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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and follow-up survey on May 13-15 and May 18, 2026.	D 000		
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the front entrance/exit doors had a continuous sounding device that was activated and audible throughout the facility when the door was opened and accessible to 3 of 3 residents (#1, #2, #3) who were documented as and known to be disoriented	D 067		

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including 2 residents who wandered and left the facility without staff's knowledge (#1, #2).

The findings are:

Review of the facility's current license dated 01/01/26 revealed the facility's licensed capacity was 84 with 40 assisted living (AL) beds and 44 special care unit (SCU) beds.

Review of the facility's census report dated 05/13/26 revealed there were 37 residents in the AL and 42 residents in the SCU.

Observation of the AL front entrance on 05/13/26 at 8:15am revealed:
-There was a set of automatic sliding glass doors that led into a foyer with a second set of automatic sliding glass doors that opened into the lobby of the AL side of the facility.
-There was no audible sound when either set of automatic doors opened or closed.
-There was a box with a digital keypad attached to the wall beside the automatic sliding door that opened into the lobby.
-There was a second white box attached to the wall beside the keypad at the automatic sliding door that opened into the lobby.

Observation of the AL entrance on 05/14/26 at 7:30am revealed both sets of automatic sliding glass doors at the entrance of the facility opened but there was no audible sound when either set of automatic doors opened or closed.

Telephone interview with a medication aide (MA) on 05/14/26 at 1:58pm revealed:
-She usually worked night shift from 7:00pm to 7:00am.
-The front door was usually locked around

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7:00pm because the front desk staff usually left at 8:00pm.
-After 8:00pm, you could leave the front entrance/exit doors, but no one could enter the front entrance doors because it was locked to prevent entry into the facility.
-She thought the front entrance/exit doors were unlocked around 6:30am when the front desk staff arrived.
-She was not aware of the front doors alarming upon entrance or exit.

Telephone interview with the Environmental Services Director (ESD) on 05/18/26 at 5:30pm revealed:
-The AL front door entrance locked overnight from 8:00pm - 7:00am.
-The inside sliding glass front doors locked from the outside but not the inside, meaning you could go out but not come back in without a key fob.
-There was also a wanderguard box/sensor at the front doors which alarmed if a resident with a wanderguard came near the front door.
-There was a web-based security camera for the property that cycled on monitors at the front desk in AL and at the independent (IL) building across the street.
-The camera footage was not monitored continuously by staff.

Interview with the Administrator on 05/14/26 at 6:30pm revealed:
-The AL front entrance/exit doors did not usually alarm unless a resident with a wanderguard device got close to the door.
-The front entrance doors were unlocked from the inside as an egress but locked from the outside at night from 8:00pm to 7:00am.
-Once you exited the front doors at night, it required a key fob to re-enter.

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-She was aware of the rule related to door alarms but their front doors had never been set to alarm because it was a "home-like" atmosphere.
-Residents were allowed to go outside if the family said a resident could go outside during care plan meetings.

1. Review of Resident #1's current FL-2 dated 10/28/25 revealed:
-Diagnoses included mild dementia, macular degeneration, hypertension, hypothyroidism, and arthritis.
-The resident was documented as intermittently disoriented.

Review of Resident #1's Resident Register revealed:
-The resident was admitted to the assisted living (AL) side of the facility on 10/17/25.
-The resident required assistance with hair care/grooming, medication, bathing, nail care, and orientation to time and place.
-The resident was documented as being forgetful and needed reminders.
-The resident's hearing and vision were documented as impaired.
-The resident was documented as having little to no short-term memory capacity and progressive cognitive decline.

Review of Resident #1's care plan dated 10/17/25 revealed:
-The resident required assistance by one staff for bathing and dressing.
-The resident exhibited some confusion and staff was to monitor and report any concerns.
-The resident could express anxiety and staff was to monitor and report any concerns.
-The resident required supervision while outside of the facility.

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D 067	Continued From page 4 -The resident needed physical assistance in the event of an emergency. -The resident's visual impairment interfered with everyday functioning. -The resident wore glasses and had a hearing device. Review of Resident #1's facility care tracking notes dated 04/02/26 at 5:40am and 6:33am revealed: -At the start of the shift, the resident seemed to be experiencing extreme anxiety. -The resident walked the halls, shaking and crying, asking for her mother and kids. -The resident was very anxious and saying that someone told her that her mother was dying. -The resident was nervous and trying to leave. -The resident was redirected back to her room several times. Review of Resident #1's facility care tracking note dated 04/17/26 at 5:37am revealed: -The resident seemed very confused and anxious. -The front desk called over the walkie talkie that she was going behind the resident to get her. -The resident had been going outside, walking across the street, not know where she was. -When redirected back to her room, the resident would come out almost in tears and shaking, looking for her family members. Review of Resident #1's mental health provider (MHP) visit note dated 04/20/26 revealed: -The resident had generalized anxiety disorder characterized by significant agitation and anxiety, particularly in the afternoons. -The resident's symptoms seemed to be worsening with an earlier onset of agitation, now noted around 11:00am.	D 067		

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-The resident had a history of dementia.
-The resident demonstrated significant cognitive impairment, evidenced by disorientation to time and inability to recall without significant prompting.
-The facility staff continued to report ongoing sundowning (a pattern of increased confusion, agitation, and restlessness in people with dementia or Alzheimer's disease that typically occurs in the late afternoon or evening).

Review of Resident #1's facility care tracking note dated 04/24/26 at 6:55am revealed:
-The resident came out of her room around 2:00am, fully dressed.
-The resident stated she was confused, she thought it was morning.
-Staff redirected the resident back to her room.

Review of Resident #1's MHP visit note dated 05/04/26 revealed:
-The resident was 93 years old with generalized anxiety disorder and sundowning.
-The resident's sundowning contributed to significant agitation, restlessness, and confusion.
-The resident continued to experience breakthrough anxiety.
-The resident had a diagnosis of dementia and presented with significant cognitive deficits, including disorientation to time and impaired recent memory.
-The resident's cognitive impairment is a significant contributor to her anxiety, agitation, and behavioral symptoms like sundowning.

Review of Resident #1's facility care tracking note dated 05/04/26 at 5:00pm revealed:
-The resident was "seen by a visitor" all the way in the cottage area and staff brought her back. (The cottage area was part of the independent

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living (IL) area outside across the street from the AL building.)
-The witness was documented as a visitor and the location was documented as "offsite".

Review of Resident #1's physician's communication form to the facility's contracted provider dated 05/04/26 (no time specified) revealed:
-Staff documented "elopement".
-The resident was seen by a visitor in the cottage area and staff brought the resident back.

Observation of the facility's security camera footage dated 05/04/26 revealed:
-At 4:35pm, Resident #1 was walking down the sidewalk on the "End of AL Building" view and went out of sight of camera view 5 seconds later.
-At 4:40pm, Resident #1 was walking down the sidewalk on the "AL Building Side Entrance" view and went out of sight of camera view 12 seconds later.
-At 4:47pm, Resident #1 was walking down the sidewalk on the "Cottage Front Dual" view and went out of sight of camera view 7 seconds later.
-At 5:04pm, Resident #1 was escorted into the AL front entrance by staff.

Review of Resident #1's Elopement Risk Assessment dated 05/05/26 revealed:
-The resident ambulated without an assistive device.
-The resident involuntarily moved in and had adjustment issues.
-The resident had anxiety, paranoia, and was exit-seeking.
-The resident scored 37 which indicated moderate risk of elopement.

Review of Resident #1's facility care tracking note

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dated 05/06/26 at 1:43pm revealed:
-The note was a late entry for 05/05/26.
-The resident was outside with her purse yesterday.
-Two staff member from AL were sitting with her because she stated she was leaving to "wait for a car".
-She had wandered off by the cottages this week and had to be brought back to the building.
-The Resident Care Supervisor (RCS) spoke with the family about the wandering incident but the family declined the use of a wanderguard.
-The resident continued to exhibit anxiety daily, frequently requiring assistance and redirected by staff.
-The resident was confused, unhappy with living at the facility and often voiced a desire to go back to her own home.

Review of Resident #1's facility care tracking note dated 05/10/26 at 5:22am revealed:
-The resident was very shaky, almost in tears, and walking the halls asking for help.
-When redirecting the resident to her room, she would come right back out.

Review of Resident #1's facility care tracking note dated 05/13/26 at 6:12am revealed:
-The resident was extremely anxious and wandering back and forth asking what should she do.
-The resident was helped to her room 3 times but continued to come out of her room very upset.

Review of Resident #1's facility care tracking note dated 05/15/26 at 5:21am revealed:
-The resident was wandering the halls and crying at the start of the shift.
-An as needed (prn) medication was administered and it seemed to be effective.

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D 067	Continued From page 8 Observation of Resident #1 on 05/15/26 at 2:45pm revealed: -Resident #1 was walking alone in the hallway near her room. -The resident was not wearing a wanderguard. Interview with Resident #1 on 05/15/26 at 2:45pm revealed: -She had been visiting with "my mother" and her "mother" did not live with her. -When asked if she ever went outside, the resident stated she went outside and walked "up and down the street". Review of Resident #1's facility care tracking note dated 05/15/26 at 6:27pm revealed: -The resident wandered in and out of the front door that evening.. -Staff were present at the door. -The resident was not open to redirection from staff and stated she was going to sit outside and wait for her sister. -The resident came in and out several times. -Redirection by staff was short lived, a wanderguard was applied, and the family was notified. -The resident remained by the front door being monitored by staff. Review of Resident #1's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry with instructions to verify placement of wanderguard every shift; perform visual check to ensure the wanderguard was in place on her right wrist. -The wanderguard check was scheduled to be done on Shift 1 (day shift) and Shift 2 (night shift). -Documentation for placement of the	D 067		

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D 067	Continued From page 9 wanderguard started on Shift 2 on 05/15/26 and continued through Shift 2 on 05/17/26. Interview with a medication aide (MA) on 05/14/26 at 4:44pm revealed: -Resident #1 wandered around the facility and stated that people were in her house. -About a week ago, Resident #1 went to the cottages behind the IL building across the road around 5:00pm. Interview with a second MA on 05/14/26 at 4:46pm revealed: -Resident #1 went independently for daily walks before the incident on 05/04/26. -She thought the resident walked further than normal on 05/04/26 and could not find her way back. Interview with a third MA on 05/18/26 at 2:50pm revealed: -Around 4:00pm on 05/04/26, Resident #1 and a family member were sitting outside near the front entrance of the facility, chatting for a while. -After the family member left (not sure what time), staff received a call on the walkie talkies from the independent living staff across the street that Resident #1 was across the street. -She went outside to look for Resident #1; she got a call on the walkie talkie that the resident had been brought back to the AL building. -The resident sometimes took walks on her own but did not usually go that far. -The resident sometimes got lost trying to find her room. Interview with Resident #1's family member on 05/18/26 at 4:24pm revealed: -Resident #1 lived in the IL building across the street prior to moving to the AL building.	D 067		

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D 067	Continued From page 10 -Resident #1 was a "walker", she loved to take walks. -The resident would go out the front entrance of the facility to take walks. -There was an event about 2 weeks ago when Resident #1 was walking outside and started going toward a pathway near the pond where she used to walk when she lived across the street in the IL building. -She was told the resident flagged someone down who was leaving the AL building and was brought back to the facility. -She had been visiting the resident that day on 05/04/26 and left around 4:30pm with the resident still sitting on the bench outside the front entrance of the AL where they had been visiting. -The MA called her later that day (not sure what time) and reported Resident #1 had gotten disoriented and was escorted back to the AL building. -This was the first elopement to her knowledge. -The resident had been unsettled in the evenings because of sundowning. -The MA mentioned a protocol for wandering with steps which included frequent checks and wanderguard. -She had never heard an alarm on the front door entrance to the facility. Interview with the RCS on 05/14/26 at 4:42pm revealed: -On 05/04/26, she thought a resident's family member (did not know who) saw Resident #1 around the cottages beside the IL building and took the resident to the IL building. -Staff at the IL building used the walkie talkies to let AL staff know they had Resident #1 and then the resident was brought back to the AL building. Interview with the Care Services Director (CSD)	D 067		

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on 05/18/26 at 5:44pm revealed:
-Resident #1 was very anxious and paranoid.
-Resident #1 was unhappy with her placement at the facility and always sought out family members.
-Resident #1 had wandering behavior for a while now.
-Resident #1 had been wandering around in the hallways all day and her family wanted the resident to go outside for walks.
-Resident #1 had visual impairment causing poor vision.
-Resident #1 was allowed by the facility to walk outside on the sidewalk by herself.
-Resident #1 recently had an elopement and was found at the cul-de-sac in the cottages to the left of the IL building.
-She was concerned about Resident #1 not being able to find her way back or getting harmed.

Interviews with the Administrator on 05/14/26 at 6:30pm and 05/18/26 at 6:56pm revealed:
-Resident #1 was found either by a resident who lived on campus at the cottages near IL building or a staff person.
-They reported it to AL staff and AL staff went and escorted Resident #1 back to the facility.
-Prior to Resident #1's elopement, the resident was allowed go outside to walk on her own because the resident's family said she could go outside.
-The RCS followed up with the family and they did not want a wanderguard.
-The family wanted Resident #1 to be able to leave the facility and walk around outside.
-The facility complied with the family's wishes but should have put safety first.

Telephone interview with Resident #1's primary care provider (PCP) on 05/18/26 at 4:01pm

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revealed:
-Resident #1's cognition was not good, and her dementia had gotten worse over the last two months.
-The resident's anxiety was overlapping with her ability to know what was going on.
-The resident had more than mild cognitive impairment at this point and was hard to redirect.
-The resident's room was at the very end of a hallway beside an exit door and family had put signs on her door to help the resident find her room.
-About a week before the resident's elopement on 05/04/26, she came to the facility and the resident was in the middle of the parking lot with facility staff redirecting her.
-She was made aware of the incident on 05/04/26 by facility staff on 05/04/26.
-It was dangerous for Resident #1 to be walking outside alone.
-There were woods and a pond nearby and the resident could not see well.
-There was also a very busy highway nearby.
-The resident could have fallen in the pond or got hit by a car.

Interview with Resident #1's MHP on 05/18/26 at 3:34pm revealed:
-Resident #1 had dementia, impaired cognition and was confused at times.
-The resident had some sundowning behaviors.
-Staff had reported the resident's behavior fluctuated and they reported the resident wandered.
-She was not aware Resident #1 eloped from the facility on afternoon of 05/04/26.
-She did not recall anyone notifying her of Resident #1's elopement and she did not see any notifications in her computer system.
-She had seen the resident earlier in the day on

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05/04/26 for a visit and the resident was in her room with a family member.

