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F 000	INITIAL COMMENTS The surveyor entered the facility on 7/12/23 to conduct a complaint survey and exited on 7/13/23. Additional information was obtained on 7/14/23 and 7/17/23. Therefore, the exit date was changed to 7/17/23. The following intakes were investigated NC00203891, NC00195694, NC0000196298. and NC 00196725. Past-noncompliance was identified at: CFR 483.12 at tag F 600 at a scope and severity G Non-noncompliance began on 5/1/23. The facility came back in compliance effective 6/1/23.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, Psychiatric Nurse Practitioner interview,	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/21/2023

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and Medical Director interview, the facility failed to protect the rights of a severely cognitively impaired resident to be free of abuse. Resident # 11, who was severely cognitively impaired, was observed by facility staff on 5/1/23 sexually fondling Resident # 8, who was moderately cognitively impaired and had a history of asking for individuals to perform sexual acts for him. Prior to this 5/1/23 incident occurring, staff had observed Resident # 11 alone in Resident #8's room on 2/13/23, and Resident #11 had his hand on top of Resident #8's bed covers at a position below Resident #8's waist. The reasonable person concept was applied to this deficiency as individuals would 1) not want to be coerced into performing sexual acts for others and 2) not want to be taken advantage of sexually when they lacked the cognitive ability to make sexual decisions. This was for one (Resident #11) of three residents reviewed for abuse. The findings included:

Record review revealed Resident # 8 was admitted to the facility on 3/14/15. The resident had diagnoses which included in part vascular dementia, cerebrovascular accident, bipolar disorder, mood disorder with depressive features, and anxiety disorder. On 8/22/22 the diagnosis of sexual disorder was added to a list of his diagnoses.

Resident # 8's annual Minimum Data Set assessment (MDS), dated 2/10/23, coded Resident # 8 as moderately cognitively impaired. He was assessed to have wandering behavior and walked with supervision. He was not assessed to have any other behaviors other than wandering during the MDS assessment period.

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Resident # 8's care plan, updated on 5/4/23, revealed Resident # 8 resided on the facility's secure memory support unit. This had been added to his care plan on 11/18/19 and remained part of his care plan. The care plan also noted Resident # 8 had sexual behaviors since his admission to the facility and would inappropriately touch staff. Some of the interventions on Resident # 8's care plan included to redirect the resident and intervene as needed to protect the rights of others.

Record review revealed Resident # 11 was admitted to the facility on 5/19/17 and had a diagnosis of vascular dementia.

Resident # 11's quarterly MDS assessment, dated 1/9/23, revealed the resident was severely cognitively impaired, had wandering behavior, and independently ambulated in the unit. Resident # 11 was not coded as having any behaviors other than wandering.

Review of Resident # 11's care plan, last updated on 7/11/23, revealed the resident resided on the secure memory support unit. This had been added to the care plan on 10/2/20 and remained part of his current care plan.

On 2/13/23 at 3:42 PM the memory support unit manager made a nursing entry into Resident # 11's record noting the following. "CNA (certified nursing assistant) reported seeing resident touching the lower half of another resident's body. Resident stated he usually massage (massaged) the other resident's shoulder and back at resident's request. Wife informed of incident. MD (medical director) informed."

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Review of the facility's investigation into the incident revealed Nurse Aide (NA) # 1 was the NA who witnessed the incident. NA # 1 had provided a written statement to the facility regarding the incident. The statement read, "I [NA #1] was conducting rounds on February 13, 2023 on MSU (Memory Support Unit) when I walked past [Resident # 8's room] and saw [Resident # 11] had (hand) on top of the covers of [Resident #8's] bed. I redirected. I reported what I saw to my supervisor."

NA # 1 was not available for interview during the survey.

On 2/15/23 at 2:37 PM the Social Worker made an entry into Resident # 11's record noting the following. "Resident was found in another resident's room giving him a massage. Staff confirmed that this is not common for him to provide massages or to touch another resident on the wing but did due to the request of that resident. Staff intervened immediately and he was redirected away from the other resident's room. The resident was also moved to another room further down the hall. Writer will continue to monitor and intervene as appropriate."

