - I think (said Resident #4's name) said something inappropriate about Staff D and that's why she had to move." - When female residents come to my house they are allowed on the porch not in the residents rooms. - No one talked to him 2 weeks ago about Resident #4 and the accusation of sexual exploitation. - "There was a Adult Protective Services (APS) worker that came out asking questions." - The Worker (APS) said Resident #4 "knew how my room looked." - "I don't know where those statements would have come from," or why Resident #4 would have said that. - "They (referring to the residents) have a lot of mental illness." - "I have never had a physical relationship with any resident." - Resident #4 is known for saying a lot of things like that "it's why she was moved" from G building. - He does walk his dog around the property daily and does walk the dog by the house where Resident #4 resides. - He could not imagine why anyone would say he had done anything with a resident. 	C 185		

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C 185	<p>Continued From page 10</p> <p>An interview on 03/02/16 at 11:15am with a Mental Health provider for Resident #4 revealed:</p> <ul style="list-style-type: none"> - Resident #4 had been seen by him for several years. - Resident #4 had a significant trauma history. - "Its concerning that a person in power would put her in that position again." - Resident #4 has been worried about "doing something wrong and not wanting to get anyone in trouble." <p>Resident #4 reported "A male SIC asked her to give him oral sex."</p> <ul style="list-style-type: none"> - Resident #4 reported "She wouldn't have done it if he had not asked." - Resident #4's mood was within normal limits, very matter of fact. - Resident #4 told another resident (Resident #2) and a staff member (referring to SIC's spouse at another house.) about she and Staff B having oral sex. - Resident #4 reported that he touched the breast and bottom of Resident #1. - The main contact for the facility is the Property Manager (PM). - He, Resident #4 and the PM had a discussion during Resident #4's visit that the incident needed to be reported to Department of Social Services (DSS). - The Property Manager asked "that DSS not be called to call her direct". - The day DSS came out to the facility the Property Manager went to Resident #4's day program to talk with her. - The Property Manager called last week and left a message stating SIC had to be moved to another facility due to Resident #4 paranoia. - "Yes, I believe that she did perform oral sex on him." - During Resident #4's 02/12/16 visit she shared 	C 185		

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C 185	<p>Continued From page 11</p> <p>the interlude between herself, Resident #1 and Staff B.</p> <p>-Resident #4 usually has an appointment once every month to 5 weeks but in February she was seen 02/05/16, 02/12/16 and 02/19/16 since this issue has come up."</p> <p>- A couple of weeks ago when DSS came out to the facility Resident #4 reported Staff B approached her when he was walking his dog and asked her to tell DSS "she was out of her mind" as he could get into alot of trouble for what they did."</p> <p>-He did not threaten her according to Resident #4.</p> <p>Confidential resident interviews revealed:</p> <p>-Resident #4 told me he made advances towards her. Resident # 4 said I felt sorry for him and gave him oral sex. "Yes! It happened, in his bedroom. I think the last time was about a month ago." I believe her, she doesn't have good judgement, she should have known better than to feel sorry for him and do that."</p> <p>- There had been some ladies in the house to see him. They went back into his room but I don't sit around and watch."</p> <p>- Staff B and Resident #1 seem to be in a relationship because of the way they talk to each other and she goes to into his facility.</p> <p>- "(Resident #1, Resident #3 names) and another lady (identified as Resident #4) have been in the house to see Staff B.</p> <p>-Ladies (names of Resident #3 and Resident #1) come over, to see him (Staff B).</p> <p>- "Nothing surprises me here, it's a zoo."</p> <p>- Resident was told by "someone who knows that there have been sexual favors with Resident #4 and Resident #3.</p> <p>Interview on 02/26/16 at 1:00pm with Staff B</p>	C 185		