2. Review of Resident #2's current FL-2 dated 01/21/26 revealed:
-Diagnoses included dementia, anxiety, acute asthma, type 2 diabetes, hypothyroidism, osteoporosis, and hyperlipidemia.
-The resident was semi-ambulatory and used a walker.
-The resident was documented as intermittently disoriented.

Review of Resident #2's Resident Register revealed:
-The resident was admitted to the facility on 04/19/21.
-The resident required assistance from staff with skin care, bathing, oral care, nail care, medication, and hair/grooming.
-The resident was documented as being forgetful and needed reminders.

Review of Resident #2's care plan dated 12/04/25 revealed:
-The resident required assistance by one staff for bathing, dressing, and grooming.
-The resident used a walker and staff provided resident reminders to use the walker.
-The resident exhibited some confusion and staff was to monitor and report any concerns.
-The resident required supervision while outside of the facility.
-The resident needed physical assistance in the event of an emergency.
-The resident's care plan was signed by the assessor on 12/04/25.
-The resident's care plan was signed by the primary care provider (PCP) on 01/14/26.

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Review of Resident #2's facility care tracking note dated 04/19/26 at 6:40am revealed:
-The resident did not sleep throughout the night and appeared very confused.
-The resident was leaving her room and trying to enter other residents' rooms.
-Staff redirected the resident back to her room multiple times.

Review of Resident #2's facility care tracking note dated 04/28/26 at 4:15am revealed:
-Resident #2 was wandering outside the facility in the parking lot around 3:00am.
-Staff from the special care unit (SCU) saw her and asked where she was going.
-The resident stated that she was going home.
-The resident was holding her bra and an incontinence brief in her hands.
-Assisted Living (AL) staff went outside, assisted the resident back inside the facility, and redirected the resident to her room.
-Around 4:00am, the resident came out of her room again into the hallway and was redirected by staff back to her room.

Review of Resident #2's incident report dated 04/28/26 at 3:00am revealed:
-Resident #2 wandered outside to the parking lot area and had to be redirected back to her room.
-The resident continued to wander in the hall for the remainder of the night and had to continuously be redirected back to her room.
-Staff documented they would continue to monitor the resident.

Observation of the facility's security camera footage dated 04/28/26 revealed:
-At 2:52am, Resident #2 walked out of the first set of double sliding glass front entrance doors and the second set to the outside of the AL

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building.
-At 2:53am, Resident #2 came back inside the outside double sliding door into the foyer and walked out of sight to the interior set of double sliding glass doors.
-At 2:54am, Resident #2 walk back outside the exterior front doors.
-At 2:55am, a male staff person came into the front entrance from the outside.
-At 2:56am, the male staff person and a female staff person exited the front doors.
-At 2:58am, Resident #2 was escorted back into the facility by both staff.

Review of Resident #2's physician's communication form to the facility's contracted provider dated 04/28/26 (no time specified) revealed:
-The resident had a wander incident around 3:00am.
-The family was notified and there was a plan to discuss further action plan with the family.
-The PCP ordered a urinalysis to check the resident's urine for infection.

Review of Resident #2's physician's communication form to the facility's contracted provider dated 05/04/26 (no time specified) revealed:
-Resident #2 had some nights where she wandered a lot throughout the night.
-The facility staff requested an as needed (prn) medication to help with sleep.

Review of Resident #2's PCP triage note dated 05/04/26 revealed:
-The resident's labs indicated she had a urinary tract infection (UTI).
-The PCP ordered an antibiotic for 7 days.

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Review of Resident #2's Elopement Risk Assessment dated 04/28/26 revealed:
-The resident ambulated without an assistive device.
-The resident had become "lost" in the community.
-The resident had actual wandering behaviors.
-The resident had delusions and sleep disturbance.
-The resident was found by staff in the parking lot at 3:00am.
-Staff escorted the resident back inside.
-The PCP ordered a urinalysis which was positive.
-The resident's power of attorney (POA) agreed to the use of a wanderguard due to elopement risk.
-The resident scored 38 which indicated moderate risk of elopement.

Review of Resident #2's May 2026 electronic medication administration record (eMAR) dated 05/01/26 - 05/18/26 revealed:
-There was an entry with instructions to verify placement of wanderguard every shift; perform visual check to ensure the wanderguard is in place on her left wrist.
-The wanderguard check was scheduled to be done from 7:00am to 7:00pm and 7:00pm to 7:00am.
-Documentation for placement of the wanderguard started from 7:00am - 7:00pm on 05/08/26 and continued through 05/18/26.

Interview with Resident #2 on 05/14/26 at 1:46pm revealed:
-She liked to go outside.
-She was unable to say when she went outside or where she went outside.
-She was unable to say if anyone went outside

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D 067	Continued From page 17 with her. Telephone interview with a medication aide (MA) on 05/14/26 at 1:58pm revealed: -She was the MA on duty on 04/28/26 when Resident #2 eloped from the facility. -One of the SCU staff had gone outside for a break and saw Resident #2 in the facility's parking lot. -The personal care aide (PCA) assigned to Resident #2 went outside to get the resident. -The PCA reported the resident was wearing pajamas and told the PCA she was going home. -She did not know how long the resident was outside on 04/28/26. -She did not see Resident #2 prior to the resident leaving the facility on 04/28/26. -The PCAs usually did routine 2-hour checks on residents. -Resident #2 went back to bed when she was brought back in the facility on 04/28/26 but came out of her room again around 4:00am or 5:00am, just opening doors to other residents' rooms at least 2 to 3 times. -The front door only alarmed if a resident was wearing a wanderguard device. -Resident #2 was not wearing a wanderguard device on 04/28/26 so the front entrance doors in the AL did not alarm. -Resident #2 had been wearing a wanderguard device since last week (not sure of date). -Resident #2 was confused and had tried to leave before (could not give specific time). -Some days Resident #2 was more confused than other days. -Resident #2 got up at night to use the bathroom and then went into other resident's rooms. -This was not new behavior for Resident #2. -She had been opening doors and trying to go into other residents' rooms since April 2025.	D 067		

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D 067	Continued From page 18 Telephone interview with a PCA on 05/15/26 at 11:27am revealed: -He was a PCA and worked at nights from 7:00pm to 7:00am. -He worked in the SCU side of the facility and had never worked on the AL side. -On 04/28/26, sometime in the middle of the night (did not remember time), he went outside the front entrance of the facility to take a break. -The weather was warm and humid. -The front door did not alarm, and you had to have a key fob to re-enter once you exited the front door. -Residents who wandered usually had a wanderguard device. -He saw a female outside walking on the sidewalk towards a car the parking lot wearing pajamas and carrying an incontinence brief, a bra, and a sock in her hands. -He did not recognize her, but he thought it was odd she was outside wearing pajamas. -The resident was about 50 to 100 feet from the front entrance of the facility. -The resident seemed confused because she was asking him what was going on. -Resident #2 told him that she needed to go to her car. -He used his key fob to come back inside the facility to get a PCA from the AL side. -The PCA was at the nurses' station doing paperwork and stated she did not see a resident walk by. -The PCA went outside and helped him redirect Resident #2 back inside the facility. -The resident did not have any injuries. Telephone interview with Resident #2's family member on 05/15/26 at 9:19am revealed: -Resident #2 had dementia and occasionally	D 067		

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wandered.
-Staff had to get the resident to meals and activities because she would not remember to go and they prompted her for dressing and grooming.
-Resident #2's memory was short and she recognized people but did not remember their names.
-When she visited the resident and left the room for 10 minutes and came back, the resident would not remember she was there 10 minutes ago.
-Staff called and notified her that Resident #2 had gotten out of the facility.
-She did not like that the resident went outside and staff did not know.
-Resident #2 told staff she needed to go home.
-Resident #2 had left the facility previously about 4 years ago by exiting a back door.
-She thought the resident had a UTI both times she left the facility.
-Resident #2 had been having more nighttime agitation and waking up.
-She went to the facility about once a week and had never heard an alarm when she entered or exited the front doors.
-They had put a wanderguard on the resident after the most recent elopement and it would make the doors alarm.
-After the elopement, she asked facility staff about locking the doors or alarming the doors.
-They told her staff checked on residents every 2 hours.
-They said they were going to evaluate the resident for the SCU.

Interview with the Resident Care Supervisor (RCS) on 05/14/26 at 4:00pm revealed:
-On 04/28/26, Resident #2 eloped from the facility.

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D 067	Continued From page 20 -Resident #2 had a steady cognitive decline in general since she was admitted about a year ago. -Resident #2 needed more prompting and direction. -Resident #2 had some moments of confusion on some days. -If Resident #2 did not get a good night's sleep, the resident had more cognitive issues the next day. -Sometimes Resident #2 did not know which way she was going, mostly in the evenings. -She spoke with Resident #2's family member after the elopement about a wanderguard. -She thought they added safety checks to note where the resident was after the elopement, but she was not sure how often or if it was documented. -She had to order the wanderguard bracelet and wait for it to be delivered. -A wanderguard was placed on Resident #2 on 05/08/26. -The front exit doors did not alarm but locked from the outside after 8:00pm, meaning you could go out but not come back in without a key. Interview with the Care Services Director (CSD) on 05/18/26 at 5:44pm revealed: -Resident #2's cognition fluctuated but she had less clear times lately. -The resident got confused and had some sundowning. -In 2023, Resident #2 had an incident of wandering outside the facility and a wanderguard was placed on her. -At some point, the wanderguard was removed and there were no further incidents of wandering at that time. -About 2 to 3 weeks ago at 3:00am, Resident #2 eloped from the facility. -She was not sure which door the resident exited.	D 067		

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D 067	Continued From page 21 -The RCS contacted the family who agreed to the wanderguard. Interview with the Administrator on 05/14/26 at 6:30pm revealed: -Resident #2 recently wandered outside at night and staff redirected the resident back inside. -She did not know all the details. -Staff put a wanderguard on Resident #2 after the incident. -Resident #2's cognition was intermittent; some days you could have a good conversation with the resident and other days she did not know where she was or what she was doing. -Resident #2 had wandered in the past but not too much and she was able to be redirected. -She had discussed moving the resident to the SCU a few times. -If the resident's confusion increased that could be a next step. -The campus had video surveillance security system for the facility, and independent living across the street 24/7. -Staff at the independent living (IL) building could notify AL staff if they saw a resident on the cameras. -The RCS would communicate that in the resident care plans. Interview with Resident #2's PCP on 05/14/26 at 10:58am revealed: -The incident on 04/28/26 was the first time Resident #2 had eloped to her knowledge since she had been providing care to the resident. -Resident #2 did not typically wander but when the resident did not sleep well, it caused the resident to be more confused. -The family agreed to the use of a wanderguard after the incident. -Resident #2 had intermittent confusion before	D 067		

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the incident due to poor sleep.
-Resident #2 had dementia and would not be able to find her way back to the facility because she was "very confused".
-The resident could fall in the pond on campus or get hit by a car.
-The facility's front door locked from the outside at night but it did not lock from the inside.
-The facility's front door should be alarmed for the safety of the residents.

Attempted telephone interview on 05/15/26 at 9:14am with the PCA on duty when Resident #2 eloped on 04/28/26 was unsuccessful.

3. Review of Resident #3's current FL-2 dated 01/07/26 revealed:
-Diagnoses included dementia, type 2 diabetes, chronic kidney disease, respiratory failure with hypoxia, chronic obstructive pulmonary disease, anemia, atrial fibrillation, and hypertensive heart.
-Resident #3 was documented as intermittently disoriented.

Review of Resident #3's current care plan dated 02/04/26 revealed:
-Resident #3 had cognitive impairment.
-Resident #3 required supervision when outside of the facility.
-Resident #3 required physical assistance in the event of an emergency.
-She required limited assistance from staff members with toileting, ambulation, bathing, dressing and grooming.

Review of Resident #3's primary care provider (PCP) visit notes dated 01/09/26 revealed Resident #3 had severe cognitive impairment.

Interview with Resident #3 on 05/14/26 at 9:48am

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revealed:
-She was able to state the name of the facility.
-She knew the day, month, and year.
-She could take care of herself with most everything.
-She required assistance with self care tasks she was unable to complete independently.
-She did not have any memory impairments.

Interview with Resident #3's family member on 05/15/26 at 3:05pm revealed:
-Resident #3 knew enough of what was going on to manage.
-Resident #3 knew the current day, month, and year.
-Resident #3 was aware of her surroundings.
-Resident #3 may forget where she put stuff sometimes.
-He must remind Resident #3 a few times a day where she placed objects because she would forget.
-Resident #3 was forgetful short-term.
-Resident #3 would forget where she placed her reading glasses and he assisted Resident #3 with locating them.
-He would not allow Resident #3 to go outside without him because Resident #3 may forget how to get back.
-He assisted with making sure Resident #3 was able to the places within the facility that she needed to go.
-Resident #3 would forget where to go without him.
-Resident #3 had never attempted to leave the facility alone.

Interview with a personal care aide (PCA) on 05/15/26 at 3:16pm revealed:
-Resident #3 had severe dementia.
-Resident #3 was unable to complete most

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everyday tasks independently without staff member assistance.
-Resident #3's family member assisted Resident #3 with all her day-to-day activities due to her cognitive impairments.
-Resident #3 was unable to remember things at time.
-Resident #3 was aware of person, place and time.
-Resident #3 was aware of her surroundings inside of the facility.
-Resident #3 was unable to go outside without supervision.
-Resident #3 had never attempted to go outside alone.
-Due to Resident #3's severe dementia ,she was afraid Resident #3 would not be able to find her way back to the facility if she was to go outside alone.

Interview with a second PCA on 05/18/26 at 3:15pm revealed:
-Resident #3 knew where she lived.
-She was unsure if Resident #3 would be able to remember it was mealtime if Resident #3 did not have her family member to remind her daily.
-Resident #3 forgot common everyday things such as where she placed a book or her glasses.
-Resident #3 forgot at times to wipe herself after using the bathroom.

Interview with a medication aide (MA) on 05/18/26 at 2:47pm revealed:
-She did not know if Resident #3 would be able to remember when mealtimes were because her family member always made sure she arrived at the dining room on time.
-Resident #3 did not always remember the medications she was currently taking.