On 2/14/23 Resident # 8 was seen by the Psychiatric Nurse Practitioner (NP) who noted the following in her progress note. She had been requested to see Resident # 8 for inappropriate sexual touching behavior. He had already been prescribed Paxil (an antidepressant) and Depakote (a medication used at times for bipolar disorder) for behavioral disturbance and sexual aggression. The Psychiatric NP noted she would recommend increasing his Depakote and placing him on Risperdal because research had shown

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Risperdal benefited residents with dementia who displayed sexual behaviors.

According to the record, orders were initiated on 2/15/23 for Resident # 8 to start Risperdal 0.25 mg (milligrams) every night at bedtime. On 3/7/23 the dosage was increased to 0.5 mg every night at bedtime. At the time of the addition of the Risperdal, Resident # 8 was already prescribed Divalproex (Depakote) extended release 500 mg twice per day. This had been prescribed on 1/18/23.

Resident # 8's behavioral care plan was updated with interventions on 2/14/ 23 and 2/16/23. The behavioral problem was also updated to reflect, "Resident engaged with another resident inappropriately on 2/13/23." The 2/14/23 intervention was to assess whether the behavior endangered the resident/ and or others. Intervene as necessary. The 2/16/23 intervention noted that there was a medication update for Resident # 8.

The Unit Manger was interviewed on 7/13/23 at 5:11 PM and reported the following. She had worked as the Unit Manger since August 2022. Resident # 8 had always made sexual comments to various individuals since she had cared for him. This could include residents, staff members, and visitors. He would make remarks to both females and males. Examples of Resident # 8's remarks included such things as asking if someone wanted to experiment, asking them to sit on his lap, or pointing to his private area and asking for them to massage it. Resident # 11 was very social and liked to talk to Resident # 8 and sit with him. They were both confused and would enjoy talking together in their own confused way. Although the conversation might not make sense

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to others, their conversations seemed to bring them enjoyment. Prior to the 2/13/23 incident, there had never been any indication that Resident # 11 or any other resident had physically touched Resident # 8 in a sexual manner. On 2/13/23 NA # 1 was making rounds and saw Resident # 11 standing in Resident #8's room. Resident #8 was in bed with the covers over the top of him. Both residents were clothed. Resident # 11 had his hand below Resident #8's waist, and the cover was between his hand and Resident # 8's body. NA # 1 asked Resident # 11 what he was doing. Resident # 11 said he was just visiting a friend and he would massage his back and shoulders. NA # 1 immediately took Resident # 11 out of the room. Following the incident, Resident # 8's room was changed to be further from Resident # 11's. Resident # 8's new room was closer to the nursing desk, and he was not placed in a room with anyone at that time. Resident # 8, who was routinely seen for psychiatric services, was evaluated and his medication was changed. She routinely made sure NAs were on the hall monitoring residents and also in the common area at all times.

The Psychiatric NP was interviewed on 7/14/23 at 1:17 PM and reported the following. She had been seeing Resident # 8 for four years. He had always made sexually inappropriate remarks to people. This might include staff, other residents, or family members. At times he would call out to people as they passed by his door and ask them to come in or sit on his bed. All of the residents on the memory support unit had severe dementia. None of them had the cognitive ability to comprehend what "come here" means except for Resident # 11. The Psychiatric NP described Resident # 11 as "really sweet, easily persuaded,

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and gullible like a child." His cognitive abilities varied. One day he might be able to answer some questions, and the next day he would not be able to answer those same questions. She (the Psychiatric NP) was aware there was an incident in February, 2023 but no one saw exactly what happened except that Resident # 11 was in Resident # 8's room with his back to the staff member who entered. When the staff member entered, Resident # 11 had his hand on top of Resident # 8's covers. She thought Resident # 8 might have lured Resident # 11 into his room. She placed Resident # 8 on the Risperdal. According to the Psychiatric NP, one contributing factor to sexual behaviors is a high level of testosterone which makes it hard for individuals with sexual disorders to control themselves. Both Depakote and Risperdal help to decrease the testosterone. When she would talk to Resident # 8 about his behaviors, he would not acknowledge details of anything but just say he was sorry. It was hard to determine to what extent he knew what he was doing. He was not as confused as the rest of the residents on the memory support unit, but he did suffer from dementia and biopolar disorder. His dementia was progressing, and she did think he had structural brain changes happening which contributed to the problem. She also routinely saw Resident # 11, and he had no recall of the event of 2/13/23.