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C 185	<p>Continued From page 12</p> <p>revealed:</p> <ul style="list-style-type: none"> - He had been sent to work at this facility and had been there for the past 3 years. - He had been a Supervisor-in-Charge (SIC) at a sister facility for 4 years prior to being moved to his current facility. - He had the only all male building in the cluster group. - "Females are only allowed on the outside porch and not inside." - "I work hard with my guys." - "I never interact with the other buildings." - "Everyone has access to each of the buildings." - Male and female residents "go to the football parties." - He did not feel he had any problems with any of the residents. - He only had 10 hours off a week and the rest of his time was spent in his building. <p>An interview on 02/29/16 at 3:45pm with the Adult Home Specialist revealed she had not received an accident/incident report for the 08/07/14 event nor the 02/11/16 event.</p> <p>Interview on 03/01/16 at 3:47pm with the Property Manager (PM) revealed:</p> <ul style="list-style-type: none"> - She oversees the daily operation of the 4 cluster homes. - "My expectations are to treat people with respect." - She did interview the residents in the building about Resident #4 and Staff B. - She informed the Administrator of the accusations regarding Staff B and the results of her interviews with the residents of Staff B's house. - If anything was going on she felt it was "consensual to go to his room and perform oral sex". 	C 185		

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C 185	<p>Continued From page 13</p> <ul style="list-style-type: none"> - "Resident #4 says she was asked to give oral sex over the summer." - The PM saw Resident #4 every day and the resident did not tell me." - Resident #4 told another resident and her therapist about the incident. - PM spoke with Resident #4 about accusations someone was cutting her hair, conversations about threesomes and sexual things. - "She would get very explicit." - The facility tried to decrease Resident #4's anxiety through mental health. - "She (referring to Resident #4) is still traumatized" from this incident. - "I never had any concerns about Staff B." - Staff B never had anything of a sexual nature on the premises. - "You should never mistreat a resident it doesn't matter who it is." - "We really care about these residents." - "We could have looked at the camera if we had known this was happening with Resident #4 as we could have looked at the house cameras but they only go back 90 days." - "No one saw (Resident #4's name) go in there, what happens if it didn't happen." - "Not even one person saw Resident#4 go in the house (where Staff B resided) and I have to be able to prove it." - "This could mess up somebody's life." <p>Interview with Administrator on 03/03/16 at 2:22pm revealed:</p> <ul style="list-style-type: none"> -In February 2016, Adult Protective Services (APS) had to come out on an allegation that was made of sexual exploitation on Resident #4. - APS said they had reviewed a report. - She was unaware until that time of any concern with Staff B. - The Property Manager went that day to the 	C 185		

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C 185	<p>Continued From page 14</p> <p>resident's day program to interview Resident #4 about last spring and summer.</p> <ul style="list-style-type: none"> - She stated Resident #4 "understood what she was doing." - Resident #4 told her she had given him oral sex of her own free will. - Resident #4 was reported as saying she had told another resident but had not told Property Manager. - The Property Manager then called Resident #4's therapist. - The Property Manager interviewed the residents of Staff B's facility. - "No one could recall or would come out and say it happened." - "Staff B said he never did anything with any of the residents." - "There were no findings." - "The police were not called with (Resident #4's incidents) I did not feel it was necessary". - She determines if it's necessary by "looking at the residents historical pattern, talking with their therapist and then I make a judgement call". - "There was another allegation in the past (08/07/14)" on Staff B. - She "could not remember" what Staff B had told her. - The Property Manager had "filed a report and contacted the police". - "No one recommended taking out charges." - "The police did whatever they do." - "There were no charges filed and he returned to work." - The Administrator could not provide an explanation as to why there was no documentation the facility had completed an investigation nor was there any documentation the NC Health Care Personnel Registry or the County Department of Social Service had been notified. 	C 185		

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C 185	<p>Continued From page 15</p> <ul style="list-style-type: none"> - "There was no reason for him not to be working." - There was another incident in February 2016 where the County Adult Protective Services (APS) came out to investigate a complaint that involved Staff B sexually abusing a resident. - A 24 hour report was made to the Health Care Personnel Registry on 02/12/16 by the Administrator. - A 5 day report was made to the Health Care Personnel Registry on 02/18/16 by the Administrator. - Residents in the house where Staff B resided were interviewed as well as the female resident involved. - There was no documentation that Staff B had been interviewed by the facility Administration. - The County Adult Home Specialist (AHS) was not notified as the complaint came from the County APS. - The Administrator did not think they needed to notify their AHS since the County Department of Social Services had called her about it. <p>THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 3, 2016.</p> <p>Plans of Protection were received from the Administrator on 2/26/16 and 2/29/16 by the Office Manager for houses G, H, I, and J. which included:</p> <ul style="list-style-type: none"> -Accused individual will be removed from the site, will not return until investigation is complete. -Accused individual instructed to have no contact with residents on the site pending the outcome of the investigation. 	C 185		