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D 067	Continued From page 25 Interview with Resident Care Supervisor (RCS) on 5/15/26 at 2:49pm revealed: -Resident #3 would not attempt to go outside without her family member. -Resident #3 had never attempted to go past the front door. -Due to Resident #3's current diagnosis of dementia, she was unsure if Resident #3 would be able to find her way back to the facility if she was to go outside unsupervised. Interview with the Care Services Director (CSD) on 05/18/26 at 5:43pm revealed: -Resident #3 resided with her husband on the assisted living side of the facility. -Resident #3 was aware of the current day, month, and year. -Resident #3 wore glasses due to visual impairment. -Resident #3 had difficulty at times with hearing. -Resident #3 had never attempted to leave the facility alone. -Resident #3's family member was always with her when she was in the hallways. -Resident #3 had not been on her radar as a wandering or elopement risk because she required assistance with ambulation. Telephone interview with Resident #3's PCP on 05/18/26 at 3:49pm revealed: -Resident #3 had severely gone down mentally over the past several months. -Resident #3 depended on her family member and facility staff members to assist her daily. -She would be afraid that Resident #3 would get confused if she was to go outside alone and be unable to find her way back to the facility. -Because of her cognitive impairments, Resident #3 would get lost if she was to wander outside unsupervised.	D 067		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 26 [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision] The facility failed to ensure the automatic sliding glass front entrance/exit doors had a continuous sounding alarm that was activated and audible throughout the facility when the door was opened and accessible to 3 residents in the assisted living (AL) side of the facility who were documented as and known to be disoriented including 2 residents with wandering behaviors (#1, #2). Resident #1 eloped from the facility on 05/04/26 and was found by a visitor across the street at the facility's independent living (IL) cottage area. Resident #2 eloped from the facility on 04/28/26 and was found by a staff person in the parking lot beside the facility. Resident #1 and Resident #2 left the facility without staff knowledge and were at risk of falling in a pond beside the IL building or getting hit by a car. Resident #3 who had dementia and was disoriented was at risk of getting lost if she wandered outside unsupervised. This failure of the facility placed the residents at substantial risk of serious physical harm or death and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/14/26 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 17, 2026.	D 067		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan	D 259		

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D 259	Continued From page 27 (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for	D 259		

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D 259	Continued From page 28 which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 5 sampled residents (#1, #2, #5) had care plans that were signed and dated by the physician within 15 days of completion of the care plan. The findings are: 1. Review of Resident #1's current FL-2 dated 10/28/25 revealed: -Diagnoses included mild dementia, macular degeneration, hypertension, hypothyroidism, and arthritis. -The resident was documented as intermittently disoriented. -The resident required assistance by staff with bathing. Review of Resident #1's Resident Register revealed: -The resident was admitted to the assisted living (AL) side of the facility on 10/17/25. -The resident required assistance with hair care/grooming, medication, bathing, nail care, and orientation to time and place. -The resident was documented as being forgetful and needed reminders. -The resident's hearing and vision were documented as impaired.	D 259		

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D 259	Continued From page 29 -The resident was documented as having little to no short-term memory capacity and progressive cognitive decline. Review of Resident #1's assessment and care plan dated 10/17/25 revealed: -The resident required assistance by one staff for bathing and dressing. -The resident exhibited some confusion, and staff was to monitor and report any concerns. -The resident could express anxiety, and staff was to monitor and report any concerns. -The resident required supervision while outside of the facility. -The resident needed physical assistance by staff in the event of an emergency. -The resident's visual impairment interfered with everyday functioning. -The resident wore glasses and had a hearing device. -The resident's care plan was signed by the assessor on 10/17/25. -The resident's care plan was signed by the primary care provider (PCP) on 11/17/25. Interview with the Resident Care Supervisor (RCS) on 05/18/26 at 5:18pm revealed: -She was responsible for completing care plans for residents living in the AL side of the facility. -She was responsible for getting the care plans signed by the PCP. -She tried to get the care plans signed within 30 days of completing the care plans. -She did not realize care plans were supposed to be signed by the PCP within 15 days of completing the care plan. -Resident #1's care plan was not signed within 15 days of completing the care plan. Interview with the Care Services Director (CSD)	D 259		

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D 259	Continued From page 30 on 05/18/26 at 5:44pm revealed: -The RCS was responsible for completing and getting care plans signed for residents residing in the AL side of the facility. -She did not know Resident #1's care plan was signed by the PCP 31 days after it was completed. -She was not aware resident care plans had to be signed by the resident's PCP within 15 days of completion of the care plan. Refer to interview with the Administrator on 05/18/26 at 6:58pm. 2. Review of Resident #2's current FL-2 dated 01/21/26 revealed: -Diagnoses included dementia, anxiety, acute asthma, type 2 diabetes, hypothyroidism, osteoporosis, and hyperlipidemia. -The resident was semi-ambulatory and used a walker. -The resident was documented as intermittently disoriented. Review of Resident #2's Resident Register revealed: -The resident was admitted to the assisted living (AL) side of the facility on 04/19/21. -The resident required assistance with skin care, bathing, oral care, nail care, medication, and hair/grooming. -The resident was documented as being forgetful and needed reminders. Review of Resident #2's assessment and care plan dated 12/04/25 revealed: -The resident required assistance by one staff for bathing, dressing, and grooming. -The resident used a walker and staff provided resident reminders to use the walker.	D 259		

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D 259	Continued From page 31 -The resident exhibited some confusion, and staff was to monitor and report any concerns. -The resident required supervision while outside of the facility. -The resident needed physical assistance by staff in the event of an emergency. -The resident's care plan was signed by the assessor on 12/04/25. -The resident's care plan was signed by the primary care provider (PCP) on 01/14/26. Interview with the Resident Care Supervisor (RCS) on 05/18/26 at 5:18pm revealed: -She was responsible for completing care plans for residents living in the AL side of the facility. -She was responsible for getting the care plans signed by the PCP. -She tried to get the care plans signed within 30 days of completing the care plans. -She did not realize care plans were supposed to be signed by the PCP within 15 days of completing the care plan. -Resident #2's care plan was not signed within 15 days of completing the care plan. Interview with the Care Services Director (CSD) on 05/18/26 at 5:44pm revealed: -The RCS was responsible for completing and getting care plans signed for residents residing in the AL side of the facility. -She did not know Resident #2's care plan was signed by the PCP 41 days after it was completed. -She was not aware resident care plans had to be signed by the resident's PCP within 15 days of completion of the care plan. Refer to interview with the Administrator on 05/18/26 at 6:58pm.	D 259		

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D 259	Continued From page 32 3. Review of Resident #5's current FL2 dated 09/30/25 revealed diagnoses included Alzheimer's disease, insomnia, and hypothyroid. Review of Resident #5's Resident Register revealed she was admitted on 11/07/24. Review of Resident #5's current assessment and care plan dated 05/29/26 revealed: -The care plan for Resident #5 was completed on 05/29/25. -The assessor signed Resident #5's care plan on 06/09/25. -The Power of Attorney signed Resident #5's care plan on 06/09/25. -The primary care provider (PCP) signed Resident #5's care plan on 09/30/25. Interview with the Memory Care Director (MCD) on 05/14/26 at 4:30pm revealed: -The facility was required to have a resident's care plan completed and signed yearly. -Resident #5's care plan was signed. -It was difficult obtaining an outside PCP's signature. -Resident #5's family member would deliver their care plan to the PCP's office to obtain their signature. -The fax machine in the PCP's office had not been working. -He had not reached out to the PCP related to obtaining their signature on Resident #5's care plan. -He did not know that the care plan had to be signed by the PCP within 15 days of the assessment. -He thought that if the PCP signed the Resident #5's care plan it was good. -He was responsible for completing and obtaining the signatures required on the care plans.	D 259		

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D 259	Continued From page 33 Interview with the Care Services Director (CSD) on 05/18/26 at 5:44pm revealed: - The MCD was responsible for completing Resident #5's care plan and obtaining the PCP's signature. -She did not know that the care plan had to be signed by the PCP within 15 days of the assessment. -The resident records were audited quarterly for items that needed to be thinned. -No current process for resident chart reviews. Attempted telephone interview with Resident #5's PCP on 05/14/26 at 9:05am was unsuccessful. Refer to interview with the Administrator on 05/18/26 at 6:58pm. _____ Interview with the Administrator on 05/18/26 at 6:58pm revealed: -The Resident Care Supervisor (RCS) and the Memory Care Director (MCD) were responsible to complete resident care plans and obtain signatures. -She did not know that the residents' care plans had to be signed by the PCP within 15 days. -There was not a process to review and audit resident's records for completeness.	D 259		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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

Based on observations, interviews and record reviews, the facility failed to provide supervision for 4 of 6 sampled residents (#1, #2, #4, #5) including two residents (#1, #2) with dementia, confusion, and wandering behaviors who left the facility without staff knowledge and two residents (#4, #5) residing in the Special Care Unit (SCU) with diagnoses of dementia and Alzheimer's disease, confusion, and wandering behaviors that were having sexual encounters.

The findings are:

1. Review of the facility's sexual expression policy dated May 2025 revealed:
-Residents living with Alzheimer's or other dementia related diagnoses may demonstrate behavioral expressions, including sexual expression in inappropriate locations like common area and associates will provide privacy for sexual expression.
-The residents' dignity will be maintained.
-Residents with impacted cognitive abilities will be safeguarded from inappropriate sexual behavior and sexual exploitation.
-For the purpose of this policy sexual expression that was deemed inappropriate based on the location of the action or the ability of a resident to give consent including undressing in public area or communal space-though this action may be

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rooted in discomfort and not sexual expression, genital exposure, fondling the private areas of another resident, associate, or visitor, a resident fondling their own genital area in a public location, sexual act with another resident who was unable to give knowing consent, made sexually explicit comments to another resident, associate, or visitor, attempted to engage in a sexual act with another resident who did not have the capacity to give consent.
-Staff would respect the residents' need for sexual expression except when it infringed on the rights of others, posed a possible safety or health risk, and involved residents who could not provide informed consent.
-Residents who expressed interest in sexual contact with another resident, each resident should be individually evaluated for resident level of awareness resident may or may not have accurate recognition of other residents, may mistakenly believe another resident was their spouse and resident consent the resident may be mentally incapable of providing consent to sexual contact and need protection from such.
-Residents should be interviewed to determine level of awareness. Update the resident's Mini Mental State Exam (MMSE) or other cognitive assessment tool to assist with determining cognitive abilities.
-Residents scoring mid-range and above on the MMSE or applicable score using another assessment tool may have the ability to actively participate in further interview.
-The decision tree used for assessing sexual competency was a guide only to gauge resident awareness and possible ability to provide informed consent.
-A resident was generally considered unaware if the interview revealed that the resident appeared unable to set limits with partner and thought they

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must always submit to sexual demand.
-When a resident appeared incapable of making informed decisions the physician would be notified and requested to provide a statement of the resident's level of mental capability in providing informed consent.
-Sexual acts that involved residents with diagnoses of primary dementia who no longer had the capacity to give informed consent upon observation immediately and calmly separate the residents, relocate the resident to a communal area and use activity as a distraction, never argue, reprimand, laugh, tease, or induce shame, report observation to supervisor immediately.
-Establish direct one-to-one oversight of the initiating resident and assign associates to also remain with any other involved resident, immediately inform the ED, Memory Care leader, and Care Services leader.
-Place the resident on a behavioral expression management program if appropriate to identify triggers, develop a service plan with interventions, in-service associates on any interventions, notify the residents physician and responsible parties, the ED, Memory Care leader, and Care Services leader.
-Reassess the residents for appropriate placement and ability to remain in community.
-If penetration had occurred upon observation staff should immediately and calmly separate residents, immediately notify the supervisor and Memory Care leader, notify the physician, ED Care Services leader and responsible parties.
-The resident's physician would be contacted for orders and to assess the residents for venereal disease and human immunodeficiency virus (HIV).
-Immediate one-to-one monitoring will be implemented with involved residents, place the resident on behavioral expression management

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program if appropriate to identify triggers, encourage activity involvement within community public areas, update the service plan, educate associates and families as appropriate.
-Report to licensing agency as appropriate, the ED, Memory Care leader, and Care Services leader would reassess the residents for appropriate placement and ability to remain in community.

a. Review of Resident #4's current FL-2 dated 03/11/26 revealed:
-Diagnoses included dementia, hypertension, chronic kidney disease, and vitamin D deficiency.
-Recommended level of care was memory care.

Review of Resident #4's Resident Register revealed he was admitted to the facility on 03/13/26.

Review of Resident #4's Care Plan dated 04/10/26 revealed:
-Resident #4 may make sexual comments to staff and other residents', staff were to redirect when that happened, use calm neutral language to shift conversation to an appropriate topic, remove resident from the situation, redirect the resident as needed when exhibiting inappropriate sexual behaviors towards residents and/or staff.
-Staff should know where Resident #4 was at all times, check on resident during hours of sleep and check on resident routinely throughout waking hours.
-The resident may attempt to exit through the courtyard; staff were to be aware of and monitor the resident's whereabouts at all times.

Review of Resident #4's brief interview for mental status (BIMS) dated 03/04/26 revealed:
-Resident #4 scored 3 points.

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D 270	Continued From page 38 -Scores between 0 and 7 indicated severe cognitive impact. Review of Resident #4's primary care provider (PCP) progress note dated 03/27/26 revealed: -Zoloft 25mg daily was faxed to the pharmacy but Resident #4's family would like to hold on medication for now (Zoloft was used to treat behaviors). -A referral to mental health for evaluation and treatment was made for Resident #4's sexual behaviors. Review of Resident #4's PCP triage note dated 04/03/26 revealed: -Resident #4 was a poor historian due to cognitive/psychiatric impairment. -Reason for visit was behavioral changes, inappropriate touching of another resident, and the facility was requesting Zoloft prescription to be sent to the pharmacy. -Resident #4 was seen for this behavior and Zoloft was recommended, but his family member wanted to hold off until he talked to other family members. -Per facility this behavior had gotten worse, the family was now in agreement with starting Zoloft 25mg and it was resent to pharmacy. Review of Resident #4's Mental Health Provider (MHP) initial consult dated 04/06/26 revealed: -Resident #4 had a diagnosis of dementia and on his mental status exam he was noted to be disoriented to his age and current president and he was pleasantly confused. -Resident #4's immediate recall was impaired. -Resident #4 demonstrated confusion regarding his family history. -Resident #4 was observed in the dining area engaged in playful interactions with a female	D 270		

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resident accompanied by inappropriate physical affection and impaired boundary awareness.
-Facility staff reported sexually inappropriate behavior.
-There was an order to discontinue Zoloft 25mg and a new order for Paxil 10mg (Paxil was used to treat behaviors).
-Staff would continue to redirect and reorient Resident #4 as needed.