Review of Resident # 11's care plan revealed it was updated on 2/14/23 with the following problem. Presence of Behavioral symptoms-Exhibits socially inappropriate touching behavior. Resident lacks cognition and engaged with another resident inappropriately 2/13/23. The care plan directed that staff should observe and report socially inappropriate

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behaviors when around others; notify MD and RP (responsible party) of any changes; assess whether the behavior endangers the resident and/or others and intervene if necessary; convey an attitude of acceptance toward the resident; and redirect resident from resident's room and unsafe situations.

On 5/1/23 at 1:49 PM the Unit Manager entered a nursing entry in Resident # 8's progress notes that he had been involved in inappropriate behavior with another resident, and Resident # 8 had stated he was "just hanging out with a friend." The Unit Manager further noted behavior monitoring would continue and that Resident # 8's responsible party was notified.

On 5/1/23 at 2:04 PM the Unit Manager made a nursing entry in Resident # 11's progress notes that she had informed Resident # 11' RP that Resident # 11 had been involved inappropriate behavior with another resident. The Unit Manger further documented that behavior monitoring would continue and that the DON (Director of Nursing) and SW were notified.

Review of the facility's investigation into the 5/1/23 incident revealed a statement by NA # 1. NA # 1 wrote, "This writer was picking up trays and when passing Room [Resident # 8's room] it was observed that a resident was in the room with [Resident #8]. Upon closer observation it was [Resident # 11]. He was fondling [Resident # 8]. I proceeded to redirect [Resident # 11] out and into his room then went and reported incident to my supervisor."

Resident # 8's care plan was updated on 5/2/23 to reflect he had been engaged with another

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resident inappropriately on 5/1/23. The care plan reflected he had been placed on one on one supervision following the incident.

Resident # 11's care plan was updated on 5/2/23 to reflect "Resident lacks cognition and was lured in by another resident to perform inappropriate touching on 5/1/23." Interventions included to assure he received a psych consult and to support appropriate mood and behaviors.

The Unit Manager was interviewed on 7/13/23 at 5:11 PM and again on 7/14/23 at 4:10 PM. The Unit Manager reported that both Resident # 8 and Resident # 11 were clothed when the 5/1/23 incident occurred. Resident # 11 had been found with his hand in Resident # 8's pants and moving his hand up and down. He was immediately separated by NA # 1. Resident # 8 was placed on one on one supervision.

The Administrator was interviewed on 7/13/23 at 4 PM and again on 7/13/23 at 6:50 PM and reported the following. Resident # 8 had always made sexual remarks to staff and around other residents, but the other residents on the secure memory support unit did not understand what he was talking about. He had been seen by psychiatric services for long term management of behaviors, and he never had displayed any sexual physical aggression or coerced a resident into doing anything sexual before 5/1/23. Resident # 11 had been in his room on 2/13/23 but the two residents were not seen doing anything on that date other than Resident # 11 having his hand on the bed covers below Resident # 8's waist. Resident # 11 was very social and liked to be with people. He was redirected and monitored following the 2/13/23

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episode. When the 5/1/23 incident occurred, they investigated the incident and reported it to the state agency. The incident had occurred right after lunch. Both residents had just eaten in the dining room and left. NA # 1 had been on the hall monitoring residents and picking up lunch trays when she went by and saw that Resident # 11 was in Resident # 8's room. Both were clothed and had recently been seen leaving the dining room only a few minutes before the incident occurred. They were separated, and Resident # 8 was placed on one-on-one supervision. He continued on one-on-one supervision as of the survey date. They were currently seeking alternative placement, which offered more than skilled nursing care, for Resident # 8 where he could receive psychiatric treatment. She had informed the responsible party of both residents regarding the incident. They had updated Resident # 11's care plan to reflect he was lured into the room in order that Resident # 11's care plan show that he did not have sexual behaviors himself and he was not sexually aggressive towards anyone.