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C 249	Continued From page 16	C 249		
C 249	<p>10A NCAC 13G .0902(c)(3)(4) Health Care</p> <p>10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure that 1 of 4 sampled residents (Resident # 3) received follow-up for an order from the physician for referral to dermatology, gastroenterology and orthopedics.</p> <p>The findings are:</p> <p>Review of Resident Register for Resident #3 revealed a date of admission of 12/11/2009.</p> <p>Review of the current FL2 dated 10/21/2015 for Resident #3 included: -Diagnoses of bipolar disorder, hypertension, tremors, schizophrenia, hypothyroidism, atopic dermatitis, anxiety, agitation, memory disturbance, Alzheimer's, open reduction internal fixation (orif) right ankle fracture. -Medications including Amlodopine 5mg. 1 tablet by mouth for heart and blood pressure; Clonazepam (for anxiety) 1mg by mouth at bed; Divalproex ER (for bi-polar disorder) 500mg 1 tab twice daily; HCTZ (a fluid pill) 25mg tablets; 1 by mouth every morning; Hydrocerin cream (for dry skin) 4 times daily; Levothyroxine (for thyroid); 100mcg tablets 1 daily for thyroid; Montelukast (for allergies) 10mg tabs 1 by mouth daily;</p>	C 249		

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C 249	<p>Continued From page 17</p> <p>Propranolol ER (for hypertension) 50mg; 1 capsule at bed for hypertension; Risperidone ER (extended release) 1mg; 2 tabs at bed for thought disorder; Risperidone 1mg daily; Triamcinolone (a topical ointment to treat itching, redness, dryness, crusting, scaling, inflammation and discomfort) 0.1% ointment apply twice daily; Trihexyphenidyl 2mg tabs 1 tablet three times a day for abnormal movements; Ziprasadone (antipsychotic) 50mg caps; 1capsule by mouth at bed; Immodium (an antidiarrheal) 2mg tabs with water for loose stool; Combivent Inhaler (for breathing problems) 2 puffs by mouth 4 times daily; Ibuprofen (for pain) 500mg, 1 tablet every 6 hours as needed; Risperidone 1mg tablet - ½ tablet twice daily as needed for psychosis.</p> <p>Review of a Report of Consultation with physician dated 05/26/2015 revealed: -Findings of "left leg swollen" and "ankle edema". -Recommendation to "refer to Ortho if no better" .</p> <p>Review of a Report of Consultation with physician dated 06/25/2015 revealed: -Concerns of severe redness on right wrist and forearms. -Findings of "rash right hand for one month." -Referral to Dermatology.</p> <p>Review of a Report of Consultation with physician for Resident # 3 dated 02/17/2016 revealed: -Findings of "blood in stool". -Findings of "right shoulder pain". -Referral to Gastroenterology. -Referral to Orthopedic.</p> <p>Record review for Resident # 3 revealed: -No documentation of appointment with dermatology (from June referral), orthopedics or gastroenterology.</p>	C 249		

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C 249	<p>Continued From page 18</p> <p>-No documentation about resident ankle getting better.</p> <p>Interview with Resident #3 on 02/29/2016 at 2:00 PM revealed:</p> <p>-The rash that the resident had on her hand went away.</p> <p>-She is not currently having problems with a rash on her hand.</p> <p>-The resident's arm is difficult to move due to problems with her shoulder.</p> <p>-She had a problem with pain and swelling in her ankle last year.</p> <p>-Resident had blood in her stool, but that was "quite some time ago."</p> <p>Observation of Resident #3 at 2:00 PM on 02/29/2016 revealed:</p> <p>-No obvious rash on hand.</p> <p>-Resident demonstrated limitations in movement with her right shoulder.</p> <p>Interview with Business Office Manager on 02/29/2016 at 2:30 PM revealed:</p> <p>-The ankle problem that was identified on visit on documentation from 05/26/2015 visit stated "if no better."</p> <p>-Resident #3 ankle did get better so did not warrant a referral to orthopedics.</p> <p>-The dermatology appointment was not made for Resident #3.</p> <p>-There was staff turnover at the time that Resident #3 needed to go to dermatologist, so staff at the time did not follow-up.</p> <p>-An appointment will be made immediately.</p> <p>-Referrals for orthopedics and gastroenterologist were sent over on 02/17/2016.</p> <p>-Additional information was sent today (02/29/2016) for referral to orthopedic and</p>	C 249		