Review of Resident #4's MHP progress note dated 04/20/26 revealed:
-Resident #4's cognitive impairment was evident in his disorientation.
-Staff reported ongoing sexually inappropriate behavior.
-Paxil 10mg was increased to Paxil 20mg every morning.
-Continued monitoring of Resident #4 by staff was recommended to document specific behaviors and triggers.

Review of Resident #4's incident report dated 05/06/26 at 5:36pm revealed:
-Resident #4 was found in his room completely naked attempting to penetrate a female resident.
-Staff heard moaning when they entered Resident #4's room.
-Staff notified Resident #4's family and the MHP.

Review of Resident #4's incident report dated 05/11/26 at 5:13pm revealed:
-A female resident was asleep on the couch next to Resident #4 and he put his hands down into her pants.
-The MHP was notified.

Review of Resident #4's staff care tracking log for March 2026 revealed:
-On 03/18/26, Resident #4 was observed

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showing increased interest in a female resident and engaged in frequent physical contact; redirection was attempted and boundaries were reinforced, the MA and charge nurse were notified and further guidance requested.
-On 03/27/26, Resident #4 had been close to a female resident and took her to his room; staff redirected and he was started on Zoloft and was to follow up with the MHP on Monday, 03/30/26.
-On 03/27/26, Resident #4 had displayed signs of sexual behaviors toward two female residents; he was seen performing unwanted physical touch (kissing and groping resident's shoulders and breast) this was also witnessed by the PCP.
-On 03/28/26, Resident #4 continued inappropriate sexual touching of female resident and tried to get the resident to come into his room; he was redirected by staff and the MA and supervisor notified.
-On 03/28/26, Resident #4 had been inappropriate with the female residents by touching, kissing, holding them and tried to get one of them to come in his room.
-On 03/31/26, Resident #4 was seen holding and kissing a female resident; the redirecting by the staff was not effective.

Review of Resident #4's staff care tracking log for April 2026 revealed:
-On 04/01/26, Resident #4 displayed sexual behaviors toward female residents, walked one female resident to his room and kissed her neck and staff intervened, then he was standing with his crotch in the female resident's face and rubbing her shoulders.
-On 04/03/26, the Memory Care Director (MCD) called the PCP and attempted to call family to discuss Resident #4's behaviors; family had declined to start medication to help with sexual behaviors.

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D 270	Continued From page 41 -On 04/03/26, family agreed to start the medication recommended for sexual behaviors; the PCP was notified to send prescription to pharmacy. -On 04/05/26, Resident #4 continued to ask residents for sexual favors. -On 04/05/26, Resident #4 continued to touch and kiss other residents. -On 04/06/26, Resident #4 told a female resident that he wanted to take her to the basement, take off her clothes and kiss her body; the female resident was removed from the situation. -On 04/06/26, Resident #4 held hands with and kissed the female resident. -On 04/07/26, Resident #4 expressed unwanted sexual behaviors toward a female resident during breakfast. -On 04/08/26, the Care Services Director (CSD) spoke with the PCP related to Resident #4's behaviors, due to redirection not being successful and not well received; she spoke with the family again and they agreed to start the new medication. -On 04/09/26, Resident #4 had been touching, kissing, and tried to take a female resident to his room. -On 04/09/26, Resident #4 would not keep his hands to himself, touched and kissed the other residents. -On 04/09/26, Resident #4 displayed signs of unwanted touching to residents. -On 04/10/26, Resident #4 kissed a female resident on the mouth. -On 04/11/26, Resident #4 kissed and rubbed a female residents' neck and arms. -On 04/14/26, Resident #4 had a female resident in his room holding hands. -On 04/14/26, Resident #4 had kissed and sexually touched a resident and followed them into their room.	D 270		

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D 270	Continued From page 42 -On 04/15/26, Resident #4's family notified staff that he had a female resident in his room with her laying on the bed and him sitting on the bed with his hands inside of her pants and they were kissing. -On 04/16/26, Resident #4 kissed and touched a female resident. -On 04/18/26, Resident #4 kissed a female resident. -On 04/20/26, Resident #4 pulled a female resident onto his lap. -On 04/22/26, Resident #4 kissed a female resident. -On 04/23/26, Resident #4 kissed another resident. -On 04/24/26, Resident #4 kissed a female resident. -On 04/25/26, Resident #4 touched a female resident's breast. -On 04/25/26, Resident #4 displayed signs of sexual behaviors throughout the shift with two female residents. -On 04/26/26, Resident #4 continued to seek after the female residents. -On 04/28/26, Resident #4 continued to kiss other residents. -On 04/30/26, the CSD documented that she spoke with the PCP and the MHP related to Resident #4's sexual behaviors; the MHP wanted to give the medication more time before making any changes or additions, staff were to continue to intervene and redirect resident. Review of Resident #4's staff care tracking log for May 2026 revealed: -On 05/03/26, during dinner the medication aide (MA) was called to the table and a female resident asked her to protect her; Resident #4 said she must learn she was his wife and she belonged to him.	D 270		

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D 270	Continued From page 43 -After dinner Resident #4 said he was going to shoot the female resident's husband and told him to stop his "bull shit." -On 05/04/26, Resident #4 was feeling and touching a female resident. -On 05/06/26, Resident #4 was found in his room naked attempting to penetrate a female resident; staff heard moaning when they entered the room. -On 05/06/26, Resident #4 touched a female resident throughout the shift. -On 05/08/26, Resident #4 displayed sexual behaviors and touched and kissed two female residents. -On 05/11/26, Resident #4 was putting his hands down a female resident's pants while she was asleep on the couch. -On 05/12/26, the CSD reached out to the PCP and the MHP related to Resident #4's sexual behavior expression that occurred on 05/11/26 to update them and the need for further evaluation of medication regime; staff would continue to monitor and intervene when he acted out sexually. -On 05/12/26, the Memory Care Director (MCD) spoke with Resident #4's family related to his sexual behaviors and they were going to arrange for male sitters and they were open to any medication that could lower his sexual need. -On 05/12/26, Resident #4 had been kissing a female resident. -On 05/14/26, Resident #4 while in the dining room with his sitter and attempted to grab three female residents and when redirected he showed aggression and started to swing at staff. -On 05/15/26, Resident #4 was placed on 15-minute checks. Telephone interview with Resident #4's family on 05/14/26 at 11:20am revealed: -Resident #4 was having extreme sexual	D 270		

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behaviors.
-The facility suggested they hire sitters to be with Resident #4 from 10:00am through 7:00pm 7 days a week for the next couple of weeks.
-The PCP had suggested medication therapy and they had wanted to try hormone therapy.
-They were not comfortable with any sexual encounter that did not have consent.
-Resident #4 did not know what he was doing related to the sexual encounters.
-The family did not want Resident #4 to have sexual contact with other residents.

Interview with a medication aide (MA) on 05/13/26 at 3:43pm revealed:
-Resident #4 was drawn to a female resident; he held her hands.
-Resident #4 had his hands in a female resident's pants recently.
-Resident #4 took another female resident in his room; both were naked when staff walked in.
-Staff had not been instructed to care for Resident #4 differently since these two incidents happened.
-Resident #4's sitter started today, 05/13/26.

Interview with another MA on 05/14/26 at 9:25am revealed:
-The staff had not been instructed to do anything different with Resident #4 due to his sexual behaviors.
-It was difficult for staff to redirect Resident #4 and he would get angry.
-Resident #4 touched a female resident's breasts and between her legs.
-The medication change for Resident #4 had not improved his behavior.

Interview with the MCD on 05/14/26 at 12:20pm revealed:

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D 270	Continued From page 45 -He provided the sitter information to the family and they were to make the arrangements. -Resident #4's sitter started on 05/13/26. -When a resident had sexual behaviors the facility would notify the PCP and family. -The PCP made decisions on the treatment of the residents. -Clinical staff monitored the residents and documented in care tracking log. -The staff that witnessed the sexual encounter would notify the MHP. -The CSD completed the BIMs on the residents. -At no time were residents allowed to engage in sexual encounters with one another. -The PCP and MHP were notified with each sexual encounter. Interview with the CSD on 05/14/26 at 8:28am revealed: -Resident #4 moved from independent living to SCU in March 2026. -Resident #4's BIMS was a 3, Indicating severe cognitive impairment. -To her knowledge Resident #4 had not been deemed incompetent. -The PCP had recommended that Resident #4 obtain a male sitter and made medication changes that would take a couple of weeks for the full effects. -The MHP wanted redirection of Resident #4 and she was going to see him on 05/18/26. -There had been an incident with Resident #4 on 05/06/26 where he was naked with a female resident and on 05/11/26 where he put his hands down another female resident's pants while she was asleep on the couch. -When sexual behavior had been identified the staff notified the PCP, MHP, and family. -She completed a sexual competency tree on the residents.	D 270		

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D 270	Continued From page 46 -She performed BIMS on the residents every three months. -Staff would round, intervene, and redirect residents when needed. Interview with the Administrator on 05/14/26 at 1:33pm revealed: -Resident #4 transferred from independent living to SCU. -When Resident #4 first moved in he was verbally sexual and that had progressed. -The CSD and the MCD had communicated with Resident #4's family related to the sexual encounters. -The clinical staff were to keep a check on Resident #4. -The possibility of 1:1 supervision had been discussed for Resident #4 or a part time sitter. -The CSD performed the decision tree for sexual competency. -The PCP, MHP, and family were notified when a sexual encounter took place. -The facility policy required staff to initiate an intervention and notify the families of the residents impacted. -All staff were responsible for ensuring the safety of the residents and families. -The facility would not knowingly admit a resident that was a sexual aggressor to the community. -She had not met with Resident #4's family since the 05/06/26 sexual encounter. Telephone interview with Resident #4's PCP on 05/14/26 at 11:00am revealed: -Resident #4 had a history of sexual encounters when he was living in the independent living facility. -She was concerned about Resident #4 touching other residents and protecting the other residents. -The MHP admitted Resident #4 on 04/06/26.	D 270		

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-The first step in Resident #4's treatment were selective serotonin reuptake inhibitors (SSRI) they worked well in decreasing behaviors.
-Paxil 10mg was started on 04/06/26, was increased to Paxil 20mg, and then Paxil 30mg this could take several weeks to be effective (Paxil was used to treat his behaviors).
-On 05/11/26 it was determined that Resident #4 needed a sitter during daytime hours.
-Resident #4 would need a sitter for several weeks until the medication was at an effective dose.
-She was not notified about the sexual encounters that took place on 05/06/26 and 05/11/26 and should have been notified.
-Resident #4 did not know boundaries and was not competent to consent to sexual relations.
-The staff should keep eyes on him and engage him in activities.

Telephone interview with Resident #4's MHP on 05/14/26 at 2:30pm revealed:
-Resident #4 had cognitive impairment disorder.
-She had been requested to see Resident #4 for his sexual behaviors on 04/01/26.
-She placed him on Paxil 10mg daily.
-Resident #4 was confused and not competent to engage in sexual behaviors.
-Resident #4 could not answer questions.
-She saw Resident #4 again on 04/20/26 and he continued acting inappropriately and had sexual behaviors; she increased his Paxil to 20mg daily.
-Resident #4's PCP called her and the facility sent her an email that he was found in the day room with his hands down a female resident's pants and she instructed the facility to redirect the resident and continue current management and she would see him on 05/18/26.
-His sexual behavior was an impulse and the facility needed to keep an eye on him.

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-She increased his Paxil to 30mg daily and he needed to be on it for 1-2 weeks to see if it would work.
-Resident #4 needed to be kept out in the open spaces.

Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable.

b. Review of Resident #5's current FL-2 dated 09/30/25 revealed:
-Diagnoses included Alzheimer's disease, insomnia, and hypothyroidism.
-The recommended level of care was memory care.
-She was intermittently disoriented.

Review of Resident #5's Resident Register revealed she was admitted to the facility on 11/07/24.

Review of Resident #5's Care Plan dated 05/29/25 and 02/23/26 revealed:
-If she was becoming too involved with another male resident, staff should approach the situation with sensitivity by redirecting her or removing her from the situation.
-Additional safety checks were needed, frequent safety checks on resident multiple times per shift and staff should know resident's whereabouts; resident had become overly involved with one other male.
-Her communication ability was impaired but did not interfere with everyday functioning.
-Her understanding ability was impaired but did not interfere with everyday functioning.

Review of Resident #5's primary care provider's (PCP) progress note dated 09/16/25 revealed:

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-Resident #5 had Alzheimer's disease, severe stage with unintentional weight loss, underweight, appetite loss, and urinary incontinence.
-Resident #5 continued to give food to a gentleman at the facility that she was interested in.
-Resident #5 was alert, aware, smiled, was happy, but could not reliably answer questions.
-Resident #5 had developed a close relationship with a male resident, which lead to behavioral issues.
-She had been observed kissing and holding hands with him and became agitated when separated, even attempting to fight staff.
-She was resistant to leaving the facility for outings with her daughter preferring to stay with the male resident.
-Overall behavioral issues had been better and her mood better since she was last seen and stabilized on Sertraline 75mg daily (Sertraline was used to treat mood).
-Her family noted a single incident of vaginal bleeding after an interaction with the male resident, it was attributed to possible tissue atrophy and had not recurred and the daughter had not wanted to pursue workup.

Review of Resident #5's brief interview for mental status (BIMS) (BIMS was a quick cognitive assessment to evaluate basic memory, learning and temporal orientation), dated 10/11/24 revealed she scored one point (a BIMS score of 0 to 7 indicated there was severe cognitive impairment).