During the interview with the Psychiatric Nurse Practitioner on 7/14/23 at 1:17 PM, the Psychiatric NP reported the following. She continued to see Resident # 8 following the 2/13/23 incident and she felt he was doing well with the medication adjustment up until the 5/1/23 incident. When the 5/1/23 incident occurred, she told the staff he needed to be kept on one on one supervision. An increase in Depakote might be helpful, but Resident # 8 would not allow the staff to draw blood work, and therefore she could not increase his Depakote any further without blood work because it can cause toxicity at higher levels. Therefore, she felt he needed to reside in

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a living environment which was suited to treat his behaviors and manage his medications. The Psychiatric NP further reported that the facility keeps a lot of staff in the secure memory care unit and predominantly the residents are in the front of the unit in a common area where they are monitored when she visits.

The Medical Director was interviewed on 7/14/23 at 2:45 PM and reported the following. The staff had made him aware of Resident # 8's atypical behaviors. Resident # 8 had never assaulted anyone. He felt his behaviors were a manifestation of his advanced dementia and that Resident # 8 had no awareness of what he was doing when he displayed socially inappropriate sexual behaviors.

NA # 2, who worked on the memory secure unit, was interviewed on 7/13/23 at 3:50 PM and reported Resident # 8 would say sexual things to staff, but he had never witnessed Resident #8 coerce a resident to do sexual things for him or do anything inappropriate with other residents.

NA # 3, who worked on the memory secure unit, was interviewed on 7/13/23 at 6:15 PM and reported she was aware Resident # 8 would say inappropriate sexual things but she had never witnessed him coerce another resident to do sexual things for him or do anything inappropriate with other residents.

NA # 4, who worked on the memory secure unit, was interviewed on 7/13/23 at 6:17 PM and reported Resident # 8 would say inappropriate things to staff, but she had never witnessed him saying inappropriate things to other residents or doing anything inappropriate with other residents.

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NA # 5, who worked on the memory secure unit, was interviewed on 7/13/23 at 6:30 PM and reported she knew Resident # 8 would ask staff members to get in bed with him, but she had never witnessed him doing anything inappropriate with a resident.

On 7/17/23 the Administrator presented that the facility had completed a corrective action plan. The corrective action plan included the following:
Step 1.
a. Resident #8 was placed on 1:1 supervision immediately and referred to psych services on 5/1/2023. Resident #8 was added to the Behavior Management Program on 5/1/2023.
b. Resident #11 was easily redirected out of the situation and referred to psych services on 5/1/2023.
c. On 5/2/2023 the facility verified there were no other residents on the memory support unit with sexual behaviors. The behavioral management committee reviewed all residents on the memory secure unit and did not identify anyone else at risk for abuse.

Step 2.
a. Resident #8 was seen psychiatry on 5/2/2023, 5/9/2023, 5/16/2023, 6/6/2023, 7/4/2023.
b. Psychiatry ordered medication changes for Resident #8 on 5/2/2023 for Depakote 500mg to increase to 1000 mg twice daily.
c. Resident #8 was seen by the Medical Director on 5/5/2023. Medical Director ordered labs to be drawn for Resident #8.
d. SLP referral ordered for Resident #8 on 5/4/2023.