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C 249	Continued From page 19 gastroenterologist. -It is hard to tell if there would have been follow-up for these appointments, had it not been identified. -SIC is responsible for follow-up on appointments.	C 249		
C 257	10A NCAC 13G .0904(a)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure all food items, stored, prepared, or served by the facility were protected from contamination. The findings are: Observation of the kitchen reffridgerator on 02/25/16 during the initial morning tour revealed: - A 1 gallon clear plastic bag with fried chicken was not labeled or dated sitting on the second shelf in the reffridgerator. - A 1 gallon clear plastic bag with 4 raw pieces of chicken breast sitting in a round metal bowl was not dated or labeled sitting on the second shelf in the reffridgerator. - A clear plastic bag contained 1/2 of a cream pie that was not labeled or dated in the very back of the third shelf in the reffridgerator. - An unopened bottle of Probiotic Acidophilus was on the top shelf of the refrigerator door that belonged to the Supervisor-in-Charge (SIC).	C 257		

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C 257	<p>Continued From page 20</p> <p>Observation of the kitchen refridgerator on 02/25/16 at 1:00pm after lunch revealed:</p> <ul style="list-style-type: none"> - A 1 gallon clear plastic bag with fried chicken was not labeled or dated still sitting on the second shelf. - A 1 gallon clear plastic bag with 4 raw pieces of chicken breast sitting in a round metal bowl was not dated or labeled sitting on the second shelf. - A clear plastic bag contained 1/2 of a cream pie that was not labeled or dated sitting in the very back of the third shelf in the refridgerator. - An unopened bottle of Probiotic Acidophilus was on the top shelf of the refrigerator door that belonged to the (SIC). <p>An interview with the Supervisor-in-Charge (SIC) on 02/25/16 at 1:45pm revealed:</p> <ul style="list-style-type: none"> - Leftovers are placed in a container and placed in the refrigerator. - "The chicken in the refrigerator is for tonight's dinner." - "I usually label but I don't label my own stuff." - "The Probiotics in the fridge is mine." - "Its just over the counter is not a prescription." <p>An interview with the Property Manager on 2/25/16 at 1:45pm revealed:</p> <ul style="list-style-type: none"> - Foods should be stored, labeled and dated appropriately. - The Property Manager explained to SIC that even over the counter medications or supplements should not be kept in the kitchen refrigerator. - "We will take care of getting everything labeled and dated today." <p>Observation of the dinner meal on 02/25/16 at 5:00pm revealed:</p> <ul style="list-style-type: none"> - The SIC was plating resident plates with chicken 	C 257		

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C 257	Continued From page 21 thighs no chicken breast and lima beans. - There was a green garden salad on the table with each place setting.	C 257		
C 264	<p>10A NCAC 13G .0904(c)(1) Nutrition And Food Service</p> <p>10A NCAC 13G .0904 Nutrition And Food Service (c) Menus in Family Care Homes: (1) Menus shall be prepared at least one week in advance with serving quantities specified and in accordance with the Daily Food Requirements in Paragraph (d) of this Rule.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record review the facility failed to utilize a menu in the preparation of meals.</p> <p>The findings are:</p> <p>Observation on 02/25/16 at 11:45am revealed the following food items for the residents meal: - There was no posted menu. - A sandwich with turkey, regular mayonnaise, a lettuce leaf. - A bowl of chicken noodle soup - 8oz. milk beverage - A small cup of mandarin oranges. 1 resident recieved potato chips and a diet cola drink with her sandwicks.</p> <p>Interview on 02/25/16 at 11:58am with the Supervisor-in-Charge (SIC) revealed: - She had been the SIC for the past 5 months. - "I just substitute with what I have." - She was unaware if the facility had a registered dietician to prepare or review the menu's.</p>	C 264		