Review of Resident #5's staff care tracking log for April 2026 revealed:
-On 04/10/26, Resident #5 was walking around with male residents kissing him on the mouth.
-On 04/14/26, Resident #5 was found in a male

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D 270	Continued From page 50 resident's room holding hands. -On 04/14/26, Resident #5 was kissing a male resident. -On 04/14/26, Resident #5 was kissing other residents and inviting them in her room and became very combative when staff tried to redirect her. -On 04/15/26, the MA was notified by a family member of another resident that Resident #5 was in their family members room lying on the bed and his hands were inside her pants and they were kissing. -The MA called out to both residents to not engage in sexual behaviors and attempted to redirect Resident #5 out of the room; she became combative and displayed signs of aggression. -On 04/15/26, the PCA notified the MA that Resident #5 was displaying sexual behaviors to a male resident and was kissing and rubbing on the male resident while he was trying to eat. -On 04/16/26, Resident #5 continued to follow another resident as soon as she got out of bed and they had been inseparable all morning; she was separated from another resident and became agitated and snappy. -On 04/18/26, Resident #5 was kissing a male resident throughout the shift. -On 04/19/26, Resident #5 tried a couple of times to get into a male resident's room, hugging and kissing him. -On 04/21/26, Resident #5 was chasing behind another resident: staff were paged to the middle living room and they were physical and had to be separated. -On 04/22/26, Resident #5 was kissing a male resident. -On 04/23/26, Resident #5 was kissing another resident and staff attempted to separate them numerous times and were unsuccessful.	D 270		

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D 270	Continued From page 51 Review of Resident #5's staff care tracking log for May 2026 revealed: -On 05/06/26, Resident #5 was found by staff completely naked in a male resident's room and the male resident was attempting to penetrate Resident #5. -On 05/12/26, Resident #5 was kissing another male resident. Interview with Resident #5's family member on 05/13/26 at 3:50pm revealed: -She knew that Resident #5 was found in a male resident's room naked about 1.5 weeks ago. -She did not like that this happened with Resident #5. -The facility assured her this would not happen again. -There had been no communication with her from administration since the incident happened. -This was not the first time Resident #5 had engaged in sexual activity since she moved in; it had happened several times over the past couple of years. -This incident with her family member was alarming. -She did not want Resident #5 engaging in sexual activity and preferred that the staff were able to observe the resident's where abouts. Interview with a MA on 05/14/26 at 7:05am revealed: -There had been sexual behaviors on the night shift. -A male resident had been found in Resident #5's room naked. -Resident #5 had sexual encounters with other residents who were no longer at the facility. Interview with another MA on 05/14/26 at 9:25am revealed:	D 270		

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D 270	Continued From page 52 -Resident #5 would come and seek out a male resident. -She had found Resident #5 sitting on a male resident's lap. Interview with the Memory Care Director (MCD) on 05/14/26 at 12:20pm revealed: -When a resident had sexual behaviors the facility would notify the PCP and family. -The PCP made decisions on the treatment of the residents. -Clinical staff monitored the residents and documented in care tracking log. -The staff that witnessed the sexual encounter would notify the MHP. -The Care Services Director (CSD) completed the BIMs on the residents. -At no time were residents allowed to engage in sexual encounter. -The PCP and MHP were notified with each sexual encounter. Interview with the CSD on 05/14/26 at 8:28am revealed: -Resident #5's family had told her that she did not want her having sexual relations. -Resident #5's BIMs was zero and it was presumed she could not provide consent for sexual relations. -Resident #5 was naked with a male resident on 05/06/26. -When sexual behavior had been identified the staff notified the PCP, MHP, and family. -She completed a sexual competency tree on the residents. -She performed BIMS on the residents every three months. -Staff would round, intervene, and redirect residents when needed.	D 270		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 53 Interview with the Administrator on 05/14/26 at 1:33pm revealed: -Resident #5 had been sexually aggressive in the past with multiple male residents. -The facility worked with Resident #5's PCP, MHP and family related to her sexual encounters. -The CSD performed the decision tree for sexual competency. -The PCP, MHP, and family were notified when a sexual encounter took place. -The facility policy required staff to initiate an intervention and notify the families of the residents impacted. -All staff were responsible for ensuring the safety of the residents and families. -The facility would not knowingly admit a resident that was a sexual aggressor to the community. Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable. 2. Review of the facility's policy for Monitoring Residents dated 07/23/25 revealed: -Residents would be checked on regularly to monitor for changes in condition. -Each resident would be checked on at least once during the day and night shift or as indicated in the resident's care plan. -Examples of individuals requiring night shift checks included residents with dementia or other cognitive impairment living in the unsecured assisted living (AL) area. -When warranted by a change in the resident's condition or other circumstances, the Care Services Director (CSD) could implement night checks. Review of the facility's Elopement, Wandering, and Missing Resident Policy dated May 2025	D 270		

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D 270	Continued From page 54 revealed: -It was the policy of the facility to provide a safe and secure environment for all residents. -Wandering was defined as meandering, aimless, or repetitive locomotion that may expose the individual to harm; may or may not be goal directed. -Elopement was defined as the act of leaving a safe area unsupervised and unnoticed. -AL residents' cognitive capabilities were evaluated for risk of wandering during move-in and during the standard reassessment process. -If an AL resident was found to be at risk for wandering, the physician and responsible party were notified -The Elopement Screening form would be used to document a resident's risk. -Appropriate interventions implemented to protect the welfare of the resident may include, but were not limited to the following: termination of the residency agreement; transfer to appropriate level of care; physician evaluation, including medication review; personal sitter for immediate (24/7) resident safety; and monitoring of the resident's whereabouts using means appropriate to the facility (e.g. wanderguard). -Additional behavioral interventions may include: adaptation of the environment with way-finding cues and landmarks; encouragement to engage in activities; notification of physician for changes in behavior such as increasing insistence or attempts to leave; and additional resident and family involvement and education. Review of the facility's Wander Management System dated 07/23/25 revealed: -Personal wander management systems such as a wanderguard (egress alert device) may be used as part of a comprehensive assessment and departure prevention program to assist in	D 270		

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deterring elopements.
-Residents who were known to be an elopement risk would be evaluated to determine the appropriateness of use of an egress alert device worn by the resident or carried on the resident's person.
-If a resident wearing an egress alert device attempted to leave an alarmed facility, it would trigger a visual alert or alarm indicating a resident was attempting to leave.
-If an egress alert device was to be worn, the resident's care plan would be updated to include the resident's behavior or conditions indicating the need for the device, the physician's recommendations, and resident notification of the egress alert device recommendation.
-Prior to the use of an egress alert device by a resident living in a non-secured AL environment, the resident's physician would be consulted to obtain physician's instructions regarding the resident's need for supervision.
-If the physician indicated the resident was unable to leave the facility without supervision, access to exits must be alarmed or an egress alert device, such as a wanderguard may be advised.

a. Review of Resident #1's current FL-2 dated 10/28/25 revealed:
-Diagnoses included mild dementia, macular degeneration, hypertension, hypothyroidism, and arthritis.
-The resident was documented as intermittently disoriented.

Review of Resident #1's Resident Register revealed:
-The resident was admitted to the assisted living (AL) side of the facility on 10/17/25.
-The resident required assistance from staff with hair care/grooming, medication, bathing, nail

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care, and orientation to time and place.
-The resident was documented as being forgetful and needed reminders.
-The resident's hearing and vision were documented as impaired.
-The resident was documented as having little to no short-term memory capacity and progressive cognitive decline.

Review of Resident #1's care plan dated 10/17/25 revealed:
-The resident required assistance of one staff for bathing and dressing.
-The resident exhibited some confusion and staff were to monitor and report any concerns.
-The resident could express anxiety and staff were to monitor and report any concerns.
-The resident required supervision while outside of the facility.
-The resident needed physical assistance from staff in the event of an emergency.
-The resident's visual impairment interfered with everyday functioning.
-The resident wore glasses and had a hearing device.

Review of Resident #1's mental health provider (MHP) visit note dated 03/09/26 revealed:
-The resident had generalized anxiety disorder.
-The resident's family and facility staff reported afternoon nervousness suggesting poorly controlled symptoms likely due to "sundowning" (a pattern of increased confusion, agitation, and restlessness in people with dementia or Alzheimer's disease that typically occurs in the late afternoon or evening).
-The resident had significant sundowning behavior characterized by a marked change in personality and increased nervousness every afternoon around 2:00pm.

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D 270	Continued From page 57 Review of Resident #1's facility care tracking note dated 03/12/26 at 6:42pm revealed: -The resident continued exhibiting increased anxiety, particularly in the late afternoon. -The resident repeatedly came to the front desk for help. -The resident did not recognize the facility as her home and needed frequent reassurance and redirection. Review of Resident #1's facility care tracking note dated 03/20/26 at 6:52am revealed: -The resident wandered the halls, asking about money that she says was stolen, and wanting to go home. -The resident was redirected to her room, where she finally went to bed and stayed in bed after 12:00am. Review of Resident #1's facility care tracking note dated 03/23/26 at 6:46pm revealed: -The resident was in the lobby crying, shaking, and asking for help. -The resident said she needed to go home and she could not remember why she was here. -Staff escorted the resident back to the AL side of the facility. Review of Resident #1's facility care tracking note dated 03/24/26 at 5:46am revealed: -At the start of the shift, the resident was walking the halls crying and shaking. -This continued for a couple of hours then staff were finally able to redirect the resident back to her room where she stayed the remainder of the shift. Review of Resident #1's facility care tracking note dated 03/28/26 at 5:55am revealed:	D 270		

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D 270	Continued From page 58 -As soon as the shift started, the resident came out of her room, walking the halls, crying, shaking, and asking for help. -She stated a man just got out of prison and was moving across from her family member and she had to warn her. -Staff assisted the resident in calling her family member. Review of Resident #1's facility care tracking note dated 03/30/26 at 5:20am revealed: -The resident seemed to be experiencing some anxiety and she walked the halls. -Staff had to keep redirecting the resident to her room and she finally laid down after 9:00pm. Review of Resident #1's facility care tracking note dated 03/31/26 at 6:19am revealed: -The resident was wandering around, shaking, and asking for her family. -The resident calmed down, then wandered out of her room again asking for help. Review of Resident #1's facility care tracking notes dated 04/02/26 at 5:40am and 6:33am revealed: -At the start of the shift, the resident seemed to be experiencing extreme anxiety. -The resident walked the halls, shaking and crying, asking for her mother and kids. -The resident was very anxious and saying that someone told her that her mother was dying. -The resident was nervous and trying to leave. -The resident was redirected back to her room several times. -It was almost midnight when the resident finally settled down. Review of Resident #1's facility care tracking note dated 04/17/26 at 5:37am revealed:	D 270		

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D 270	Continued From page 59 -The resident seemed very confused and anxious. -The front desk called over the walkie talkie that she was going behind the resident to get her. -The resident had been going outside, walked across the street, and did not know where she was. -When redirected back to her room, the resident would come out almost in tears and shaking, looking for her family members. Review of Resident #1's MHP visit note dated 04/20/26 revealed: -The resident had generalized anxiety disorder characterized by significant agitation and anxiety, particularly in the afternoons. -The resident's symptoms seemed to be worsening with an earlier onset of agitation, now noted around 11:00am. -The resident had a history of dementia. -The resident demonstrated significant cognitive impairment, as evidenced by disorientation to time and inability to recall without significant prompting. -The facility staff continued to report ongoing sundowning. Review of Resident #1's facility care tracking note dated 04/24/26 at 6:55am revealed: -The resident came out of her room around 2:00am, fully dressed. -The resident stated she was confused; she thought it was morning. -Staff redirected the resident back to her room. Review of Resident #1's MHP visit note dated 05/04/26 revealed: -The resident was 93 years old with generalized anxiety disorder and sundowning. -The resident's sundowning contributed to	D 270		

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significant agitation, restlessness, and confusion.
-The resident continued to experience breakthrough anxiety.
-The resident had a diagnosis of dementia and presented with significant cognitive deficits, including disorientation to time and impaired recent memory.
-The resident's cognitive impairment was a significant contributor to her anxiety, agitation, and behavioral symptoms like sundowning.

Review of Resident #1's facility care tracking note dated 05/04/26 at 5:00pm revealed:
-The resident was "seen by a visitor" all the way in the cottage area and staff brought her back. (The cottage area was part of the independent living (IL) area outside across the street from the AL building.)
-The witness was documented as a visitor and the location was documented as "offsite".

Review of Resident #1's provider communication form to the facility's contracted provider dated 05/04/26 (no time specified) revealed:
-Staff documented "elopement".
-The resident was seen by a visitor in the cottage area and staff brought the resident back.
-The resident's blood pressure was documented as 166/91 and her heart rate was 95.

Observation of the facility's security camera footage dated 05/04/26 revealed:
-At 4:35pm, Resident #1 was walking down the sidewalk on the "End of AL Building" view and went out of sight of camera view 5 seconds later.
-At 4:40pm, Resident #1 was walking down the sidewalk on the "AL Building Side Entrance" view and went out of sight of camera view 12 seconds later.
-At 4:47pm, Resident #1 was walking down the

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sidewalk on the "Cottage Front Dual" view and went out of sight of camera view 7 seconds later.
-At 5:04pm, Resident #1 was escorted into the front entrance by staff.

Review of Resident #1's Elopement Risk Assessment dated 05/05/26 revealed:
-The resident ambulated without an assistive device.
-The resident involuntarily moved in and had adjustment issues.
-The resident had anxiety, paranoia, and was exit-seeking.
-The resident scored 37 which indicated moderate risk of elopement.
-There was no information regarding interventions to prevent elopements on this form.

Review of Resident #1's facility care tracking note dated 05/05/26 at 12:40pm revealed:
-The Resident Care Supervisor (RCS) talked with the resident's family regarding the wandering incident that occurred the previous evening.
-At that time, the family declined the use of a wanderguard.
-Safety checks (specific frequency not specified) throughout the shifts were added to the care plan.

Review of Resident #1's facility care tracking note dated 05/05/26 at 6:52pm revealed:
-The resident was very agitated and very emotional.
-The resident was redirected several times throughout the day.

Review of Resident #1's reassessment and care plan dated 05/05/26 revealed:
-The resident required assistance of one staff for bathing and dressing.
-The resident exhibited some confusion and staff

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were to monitor and report any concerns.
-The resident could express anxiety and staff were to monitor and report any concerns.
-Staff were to provide support when the resident appeared anxious or reported anxiety.
-The medication aide (MA) was to be notified when anxiety was reported or observed.
-The resident could express forgetfulness and staff were to monitor and report any concerns.
-The resident needed assistance with "other behavioral expression".
-The resident needed safety checks throughout the day (frequency not specified).
-The resident was to be checked on routinely throughout waking hours (specific timeframe not specified).
-Safety checks were to be done every 2 hours - staff must see the resident every 2 hours.
-The resident required supervision while outside of the facility.
-The resident needed physical assistance from staff in the event of an emergency.
-The resident's visual impairment interfered with everyday functioning.
-The resident wore glasses and had a hearing device.