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e. Resident #8 was seen by psychotherapy on 5/10/2023 and 5/24/2023.
f. For Resident #8 a 30 -day Intent to Discharge notice was issued on 5/5/2023. Resident #8 will discharge to a psychiatric facility from the North Carolina State Veterans Home Fayetteville.
g. Resident #8 will continue on 1:1 Supervision until he is discharged from the North Carolina State Veterans Home Fayetteville.
h. Resident #11 was seen by the Medical Director on 5/2/2023.
i. Resident #11 was sent to the hospital for an unrelated syncope episode.
j. Resident #11 was seen by psychiatric services on 5/16/2023, 6/13/2023, and 7/11/2023.
Step 3.
a. Staff working on the Memory Support Unit, as they are trained in Dementia care and person-centered care, were educated on Sexual Behaviors, De-Escalation: Crisis vs Opportunity, and Contributing Factors for Behaviors on 5/10/2023.
b. Staff working the Memory Support Unit, as they are trained in Dementia care and person-centered care, we educated on 5/1/2023 to ensure Resident #8 remains on 1:1 supervision until he is discharged to a psychiatric facility from the North Carolina State Veterans Home Fayetteville.
c. Staff working on the Memory Support Unit, as they are trained in Dementia Care and person-centered care, were educated on 5/1/2023 to ensure that Resident #11 refrains from "hanging out" with Resident #8 in an effort to continue person-centered care.
d. All partners have been educated on Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property on 5/5/2023, 6/6/2023, and 7/13/2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345492	A. BUILDING _____ B. WING _____	C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS HOME - FAYETTEVILLE	214 COCHRAN AVENUE FAYETTEVILLE, NC 28301

(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) COMPLETION DATE
F 600	Continued From page 13	F 600		

Monitoring will be done 5 times per week x 4 weeks, 2 times per week x 3 months, and monthly for three months.

Step 4.
a. Administrator, Director of Nursing (RN) /Designee, Memory Support Unit Coordinator (RN)/Designee will be responsible to monitor the safety of Resident #8 and Resident #11, 5 times per week x 4 weeks, 2 times per week x 4 weeks, and monthly times 3 months.
Monitoring will occur 5 times per week for 4 weeks, then 2 times per week for 4 weeks, and monthly for 3 months. Results of the monitoring, with tracking and trending, will be reported by Director of Nursing (RN)/Designee monthly to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes.
Completion date - 6/1/2023.

The facility's corrective action plan was validated by the following.

During the survey dates of 7/12/23 and 7/13/23 Resident # 8 was observed to have a one-on-one NA with him, and other residents were being monitored and supervised. Specific observations related to Resident # 8 and Resident # 11 included the following. On 7/13/23 at 2:00 PM, Resident # 8 was in his room with a one-on-one NA. At that time Nurse # 1 reported Resident # 11 was in the shower with a NA. On 7/13/23 at 6:00 PM during meal time, Resident # 8 was observed in the common dining room at a table. There were no other residents at Resident #8's table. There was a one-on-one NA with him at the table. When Resident # 8 left the dining room, the NA

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	345492	A. BUILDING _____ B. WING _____	C 07/17/2023

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also left with him and accompanied him to his room. Resident # 11 was seated at a different table on 7/13/23 at 6:00 PM.

Other observations not specific to Resident # 8 and # 11 included the following. On 7/12/23 at 11:05 AM during an initial tour of the secured memory care unit, multiple staff members were observed in attendance and monitoring residents. Staff were both on the hallway and in the common area. An observation on 7/12/23 at 5:22 PM revealed multiple staff in attendance and monitoring residents on the secure memory unit. Staff were both in the common area and on the hallway.

Review of records revealed Resident # 8 and Resident # 11 had been seen by their health care providers as noted in the facility's plan of correction.

On 7/17/23 the facility provided documentation and sign in sheets of training as noted in their plan of correction.

On 7/13/23 Nurse Aides were interviewed and reported they were aware they were to monitor Resident # 8 for inappropriate behavior. They also confirmed they had received training as noted in the facility's plan of correction.

The facility presented documentation of audits for behavioral monitoring. Review of the records of other sampled residents, who resided on the memory support unit, revealed weekly behavioral management team meetings were being held to address behaviors.

On 7/17/23 the facility's corrective action plan

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	345492	A. BUILDING _____ B. WING _____	C 07/17/2023

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F 600	Continued From page 15 date of 6/1/23 was validated.	F 600		