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C 264	<p>Continued From page 22</p> <ul style="list-style-type: none"> - The SIC pulled out a clear packet with a wet old menu out of the drawer beside the stove. -The menu was from October, November and December of 2013. - "I don't use menus, I eat healthy and I fix them healthy meals with what I have." "We have diabetics, I just keep them away from sugars." <p>Interview on 02/26/16 at 10:15am with the Business Office Manager (BOM) revealed:</p> <ul style="list-style-type: none"> -She was unaware the SIC did not have a menu book. -The SIC was responsible for using the facilities menu book and she would have one to her by 02/29/16. -She expected the SIC to follow the diets as ordered by the physician in accordance to their menus. <p>Observation on 02/29/16 at 10:00am BOM delivered menu book signed by a Registered Dietician to SIC and reviewed the menu book with her.</p>	C 264		
C 284	<p>10A NCAC 13G .0904(e)(4) Nutrition and Food Service</p> <p>10A NCAC 13G .0904 Nutrition and Food Service</p> <p>(e) Therapeutic Diets in Family Care Homes:</p> <p>(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide a no concentrated sweets diet as ordered by the</p>	C 284		

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C 284	<p>Continued From page 23</p> <p>physician for 2 of 3 sampled residents (Resident #1 and #6).</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL2 dated 02/20/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses that included diabetes mellitus. - A no concentrated sweets diet (NCS). - Resident was on sliding scale insulin. <p>A review of the resident register revealed Resident #1 was admitted to the facility on 07/26/13.</p> <p>A rerord of Resident #1's Medication Administration Record (MAR) revealed:</p> <ul style="list-style-type: none"> - She used her sliding scale insulin 4 times during January 2016. - She used her sliding scale insulin 1 time in February 2016. <p>Blood sugar checks for Resident #1 revealed:</p> <ul style="list-style-type: none"> - On 1/5/16 revealed a blood sugar of 163 and required 2 unit dosages of insulin at 7am. - On 1/5/16 revealed a blood sugar of 152 and required 2 unit dosages of insulin at 4pm - On 1/8/16 revealed a blood sugar of 166 and required 2 unit dosages of insulin at 4pm. - On 1/24/16 revealed a blood sugar of 166 and required 2 unit dosages of insulin at 4pm. - On 1/5/16 revealed a blood sugar of 163 and required 2 unit dosages of insulin at 7am. - On 2/3/16 revealed a blood sugar of 155 and required 2 unit dosages of insulin at 7pm. <p>Interview on 02/25/16 at 11:30am with Resident #1 revealed:</p> <ul style="list-style-type: none"> - She does her own blood sugar checks 4 times a day and gives her own insulin. 	C 284		

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C 284	<p>Continued From page 24</p> <ul style="list-style-type: none"> - She doesn't feel she gets enough food. - At lunch "we just have sandwiches" daily. - Her blood sugar has been running low between 60-80. - SIC says "smart things" to her about it. <p>An observation on 02/25/16 at 11:45am revealed the following food items for the residents meal:</p> <ul style="list-style-type: none"> - Sandwich with turkey, regular mayonnaise and a lettuce leaf. - A bowl of chicken noodle soup. - 8oz. milk beverage. -A small cup of mandarin oranges. <p>In a interview on 02/25/16 at 11:58am with the Supervisor-in-Charge (SIC) revealed:</p> <ul style="list-style-type: none"> - She had worked at the facility since October 2015. - Her duties included medication administration, chart reviews, food preparation/cook and cleaning. - "All the residents are on a regular diet." - "I just substitute with what I have." - She did not use a menu. - She "just doesn't give (Resident #1's name) things with sugar." - She was not sure if the facility had a registered dietician that prepared or reviewed the therapeutic menus. - The SIC pulled out a clear packet with a wet old menu out of the drawer beside the stove. -The menu was from October, November and December of 2013. - "I don't use menus, I eat healthy and I fix them healthy meals with what I have." <p>"We have diabetics and I just keep them away from sugars. I can't help what they have in their rooms."</p> <p>Refer to interview on 02/25/16 at 11:58am with</p>	C 284		