Review of Resident #1's facility care tracking note dated 05/06/26 at 1:43pm revealed:
-The note was a late entry for 05/05/26.
-The resident was outside with her purse yesterday.
-Two staff members from AL were sitting with her because she stated she was leaving to "wait for a car".
-She had wandered off by the cottages that week and had to be brought back to the building.
-The RCS spoke with the family about the wandering incident but the family declined the use of a wanderguard.

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D 270	Continued From page 63 -The resident continued to exhibit anxiety daily, frequently requiring assistance and had to be redirected by staff. -The resident was confused, unhappy with living at the facility and often voiced a desire to go back to her own home. Review of Resident #1's facility care tracking note dated 05/13/26 at 6:12am revealed: -The resident was extremely anxious and wandering back and forth asking what should she do. -The resident was helped to her room 3 times but continued to come out of her room very upset. Review of Resident #1's facility care tracking note dated 05/15/26 at 5:21am revealed: -The resident was wandering the halls and crying at the start of the shift. -An as needed (prn) medication was administered and it seemed to be effective. Observation of Resident #1 on 05/15/26 at 2:45pm revealed the resident was walking alone in the hallway near her room. Interview with Resident #1 on 05/15/26 at 2:45pm revealed: -She had been visiting with "my mother" and her "mother" did not live with her. -When asked if she ever went outside, the resident stated she went outside and walked "up and down the street". Review of Resident #1's facility care tracking note dated 05/15/26 at 6:27pm revealed: -The resident wandered in and out of the front door that evening. -Staff were present at the door to address the exit alarm (which had been turned on the previous	D 270		

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day).
-The resident was not open to redirection and stated she was going to sit outside and wait for her sister.
-The resident came in and out several times.
-Redirection was short lived, a wanderguard was applied, and the family was notified.
-The resident remained by the front door being monitored by staff.

Review of Resident #1's Care Tracking Log dated 05/05/26 - 05/15/26 revealed:
-Safety checks "throughout day" were documented from 05/05/26 - 05/15/26.
-Safety check times were noted to be: 1st Morning 7:00am - 11:00am, 1st Midday 11:00am - 3:00pm, 2nd Afternoon 3:00pm - 7:00pm, 2nd Evening 7:00pm - 11:00pm, 3rd Overnight 11:00pm - 3:00am, and 3rd Early Morning 3:00am - 7:00am.
-The first safety check was documented as completed on 05/05/26 at 12:20pm during the 1st Midday 11:00am - 3:00pm check.

Review of Resident #1's Safety Check Log dated 05/14/26 - 05/17/26 revealed:
-Staff started documentation of 15-minute checks for Resident #1 on 05/14/26 at 8:30pm - 05/17/26 at 11:45pm.
-Staff documented the location of the resident at the 15-minute checks.

Review of Resident #1's May 2026 electronic medication administration record (eMAR) dated 05/01/26 - 05/18/26 revealed:
-There was an entry with instructions to verify placement of wanderguard every shift; perform visual check to ensure the wanderguard is in place on her right wrist.
-The wanderguard check was scheduled to be

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done on Shift 1 (day shift) and Shift 2 (night shift).
-Documentation for placement of the wanderguard started on Shift 2 on 05/15/26 and continued through Shift 2 on 05/17/26.

Interview with a MA on 05/14/26 at 4:44pm revealed:
-Resident #1 wandered around the facility and stated that people were in her house.
-About a week ago, Resident #1 went to the cottages behind the IL building across the street around 5:00pm.
-After the incident, Resident #1 was put on 2-hour safety checks.
-Resident #1 did not preciously or currently have a wanderguard in place.

Interview with a second MA on 05/14/26 at 4:46pm revealed:
-Resident #1 went independently for daily walks before the elopement on 05/04/26.
-She thought the resident walked further than normal on 05/04/26 and could not find her way back.

Interview with a third MA on 05/18/26 at 2:50pm revealed:
-Around 4:00pm on 05/04/26, Resident #1 and a family member were sitting outside near the front entrance of the facility, chatting for a while.
-After the family member left (not sure what time), staff received a call on the walkie talkies from the IL across the street that Resident #1 was across the street.
-She went outside to look for Resident #1 and she got a call on the walkie talkie that the resident had been brought back to the AL building.
-The resident sometimes took walks on her own but did not usually go that far.
-The resident sometimes got lost trying to find her

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room.
-Staff usually did routine 2 hours checks on the residents living in the AL side of the facility.
-After the incident on 05/04/26, she usually checked on Resident #1 every 30 minutes - 1 hour and tried to keep her in the common areas of the facility.
-Staff sometimes documented supervision checks of residents, but she could not recall if they documented checks for Resident #1.
-The resident was now wearing a wanderguard.

Interview with Resident #1's family member on 05/18/26 at 4:24pm revealed:
-Resident #1 lived in the IL building across the street prior to moving to the AL building.
-Resident #1 was a "walker"; she loved to take walks.
-The resident would go out the front entrance of the facility to take walks.
-There was an incident about 2 weeks ago when Resident #1 was walking outside and started going toward a pathway near the pond where she used to walk when she lived across the street in the IL building.
-She was told the resident flagged someone down who was leaving the AL building and was brought back to the facility.
-She had been visiting the resident that day on 05/04/26 and left around 4:30pm with the resident still sitting on the bench outside the front entrance of the AL where they had been visiting.
-The MA called her later that day (not sure what time) and reported Resident #1 had gotten disoriented and was escorted back to the AL building.
-That was the first elopement to her knowledge.
-The resident had been unsettled in the evenings because of sundowning.
-The MA mentioned a facility protocol for

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wandering which included frequent checks and the use of a wanderguard.
-The family set up a meeting with the Administrator.
-The plan was for the facility to do frequent checks (no timeframe was specified).
-She had observed the facility staff check on the resident sometimes when she visited.

Interview with the RCS on 05/14/26 at 4:42pm revealed:
-The staff usually did room rounds every 2 hours in the AL side of the facility, but residents could also be seen in the hallways or during medication pass.
-On 05/04/26, she thought a resident's family member (did not know who) saw Resident #1 around the cottages beside the IL building and took the resident to the IL building.
-Staff at the IL building used the walkie talkies to let AL staff know they had Resident #1 and then the resident was brought back to the AL building.
-The facility staff did 2-hour safety checks on Resident #1 where staff had to physically check the resident's location every 2 hours.
-When asked the difference between routine 2 hours checks and 2-hour safety checks, the RCS stated they physically checked the location of the resident for both checks.
-It was not clear what the difference was between the 2-hour routine checks and the safety checks.

Second interview with the RCS on 05/18/26 at 4:55pm revealed:
-After the incident on 05/04/26 with Resident #1, the family did not want a wanderguard so they did safety checks.
-On Friday, 05/15/26, she got a phone message from the Care Services Director (CSD) that Resident #1 now had a wanderguard because the

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D 270	Continued From page 68 resident had been going in and out the front door looking for her family member. Interview with the CSD on 05/18/26 at 5:44pm revealed: -Resident #1 was very anxious and paranoid. -Resident #1 was unhappy with her placement at the facility and always sought out family members. -Resident #1 had wandering behavior for a while now. -Resident #1 had been wandering around in the hallways all day and her family wanted the resident to go outside for walks. -Resident #1 had visual impairment causing poor vision. -Resident #1 was allowed to walk outside on the sidewalk by herself. -Resident #1 recently had an elopement and was found at the cul-de-sac in the cottages to the left of the IL building. -She was concerned about Resident #1 not being able to find her way back or getting harmed. -She was not sure if Resident #1 was put on safety checks prior to the elopement. -On Friday night, 05/15/26, Resident #1 was in and out of the front door and sat on a bench outside; staff watched her. -They called the family and a wanderguard was placed on Resident #1 on 05/15/26 because she kept going in and out the front door. Interview with the Administrator on 05/14/26 at 6:30pm revealed: -Resident #1 recently wandered outside at night and staff redirected the resident back inside. -She did not know all the details. -Staff put a wanderguard on Resident #1 after the incident. -Resident #1's cognition was intermittent; some	D 270		

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days staff could have a good conversation with the resident and other days she did not know where she was or what she was doing.
-Resident #1 had wandered in the past but not too much and she was able to be redirected.
-She had discussed moving the resident to the special care unit (SCU) a few times.
-If the resident's confusion increased that could be a next step.
-Staff usually did 2-hour routine checks on residents in the AL side of the facility.
-She did not know if Resident #1's supervision was increased after documented behaviors prior to the elopement on 05/04/26 or after the elopement on 05/04/26.
-The campus had a video surveillance security system for the facility, and independent living across the street 24/7.
-Staff at the IL building could notify AL staff if they saw a resident on the cameras.
-If a resident could not be redirected, they would try a wanderguard.
-They would try a wanderguard for about 30 - 45 days and if that did not help, they would have to discuss moving to the SCU or have the family consider a sitter.
-Residents were allowed to go outside if the family said a resident could go outside during care plan meetings.
-Prior to Resident #1's elopement, the resident was allowed go outside to walk on her own because the resident's family said she could go outside.

Telephone interview with Resident #1's primary care provider (PCP) on 05/18/26 at 4:01pm revealed:
-Resident #1's cognition was not good, and her dementia had gotten worse over the last two months.

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D 270	Continued From page 70 -The resident's anxiety was overlapping with her ability to know what was going on. -The resident had more than mild cognitive impairment at that point and was hard to redirect. -The resident's room was at the very end of a hallway beside an exit door and family had put signs on her door to help the resident find her room. -About a week before the elopement on 05/04/26, she came to the facility and the resident was in the middle of the parking lot with facility staff redirecting her. -She was made aware of the incident on 05/04/26 by facility staff on 05/04/26. -It was dangerous for Resident #1 to be walking outside alone. -There were woods and a pond nearby and the resident could not see well. -There was also a very busy highway nearby. -The resident could have fallen in the pond or gotten hit by a car. -She was not aware the resident attempted to leave the facility again on 05/15/26. -If the facility had not placed a wanderguard on the resident on 05/15/26, she would have told them the resident needed a wanderguard, or potentially a sitter, or the resident may have needed to go to the SCU. -The facility staff should have notified her on 05/15/26 when Resident #1 attempted to leave the facility again multiple times and that they had placed a wanderguard on the resident. Interview with Resident #1's MHP on 05/18/26 at 3:34pm revealed: -Resident #1 had dementia, impaired cognition and was confused at times. -The resident had some sundowning behaviors. -Staff had reported the resident's behavior fluctuated and they reported the resident	D 270		

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D 270	Continued From page 71 wandered. -She was not aware Resident #1 eloped from the facility on afternoon of 05/04/26. -She did not recall anyone notifying her of Resident #1's elopement and she did not seen any notifications in her computer system. -She had been at the facility today, 05/18/26, and no one reported the elopement to her. -She had seen the resident earlier in the day on 05/04/26 for a visit and the resident was in her room with a family member. -If she had known about the elopement on 05/04/26, she would have encouraged facility staff to engage the resident in activities and to provide supportive measures to keep the resident busy. -Resident #1 was 93 years old and it was not safe for her to wander away from the facility given her age and cognitive status. -Resident #1 needed supervision when outside of the facility. -She was not aware a wanderguard had been placed on Resident #1. Second interview with the Administrator on 05/18/26 at 6:56pm revealed: -Resident #1 was found either by a resident who lived on campus at the cottages near IL building or a staff person. -They reported it to AL staff and AL staff went and escorted Resident #1 back to the facility. -The RCS followed up with the family and they did not want a wanderguard. -The family wanted Resident #1 to be able to leave the facility and walk around outside. -The facility complied with the family's wishes but should have put safety first. -She met with Resident #1's family again that past weekend because the resident was going in and out of the front door.	D 270		

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D 270	Continued From page 72 -The family agreed to a wanderguard on Friday, 05/15/26, and it was placed on the resident at that time. -She was not aware the facility's policy required contacting the provider prior to placing a wanderguard. -The facility's security cameras were on 24/7 and monitored by the front desk and IL staff but it was not continuously monitored. b. Review of Resident #2's current FL-2 dated 01/21/26 revealed: -Diagnoses included dementia, anxiety, acute asthma, type 2 diabetes, hypothyroidism, osteoporosis, and hyperlipidemia. -The resident was semi-ambulatory and used a walker. -The resident was documented as intermittently disoriented. Review of Resident #2's Resident Register revealed: -The resident was admitted to the assisted living (AL) side of the facility on 04/19/21. -The resident required assistance from staff with skin care, bathing, oral care, nail care, medication, and hair/grooming. -The resident was documented as being forgetful and needed reminders. Review of Resident #2's care plan dated 12/04/25 revealed: -The resident required assistance of one staff for bathing, dressing, and grooming. -The resident used a walker and staff provided resident reminders to use the walker. -The resident exhibited some confusion and staff were to monitor and report any concerns. -The resident required supervision while outside of the facility.	D 270		

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D 270	Continued From page 73 -The resident needed physical assistance from staff in the event of an emergency. Review of Resident #2's facility care tracking note dated 03/14/26 at 5:35am revealed: -The resident did not sleep at all last night. -The resident walked the halls and seemed more confused than usual. -The resident was urinating more than usual. -The primary care provider (PCP) was faxed. Review of Resident #2's physician's communication form to the facility's contracted provider dated 03/14/26 (no time specified) revealed: -The resident seemed more confused than usual. -The resident was not sleeping at night and she was up and down walking the halls. -The resident was also urinating more frequently. -The PCP ordered a urinalysis to check the resident's urine for infection. Review of Resident #2's facility care tracking note dated 03/20/26 at 6:36am revealed the resident woke up a couple of times during the night confused and disoriented. Review of Resident #2's PCP triage note dated 03/23/26 revealed: -The resident's urine was positive for a urinary tract infection (UTI). -The PCP ordered an antibiotic for 7 days. Review of Resident #2's facility care tracking note dated 04/19/26 at 6:40am revealed: -The resident did not sleep throughout the night and appeared very confused. -The resident was leaving her room and trying to enter other residents' rooms. -Staff redirected the resident back to her room	D 270		