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C 284	<p>Continued From page 25</p> <p>the SIC.</p> <p>2. A Review of Resident #6's current FL2 dated 10/21/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses that included diabetes mellitus, chronic migraines, cardiovascular accident - There was a physician order for a NCS diet. <p>In a review of Resident #6's Medication Administration Record (MAR) revealed:</p> <ul style="list-style-type: none"> - Her morning blood sugars ranged from 64-148 in January 2016. - Her morning blood sugars ranged from 95-130 in February 2016. <p>Observation on 02/25/16 at 11:45am revealed the following food items for the residents meal:</p> <ul style="list-style-type: none"> - A turkey sandwich, regular mayonnaise, tomato and a lettuce leaf. - Potato chips - diet cola beverage <p>Observation of the dinner meal on 05/25/16 at 5:00pm revealed:</p> <ul style="list-style-type: none"> - The SIC was plating resident plates with chicken thighs and lima beans. - There was a green garden salad on the table with each place setting. <p>Observation on 02/26/16 at 12:15pm revealed the following food items for the residents meal:</p> <ul style="list-style-type: none"> - A turkey sandwich, regular mayonnaise, tomato and a lettuce leaf. - Potato chips - diet cola beverage <p>Observation on 02/29/16 at 12:10pm revealed the following food items for the residents meal:</p> <ul style="list-style-type: none"> - A turkey sandwich, regular mayonnaise, tomato 	C 284		

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C 284	<p>Continued From page 26</p> <p>and a lettuce leaf.</p> <ul style="list-style-type: none"> - Potato chips - diet cola beverage <p>Refer to interview on 02/25/16 at 11:58am with the SIC.</p> <hr/> <p>An interview on 02/26/16 with the Office Manager (OM) revealed:</p> <ul style="list-style-type: none"> - She was unaware the SIC did not have a menu book. - The SIC was responsible for using the facilities menu book and she would have one to her by 02/29/16. - She expected the SIC to follow the diets as ordered by the physician in accordance to their menus. 	C 284		
C 311	<p>10A NCAC 13G .0909 Residents' Rights</p> <p>10A NCAC 13G .0909 Resident Rights A family 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.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interviews and record reviews the facility failed to ensure residents were free from abuse and exploitation as related to an allegation of sexual assault to one resident (#4) by one staff (Staff B) not being investigated or reported to the Health Care Personnel Registry until investigation by county staff.</p>	C 311		

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C 311	<p>Continued From page 27</p> <p>The findings are:</p> <p>A review of Resident #4's current FL2 dated 10/21/15 revealed:</p> <ul style="list-style-type: none"> - Diagnosis included traumatic brain injury, schizoaffective disorder, bipolar disorder, schizophrenia-paranoid type. -Orientation was noted N/A for constantly disoriented and N/A for intermittently disoriented. <p>Review of the Resident Register for Resident #4 revealed she was admitted to the facility on 12/01/12.</p> <p>Interview on 02/25/16 at 4:15 pm with Resident #4 revealed:</p> <ul style="list-style-type: none"> - She moved to her current location in August/September of 2015. - "I'm not crazy, I take my meds so I don't have those problems." - Within last couple of weeks Resident #4 was told not to go to the building where Staff B worked except on the porch to socialize. - Staff B had made passes at 6 different residents and she provided the names of each of the other residents. - Staff B told her to come over at certain times and "gave him oral sex in his bedroom when the doors were locked". - "It happened a lot during the summer and spring." - It had happened several times since she had moved to her current house. - "He won't force himself on you, he always asks would you give me a oral sex." - She didn't feel uncomfortable she felt sorry for him as he was lonely and his wife was in another state. -A couple of weeks ago Staff B approached her 	C 311		

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C 311	<p>Continued From page 28</p> <p>outside the building when he was walking his dog and ask her to tell the Department of Social Services she "was out of her mind" as he could get into a lot of trouble for what they did.</p> <ul style="list-style-type: none"> - Staff B came to the house about a month ago and was in Resident #4's room with Resident #1, all three were sitting on the bed, he would kiss one of them on the cheek and then turn his head and kiss the other one. - "I can't say for sure about (Resident #1's name) but he said things to her like "Let's make romantic noises together." - "I don't know if he was paying her or what but she was always asking him when he was getting paid or didn't he get paid today." <p>Interview with Staff B on 02/26/16 at 1:00pm.</p> <ul style="list-style-type: none"> - "I don't interact with females and I have no reason to do so." - Resident #4 used to live in Staff D's building (Unit G) but they transferred her to the building where she is now. - When female residents come to my house they are allowed on the porch not in the residents rooms. - No one talked to him 2 weeks ago about Resident #4 and the accusation of sexual exploitation. - "There was a Adult Protective Services (APS) worker that came out asking questions." - The Worker (APS) said Resident #4 "knew how my room looked." - "I don't know where those statements would have come from," or why Resident #4 would have said that. - "They (referring to the residents) have a lot of mental illness." - "I have never had a physical relationship with any resident." - Resident #4 is known for saying a lot of things 	C 311		

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C 311	<p>Continued From page 29</p> <p>like that "it's why she was moved" from G building.</p> <ul style="list-style-type: none"> - He does walk his dog around the property daily and does walk the dog by the house where Resident #4 resides. - He could not imagine why anyone would say he had done anything with a resident. <p>An interview on 03/02/16 at 11:15am with a Mental Health provider for Resident #4 revealed:</p> <ul style="list-style-type: none"> -Resident #4 had been seen by him for several years. -Resident #4 had a significant trauma history. -"Its concerning that a person in power would put her in that position again." -Resident #4 has been worried about "doing something wrong and not wanting to get anyone in trouble." -Resident #4 reported "A male SIC asked her to give him oral sex." - Resident #4 reported "She wouldn't have done it if he had not asked." -Resident #4's mood was within normal limits, very matter of fact. -Resident #4 told another resident and a staff member (referring to SIC's spouse at another house.) about she and Staff B having oral sex. -Resident #4 reported that he (Staff B) touched the breast and bottom of Resident #1. -"Yes, I believe that she did perform oral sex on him." -During Resident #4's 02/12/16 visit she shared the interlude between herself, Resident #1 and Staff B. -"Resident #4 usually has an appointment once every month to 5 weeks but in February she was seen 02/05/16, 02/12/16 and 02/19/16 since this issue has come up." - A couple of weeks ago when DSS came out to the facility Resident #4 reported Staff B 	C 311		

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C 311	<p>Continued From page 30</p> <p>approached her when he was walking his dog and asked her to tell DSS "she was out of her mind" as he could get into alot of trouble for what they did." -He did not threaten her according to Resident #4.</p> <p>Confidential resident interview revealed: -Resident #4 told me he made advances towards her. -She said I felt sorry for him and gave him oral sex. - "Yes! It happened, in his bedroom. I think the last time was about a month ago." -I believe her, she doesn't have good judgement, she should have known better than to feel sorry for him and do that." - "There had been some ladies in the house to see him." - "They went back into his room but I don't sit around and watch." - "I don't want to be around that kind of thing (referring to Staff B and the ladies)." - Staff B and Resident #1 seem to be in a relationship because of the way they talk to each other and she goes to into his facility. - "(Resident #1, Resident #3 names) and another lady (identified as Resident #4) have been in the house to see Staff B. - "Ladies do come over, to see him, (names of Resident #3 and Resident #1). - Resident was told by "someone who knows that there have been sexual favors with Resident #4."</p> <p>Interview on 02/26/16 at 1:00pm with Staff B revealed: - He had been sent to work at this facility and had been there for the past 3 years. - He had been a Supervisor-in-Charge (SIC) at a sister facility for 4 years prior to being moved to</p>	C 311		