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D 270	Continued From page 74 multiple times. Review of Resident #2's facility care tracking note dated 04/28/26 at 4:15am revealed: -Resident #2 was wandering outside the facility in the parking lot around 3:00am. -Staff from the special care unit (SCU) saw her and asked where she was going. -The resident stated that she was going home. -The resident was holding her bra and an incontinence brief in her hands. -AL staff went outside, assisted the resident back inside the facility, and redirected the resident to her room. -Around 4:00am, the resident came out of her room again into the hallway and was redirected by staff back to her room. Review of Resident #2's incident report dated 04/28/26 at 3:00am revealed: -Resident #2 wandered outside to the parking lot area and had to be redirected back to her room. -The resident continued to wander in the hall for the remainder of the night and had to continuously be redirected back to her room. -Staff documented they would continue to monitor the resident. Review of Resident #2's physician's communication form to the facility's contracted provider dated 04/28/26 (no time specified) revealed: -The resident had a wandering incident around 3:00am. -The family was notified and there was a plan to discuss further action plan with the family. -The PCP ordered a urinalysis to check the resident's urine. Observation of the facility's security camera	D 270		

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D 270	Continued From page 75 footage dated 04/28/26 revealed: -At 2:52am, Resident #2 walked out of the first set of double sliding glass front entrance doors and the second set to the outside. -At 2:53am, Resident #2 came back inside the outside double sliding door into the foyer and walked out of sight to the interior set of double sliding glass doors. -At 2:54am, Resident #2 walk back outside the exterior front doors. -At 2:55am, a male staff person came into the front entrance from the outside. -At 2:56am, the male staff person and a female staff person exited the front doors. -At 2:58am, Resident #2 was escorted back into the facility by both staff. Review of Resident #2's Elopement Risk Assessment dated 04/28/26 revealed: -The resident ambulated without an assistive device. -The resident had become "lost" in the community. -The resident had actual wandering behaviors. -The resident had delusions and sleep disturbance. -The resident was found by staff in the parking lot at 3:00am. -Staff escorted the resident back inside. -The PCP ordered a urinalysis which was positive. -The resident's power of attorney (POA) agreed to the use of a wanderguard due to elopement risk. -The resident scored 38 which indicated moderate risk of elopement. Review of Resident #2's physician's communication form to the facility's contracted provider dated 05/04/26 (no time specified)	D 270		

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revealed:
-Resident #2 had some nights where she wandered a lot throughout the night.
-The facility staff requested an as needed (prn) medication to help with sleep.
-The PCP noted she would check with the family and the resident had follow-up with neurology this week.
-The PCP signed the form on 05/04/26.

Review of Resident #2's PCP triage note dated 05/04/26 revealed:
-The resident's labs indicated she had a UTI.
-The PCP ordered an antibiotic for 7 days.

Review of Resident #2's May 2026 electronic medication administration record (eMAR) dated 05/01/26 - 05/18/26 revealed:
-There was an entry with instructions to verify placement of wanderguard every shift; perform visual check to ensure the wanderguard is in place on her left wrist.
-The wanderguard check was scheduled to be done from 7:00am to 7:00pm and 7:00pm to 7:00am.
-Documentation for placement of the wanderguard started from 7:00am - 7:00pm on 05/08/26 and continued through 05/18/26.

Review of Resident #2's reassessment and care plan dated 05/15/26 revealed:
-The resident required assistance of one staff for bathing, dressing, and grooming.
-The resident exhibited some confusion, and staff were to monitor and report any concerns.
-The resident could express forgetfulness, and staff were to monitor and report any concerns.
-Safety checks were needed for Resident #2 during hours of sleep.
-The resident wore a wanderguard for safety and

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staff were to be sure it was in place and report any concerns promptly.
-The resident required supervision while outside of the facility.
-The resident needed physical assistance from staff in the event of an emergency.

Review of Resident #2's Safety Check Logs dated 05/14/26 - 05/17/26 revealed:
-Staff started documentation of 15-minute checks for Resident #2 on 05/14/26 at 8:30pm - 05/17/26 at 11:45pm.
-Staff documented the location of the resident at the 15-minute checks.

Interview with Resident #2 on 05/14/26 at 1:46pm revealed:
-She liked to go outside.
-She was unable to say when she went outside or where she went outside.
-She was unable to say if anyone went outside with her.

Telephone interview with a medication aide (MA) on 05/14/26 at 1:58pm revealed:
-She was the MA on duty on 04/28/26 when Resident #2 eloped from the facility.
-One of the SCU staff had gone outside for a break and saw Resident #2 in the facility's parking lot.
-The personal care aide (PCA) assigned to Resident #2 went outside to get the resident.
-The PCA reported the resident was wearing pajamas and told the PCA she was going home.
-She did not know how long the resident was outside on 04/28/26.
-She did not see Resident #2 prior to the resident leaving the facility on 04/28/26.
-The PCAs usually did routine 2-hour checks on residents.

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D 270	Continued From page 78 -Resident #2 went back to bed when she was brought back in the facility on 04/28/26 but came out of her room again around 4:00am or 5:00am, just opening doors at least 2 to 3 times. -The front door only alarmed if a resident was wearing a wanderguard device. -Resident #2 was not wearing a wanderguard device on 04/28/26. -Resident #2 had been wearing a wanderguard device since last week (not sure of date). -Staff usually checked on Resident #2 often (could not say how often) because staff knew the resident always wandered. -Resident #2 was confused and had tried to leave before (could not give specific time). -Some days Resident #2 was more confused than other days. -Resident #2 got up at night to use the bathroom and then went into other resident's rooms. -This was not new behavior for Resident #2. -She had been opening and trying to go into other residents' rooms since April 2025. Telephone interview with a PCA on 05/15/26 at 11:27am revealed: -He was a PCA and worked at nights from 7:00pm to 7:00am. -He worked in the SCU side of the facility and had never worked on the AL side. -On 04/28/26, sometime in the middle of the night (did not remember time), he went outside the front entrance of the facility to take a break. -The weather was warm and humid. -The front door did not alarm, and you had to have a key fob to re-enter once you exited the front door. -Residents who wandered usually had a wanderguard device. -He saw a female outside walking on the sidewalk towards a car the parking lot wearing pajamas	D 270		

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and carrying an incontinence brief, a bra, and a sock in her hands.
-He did not recognize her, but he thought it was odd she was outside wearing pajamas.
-The resident was about 50 to 100 feet from the front entrance of the facility.
-The resident seemed confused because she was asking him what was going on.
-Resident #2 told him that she needed to go to her car.
-He used his key fob to come back inside the facility to get a PCA from the AL side.
-The PCA was at the nurses' station doing paperwork and stated she did not see a resident walk by.
-The PCA went outside and helped him redirect Resident #2 back inside the facility.
-The resident did not have any injuries.

Telephone interview with Resident #2's family member on 05/15/26 at 9:19am revealed:
-Resident #2 had dementia and occasionally wandered.
-Staff had to assist the resident to meals and activities because she would not remember to go and they prompted her for dressing and grooming.
-Resident #2's memory was short and she recognized people but did not remember their names.
-When she visited the resident and left the room for 10 minutes and came back, the resident would not remember she was there 10 minutes ago.
-Staff called and notified her that Resident #2 had gotten out of the facility.
-She did not like that the resident went outside and staff did not know.
-Resident #2 told staff she needed to go home.
-Resident #2 had left the facility previously about

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4 years ago by exiting a back door.
-She thought the resident had a UTI both times she left the facility.
-Resident #2 had been having more nighttime agitation and waking up.
-They had put a wanderguard on the resident after the recent elopement and it would make the doors alarm.
-After the elopement, she asked facility staff about locking the doors or alarming the doors.
-They told her staff checked on residents every 2 hours.
-They said they were going to evaluate the resident for the SCU.

Interview with the Resident Care Supervisor (RCS) on 05/14/26 at 4:00pm revealed:
-On 04/28/26, Resident #2 eloped from the facility.
-Resident #2 had a steady cognitive decline in general since she was admitted about a year ago.
-Resident #2 needed more prompting and direction.
-Resident #2 had moments of confusion on some days.
-If Resident #2 did not get a good night's sleep, the resident had more cognitive issues the next day.
-Sometimes Resident #2 did not know where she was going, mostly in the evenings.
-She spoke with Resident #2's family member after the elopement about a wanderguard.
-She thought they added safety checks to note where the resident was after the elopement, but she was not sure how often or if it was documented.
-She had to order the wanderguard bracelet and wait for it to be delivered.
-A wanderguard was placed on Resident #2 on 05/08/26.

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D 270	Continued From page 81 Interview with the Care Services Director (CSD) on 05/18/26 at 5:44pm revealed: -Resident #2's cognition fluctuated but she had less clear times lately. -The resident got confused and had some sundowning. -In 2023, Resident #2 had an incident of wandering outside the facility and a wanderguard was placed on her. -At some point, the wanderguard was removed and there were not further incidents of wandering at that time. -About 2 to 3 weeks ago at 3:00am, Resident #2 eloped from the facility. -She was not sure which door the resident exited. -The RCS contacted the family who agreed to the wanderguard. -The facility did not have any wanderguards available at that time. -There was a delay in putting a wanderguard on Resident #2 after the recent elopement because they were waiting on the wanderguard to be delivered. -Staff did 2-hour rounds to check on residents in the AL. -Resident #2 stayed around the nurses' station most days and staff took her to activities. -She thought staff started safety checks on Resident #2 after the recent elopement but she was not sure. -The staff member who reported an incident was responsible for reporting it to the resident's PCP. -She did not usually consult with a resident's PCP about placing a wanderguard but she did an Elopement Risk Assessment and notified the family. -She was not aware the facility's policy was to notify a provider before placing a wanderguard.	D 270		

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D 270	Continued From page 82 Interview with Resident #2's PCP on 05/14/26 at 10:58am revealed: -The incident on 04/28/26 was the first time Resident #2 had eloped to her knowledge since she had been providing care to the resident. -Resident #2 did not typically wander but when the resident did not sleep well, it caused the resident to be more confused. -After the elopement, Resident #2's urine was checked and it was positive for a UTI. -The family agreed to the use of a wanderguard after the incident. -Resident #2 had intermittent confusion before the incident due to poor sleep. -Resident #2 had dementia and would not be able to find her way back to the facility because she was "very confused". -The resident could haven fallen in the pond on campus or gotten hit by a car if she eloped from the facility. Interview with the Administrator on 05/14/26 at 6:30pm revealed: -Resident #2 recently wandered outside at night and staff redirected the resident back inside. -She did not know all the details. -The resident was tested for a UTI but she thought it came back negative. -Staff put a wanderguard on Resident #2 after the incident. -Resident #2's cognition was intermittent; some days staff could have a good conversation with the resident and other days she did not know where she was or what she was doing. -Resident #2 had wandered in the past but not too much and she was able to be redirected. -She had discussed moving the resident to the SCU a few times. -If the resident's confusion increased that could be a next step.	D 270		

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D 270	Continued From page 83 -Staff usually did 2-hour routine checks on residents in the AL side of the facility. -She did not know if Resident #2's supervision was increased after documented behaviors prior to the elopement on 04/28/26 or after the elopement on 04/28/26. -The campus had video surveillance security system for the facility, and independent living (IL) across the street 24/7. -Staff at the IL building could notify AL staff if they saw a resident on the cameras. -If a resident could not be redirected, they would try a wanderguard. -They would try a wanderguard for about 30 - 45 days and if that did not help, they would have to discuss moving to the SCU or have the family consider a sitter. -Residents were allowed to go outside if the family said a resident could go outside during care plan meetings. Attempted telephone interview on 05/15/26 at 9:14am with the PCA on duty when Resident #2 eloped on 04/28/26 was unsuccessful. _____ The facility failed to provide supervision for 4 of 6 residents (#1, #2, #4, #5) sampled for review. Resident #1 who had dementia, confusion, and wandering behaviors eloped from the facility on 05/04/26 and was found by a visitor across the street at the independent living (IL) cottages. Resident #2 who had dementia, confusion, wandering behaviors, and a history of elopement, eloped from the facility on 04/28/26 and was found by a staff person in the parking lot beside the facility. Resident #1 and Resident #2 left the facility without staff knowledge and were at risk of falling in a pond beside the IL building or getting hit by a car. Resident #4 who had dementia, confusion and wandering behaviors openly	D 270		

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D 270	Continued From page 84 pursued two female residents and was observed naked in his room with one resident multiple times in a sexual encounter and observered once with his hands down a female resident's pants while she slept on a couch in the common area, Resident #5 who had a diagnosis of Alzheimer's disease, confusion and was known to pursue male residents was observed naked in a male resident's room multiple times having sexual encounters. This failure of the facility 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 05/14/26 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 17, 2026.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure health care coordination for 1 of 5 sampled residents (#1) as related to not notifying a resident's primary care provider (PCP) of a resident, who had dementia, attempting to leave the assisted living (AL) part of the facility a second time after a previous elopement and placement of a wanderguard and not notifying the same resident's mental health	D 273		

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provider (MHP) of the resident's elopement, a second incident of the resident attempting to leave the facility, and wanderguard placement on the resident.

The findings are:

Review of Resident #1's current FL-2 dated 10/28/25 revealed:
-Diagnoses included mild dementia, macular degeneration, hypertension, hypothyroidism, and arthritis.
-The resident was documented as intermittently disoriented.

Review of Resident #1's Resident Register revealed:
-The resident was admitted to the assisted living (AL) side of the facility on 10/17/25.
-The resident required assistance from staff with hair care/grooming, medication, bathing, nail care, and orientation to time and place.
-The resident was documented as being forgetful and needed reminders.
-The resident's hearing and vision were documented as impaired.
-The resident was documented as having little to no short-term memory capacity and progressive cognitive decline.

Review of Resident #1's care plan dated 10/17/25 revealed:
-The resident required assistance from one staff for bathing and dressing.
-The resident exhibited some confusion, and staff were to monitor and report any concerns.
-The resident could express anxiety, and staff were to monitor and report any concerns.
-The resident required supervision while outside of the facility.