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C 311	<p>Continued From page 31</p> <p>his current facility.</p> <p>Confidential interview with a staff members revealed:</p> <ul style="list-style-type: none"> - Staff B may have intimidated Resident #3 because she had made sexual accusations about Staff B. - Resident #3 wanted a cigarette and Staff B would not give her one. - Resident #3 said "It's ok for (named Resident #4) and me to give you oral sex but it's not ok for me to ask you for a cigarette." - "That was back when (name of staff member) was still here about 3 weeks ago." - The Property Manager had spoken with the Administrator regarding Staff B and inappropriate behavior after each incident. - "This isn't the first time this has happened." - "Its an ongoing issue" since he has been at Unit H. <p>Interview with Administrator on 03/03/16 at 2:22pm revealed:</p> <ul style="list-style-type: none"> -In February 2016, Adult Protective Services (APS) had to come out on an allegation that was made of sexual exploitation on Resident #4. - APS said they had reviewed a report. - She was unaware until that time of any concern with Staff B. - The Property Manager went that day to the resident ' s day program to interview Resident #4 about last spring and summer. - She stated Resident #4 "understood what she was doing." - Resident #4 told her she had given him oral sex of her own free will. - Resident #4 was reported as saying she had told another resident but had not told Property Manager. - The Property Manager then called Resident #4's 	C 311		

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C 311	<p>Continued From page 32</p> <p>therapist.</p> <ul style="list-style-type: none"> - The Property Manager interviewed the residents of Staff B' facility. - "No one could recall or would come out and say it happened." - "Staff B said he never did anything with any of the residents." - "There were no findings." - "The police were not called with (Resident #4's incidents) I did not feel it was necessary". - She determines if it's necessary by "looking at the residents historical pattern, talking with their therapist and then I make a judgement call". - "There was another allegation in the past (08/07/14)" on Staff B. - She "could not remember" what Staff B had told her. - The Property Manager had "filed a report and contacted the police". - "No one recommended taking out charges." - "The police did whatever they do." - "There were no charges filed and he returned to work." - The Administrator could not provide an explanation as to why there was no documentation the facility had completed an investigation nor was there any documentation the NC Health Care Personnel Registry or the County Department of Social Service had been notified. - "There was no reason for him not to be working." - There was another incident in February 2016 where the County Adult Protective Services (APS) came out to investigate a complaint that involved Staff B sexually abusing a resident. - A 24 hour report was made to the Health Care Personnel Registry on 02/12/16 by the Administrator. - A 5 day report was made to the Health Care 	C 311		

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C 311	<p>Continued From page 33</p> <p>Personnel Registry on 02/18/16 by the Administrator.</p> <ul style="list-style-type: none"> - Residents in the house where Staff B resided were interviewed as well as the female resident involved. -There was no documentation that Staff B had been interviewed by the facility Administration . <p>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 18, 2016.</p> <hr/> <p>Plans of Protection were received from the Administrator on 2/26/16 and 2/29/16 by the Office Manager for houses G, H, I, and J. which included:</p> <ul style="list-style-type: none"> -Accused individual will be removed from the site, will not return until investigation is complete. -Accused individual instructed to have no contact with residents on the site pending the outcome of the investigation. 	C 311		
C 914	<p>G.S 131D-21(4) Declaration Of Resident's Rights</p> <p>Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure residents were free of neglect and free of abuse and exploitation as evidenced by the failure to investigate allegations of sexual explotation by a staff member (Staff B) related to sexual battery and not reporting to Health Care Personnel Registry.</p> <p>The findings are:</p>	C 914		

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C 914	<p>Continued From page 34</p> <p>A. Based on interviews and record reviews, the administrator failed to be responsible for the operation of the home as evidenced by the continued employment of a staff (Staff B) after reported allegations of sexual assault and exploitation by one staff (Staff B), with no investigation by the facility of the allegations or reporting of the allegations to the Health Care Personnel Registry; and failed to investigate additional allegations of sexual abuse and exploitation reported by residents or report the allegations to the Health Care Personnel Registry until investigation by the local county Department of Social Services. [Refer to Tag 185, 10A NCAC 13G .0601 (a) Management and Other Staff (A2 Violation)].</p> <p>B. Based on interviews and record reviews the facility failed to ensure residents were free from abuse and exploitation as related to an allegation of sexual assault to one resident (#4) by one staff (Staff B) not being investigated or reported to the Health Care Personnel Registry until investigation by county staff. [Refer to Tag 311, 10A NCAC 13G .0909 Resident Rights (Type B Violation)].</p>	C 914		