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D 273	Continued From page 86 -The resident needed physical assistance from staff in the event of an emergency. -The resident's visual impairment interfered with everyday functioning. -The resident wore glasses and had a hearing device. Review of Resident #1's facility care tracking note dated 05/04/26 at 5:00pm revealed: -The resident was "seen by a visitor" all the way in the cottage area and staff brought her back. (The cottage area was part of the independent living (IL) area outside across the street from the AL building.) -The witness was documented as a visitor, and the location was documented as "offsite". Review of Resident #1's physician's communication form to the facility's contracted provider group dated 05/04/26 (no time specified) revealed: -Staff documented "elopement". -The resident was seen by a visitor in the cottage area and staff brought the resident back. -The area on the form for physician's notes/orders, signature and date were blank. -There was a red stamp at the top of the page with "faxed" but the block to document when it was faxed was blank. -There was no documentation to indicate the form was received by the resident's primary care provider (PCP) or mental health provider (MHP). Review of Resident #1's facility care tracking note dated 05/05/26 at 12:40pm revealed: -The Resident Care Supervisor (RCS) talked with the resident's family regarding the wandering incident that occurred the previous evening. -At that time, the family declined the use of a wanderguard.	D 273		

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D 273	Continued From page 87 -Safety checks (specific frequency not specified) throughout the shifts were added to the care plan. Review of Resident #1's facility care tracking note dated 05/15/26 at 6:27pm revealed: -The resident wandered in and out of the front door that evening. -Staff were present at the door to address the exit alarm (which had been turned on the previous day). -The resident was not open to redirection and stated she was going to sit outside and wait for her sister. -The resident came in and out several times. -Redirection was short lived, a wanderguard was applied, and the family was notified. -The resident remained by the front door being monitored by staff. -There was no documentation the resident's PCP or MHP had been notified of the resident's attempt to leave on 05/15/26 or the placement of a wanderguard on the resident. Observation of Resident #1 on 05/18/26 at 4:24pm revealed: -Resident #1 was sitting on a sofa in her room with her family member. -The resident was wearing a wanderguard bracelet on her left wrist. Interview with the RCS on 05/18/26 at 4:55pm revealed: -After Resident #1's elopement on 05/04/26, the resident's family did not want a wanderguard, so staff did safety checks. -She thought the resident's provider group had been notified of Resident #1's elopement on 05/04/26, which would include the PCP and the MHP. -It was her responsibility to make sure physician	D 273		

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notification forms were signed and acknowledged by the providers.
-She did not realize there was no fax date and no provider signature on Resident #1's physician notification form for the resident's elopement on 05/04/26.
-On Friday, 05/15/26, she got a phone message from the Care Services Director (CSD) that Resident #1 now had a wanderguard because the resident had been going in and out the front door looking for her family members.
-Whichever staff implemented the wanderguard for a resident was responsible for notifying the PCP and the MHP.

Interview with the CSD on 05/18/26 at 5:44pm revealed:
-Resident #1 recently had an elopement and was found at the cul-de-sac in the cottages to the left of the IL building.
-Notification was sent to the facility's contracted provider group which included the PCP and the MHP
-The RCS was responsible for making sure the providers responded to the notification.
-On Friday night, 05/15/26, Resident #1 was in and out of the front door and sat on a bench outside; staff watched her.
-They called the family and a wanderguard was placed on Resident #1 on 05/15/26 because she kept going in and out the front door.
-She did not notify Resident #1's PCP or MHP about the incident on 05/15/26 because it was not new behavior for the resident.

Interview with the Administrator on 05/18/26 at 6:56pm revealed:
-The RCS was responsible for notifying the resident's provider of the elopement on 05/04/26.
-They usually tried to let a resident's provider

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know when a wanderguard was placed on a resident.
-She did not know if notification was sent to Resident #1's PCP or MHP about the incident on 05/15/26 which resulted in a wanderguard being placed on the resident.

Telephone interview with Resident #1's primary care provider (PCP) on 05/18/26 at 4:01pm revealed:
-Resident #1's cognition was not good, and her dementia had gotten worse over the last two months.
-The resident's anxiety was overlapping with her ability to know what was going on.
-The resident had more than mild cognitive impairment at that point and was hard to redirect.
-The resident's room was at the very end of a hallway beside an exit door and family had put signs on her door to help the resident find her room.
-About a week before the elopement on 05/04/26, she came to the facility and the resident was in the middle of the parking lot with facility staff redirecting her.
-She was made aware of the incident on 05/04/26 by facility staff on 05/04/26.
-It was dangerous for Resident #1 to be walking outside alone.
-There were woods and a pond nearby and the resident could not see well.
-There was also a very busy highway nearby.
-The resident could have fallen in the pond or gotten hit by a car.
-She was not aware the resident attempted to leave the facility again on 05/15/26.
-If the facility had not placed a wanderguard on the resident on 05/15/26, she would have told them the resident needed a wanderguard, or potentially a sitter, or the resident may have

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needed to go to the special care unit (SCU).
-The facility staff should have notified her on 05/15/26 when Resident #1 attempted to leave the facility again multiple times and that they had placed a wanderguard on the resident.
-She was at the facility today, 05/18/26, and there were no notifications in her box about Resident #1 trying to leave on 05/15/26 or the resident having a wanderguard placed on 05/15/26.

Interview with Resident #1's MHP on 05/18/26 at 3:34pm revealed:
-Resident #1 had dementia, impaired cognition and was confused at times.
-The resident had some sundowning behaviors.
-Staff had reported the resident's behavior fluctuated and they reported the resident wandered.
-She was not aware Resident #1 eloped from the facility on afternoon of 05/04/26.
-She did not recall anyone notifying her of Resident #1's elopement and she did not see any notifications in her computer system.
-She had seen the resident earlier in the day on 05/04/26 for a visit and the resident was in her room with a family member.
-If she had known about the elopement on 05/04/26, she would have encouraged facility staff to engage the resident in activities and to provide supportive measures to keep the resident busy.
-She had been at the facility today, 05/18/26, and no one reported the elopement to her.
-She was not aware of Resident #1 attempting to leave the facility again on 05/15/26 and that a wanderguard had been placed on Resident #1.
-Resident #1 was 93 years old and it was not safe for her to wander away from the facility given her age and cognitive status.
-The facility staff should have notified her of the

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D 273	Continued From page 91 resident's elopement and that they had placed a wanderguard on the resident.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to protect 1 of 3 sampled residents (#6) who resided in the Special Care Unit (SCU) from exploitation and neglect related to sexual activity between two SCU residents. The findings are: Review of the SCU Residence and Care Agreement dated February 2022 revealed: -One on one care would be provided if at any point during a residents residency at the Community, including if a termination notice has been served, we determine that (i) you have experienced a change in your physical, medical, and/or mental condition such that you require immediate one-on-one care; (ii) you have engaged in conduct that makes you a wander risk; (iii) you have engaged in behavior that poses a potential threat to your safety or the safety of others, we reserve the right to require that you, or we may retain on your behalf, a twenty-four (24) hour private duty personnel. We will provide you	D 338		

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with a written notice of any such determination of requirement of private duty personnel. You will be financially responsible for this service, which will be billed directly to you by the responsible company or Community.
-Residents must not engage in conduct that poses a danger to themselves or others in the Community.
-Residents must not be disruptive, must not create unsafe conditions, and must not be verbally, mentally, physically or sexually abusive to other residents or staff.
-Residents must not engage in conduct that violates federal, state, or local laws or ordinances.

Review of the SCU Resident Rights dated 10/15/20 revealed:
-Residents had the right to be treated with respect, consideration, dignity, and full recognition of your individuality and right to privacy.
-Residents had the right to be free of mental and physical abuse, neglect, and exploitation.

Review of the facility's sexual expression policy dated May 2025 revealed:
-Memory care recognizes residents' need for sexual expression.
-Residents living with Alzheimer's or other dementia related diagnosis may demonstrate behavioral expressions, including sexual expression in inappropriate locations like common area and associates will provide privacy for sexual expression.
-The residents' dignity will be maintained.
-Residents with impacted cognitive abilities will be safeguarded from inappropriate sexual behavior and sexual exploitation.
-For the purpose of this policy sexual expression

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D 338	Continued From page 93 that was deemed inappropriate based on the location of the action or the ability of a resident to give consent including undressing in public area or communal space-though this action may be rooted in discomfort and not sexual expression, genital exposure, fondling the private areas of another resident, associate, or visitor, a resident fondling their own genital area in a public location, sexual act with another resident who was unable to give knowing consent, made sexually explicit comments to another resident, associate, or visitor, attempted to engage in a sexual act with another resident who did not have the capacity to give consent. -Staff would respect the residents' need for sexual expression except when it infringed on the rights of others, posed a possible safety or health risk, and involved residents who could not provide informed consent. -Residents who expressed interest in sexual contact with another resident, each resident should be individually evaluated for resident level of awareness resident may or may not have accurate recognition of other residents, may mistakenly believe another resident was their spouse and resident consent the resident may be mentally incapable of providing consent to sexual contact and need protection from such. -Residents should be interviewed to determine level of awareness and update the resident's Mini Mental State Exam (MMSE) or other cognitive assessment tool to assist with determining cognitive abilities. -Residents scoring mid-range and above on the MMSE or applicable score using another assessment tool may have the ability to actively participate in further interview. -The decision tree used for assessing sexual competency was a guide only to gauge resident awareness and possible ability to provide	D 338		

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informed consent.
-A resident was generally considered unaware if the interview revealed that the resident appeared unable to set limits with partner and thought they must always submit to sexual demand.
-When a resident appeared incapable of making informed decisions the physician was notified and requested to provide a statement of the resident's level of mental capability in providing informed consent.
-Sexual acts that involved residents with diagnoses of a primary dementia who no longer have the capacity to give informed consent upon observation immediately and calmly separate the residents, relocate the resident to a communal area and use activity as a distraction, never argue, reprimand, laugh, tease, or induce shame, report observation to supervisor immediately, establish direct one-to-one oversight of the initiating resident and assign associates to also remain with any other involved resident, immediately inform the Executive Director (ED), Memory Care leader, and Care Services leader.
-Place the resident on a behavioral expression management program if appropriate to identify triggers, develop a service plan with interventions, in-service associates on any interventions, notify the residents physician and responsible parties, the ED, Memory Care leader, and Care Services leader will reassess the residents for appropriate placement and ability to remain in community.
-If penetration had occurred upon observation immediately and calmly separate residents, immediately notify the supervisor and Memory Care leader, notify the physician, ED Care Services leader and responsible parties, the resident's physician would be contacted for orders and to assess the residents for venereal disease and human immunodeficiency virus (HIV), immediate one to one monitoring will be

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implemented with involved residents, place on behavioral expression management program if appropriate to identify triggers, encourage activity involvement within community public areas, update the service plan, educate associates and families as appropriate.
-Report incident to licensing agency as appropriate, and the ED, Memory Care leader, and Care Services leader would reassess the residents for appropriate placement and ability to remain in community.

Review of Resident #6's current FL-2 dated 09/17/25 revealed:
-Diagnoses included early Alzheimer's disease with psychosis.
-Recommended level of care was memory care.
-Resident #6 was constantly disoriented.
-Resident #6 was a wanderer.

Review of Resident #6's Resident Register revealed she was admitted to the facility on 08/31/25.

Review of Resident #6's Care Plan dated 04/24/26 revealed in the cognitive safety section, Resident #6 thought people were coming to get her: staff should explain what they are about to do if she became frustrated re-approach later, check on resident routinely throughout waking hours, and check on resident during hours of sleep.

Review of Resident #6's mental health progress note dated 03/02/26 revealed:
-Resident #6 was noncommunicative during the visit.
-Resident #6 had Alzheimer's disease with late onset dementia and related behaviors.

Review of Resident #6's mental health progress

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note dated 03/30/26 revealed Resident #6 had early onset Alzheimer's disease and her presentation was consistent with significant cognitive impairment, as she was a poor historian and provided unreliable answers to questions.

Review of Resident #6's brief interview for mental status (BIMS) dated 03/05/26 revealed:
-Resident #6 was unable to complete the BIMS and given a total points of 99 (if unable to complete BIMS could indicate severe cognitive impairment and advanced dementia).
-None of the questions were marked with an answer.
-The reason for the 99 points was not documented by the assessor.

Review of Resident #6's staff care tracking log for April 2026 revealed:
-On 04/01/26, staff attempted to keep a male resident from displaying sexual behaviors toward Resident #6 and walked her to his room and kissed her on her neck. The male resident was standing in front of Resident #6 with his crotch in her face and rubbing on her shoulders, medication aide (MA) and Memory Care Director (MCD) notified.
-On 04/07/26, the male resident had expressed unwanted sexual behaviors toward Resident #6 and kissed her hands and neck.

Review of Resident #6's staff care tracking log for May 2026 revealed:
-On 05/11/26, Resident #6 was napping and a male resident stuck his hands down her pants; family and Mental Health Provider (MHP) were notified.
-On 05/15/26, Resident #6 was placed on 15-minute checks.

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D 338	Continued From page 97 Interview with a MA on 05/14/26 at 9:25am revealed: -A male resident touched Resident #6's breasts and between her legs. -Resident #6 did not understand what the male resident had been doing to her. Interview with the Administrator on 05/14/26 at 1:33pm revealed: -She had been informed about the 05/11/26 sexual encounter when a male resident put his hands down Resident #6's pants while she was asleep on the couch. -She had not met with Resident #6's family since the 05/11/26 sexual encounter. Interview with Resident #6's family member on 05/14/26 at 10:45am revealed: -Resident #6 had lived at the facility for 6 months. -On 05/11/26, the facility called to inform him that a male resident had put his hands down Resident #6's pants and that she was fine and they separated them. -He was not comfortable with a male resident putting his hand down Resident #6's pants. -He would prefer that this did not happen again. -The primary care provider (PCP) nor the MHP had talked with him about the sexual encounter. -He felt like the communication at the facility was lacking and there was no follow up. Telephone interview with Resident #6's PCP on 05/14/26 at 11:00am revealed: -Resident #6 was not competent to consent to sexual encounters. -She was not informed about the 05/11/26 sexual encounter and she should have been notified. -Resident #6 was not mentally able to stop another resident's sexual behaviors.	D 338		

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D 338	Continued From page 98 Second telephone interview with Resident #6's PCP on 05/18/26 at 4:20pm revealed: -Resident #6 could not verbalize or say no and that limited her ability to be able to protect herself or understand what happened when the male resident put his hands down her pants. -A male resident thought Resident #6 was his wife. -Resident #6's had a BIMs score of 0, she was not competent to consent. Interview with Resident #6's MHP on 05/18/26 at 3:45pm revealed: -Resident #6 was pleasantly confused and had no aggressive behaviors. -Resident #6 could be confused and scared that a male resident put his hands down her pants. -This sexual encounter should not have happened. -The facility should always have eyes on Resident #6 to protect her. -Resident #6's husband said that she got nervous and was scared of the male resident. -Resident #6 should be kept in the open and staff should know where she was at all time. -The residents needed to be distracted and occupied, not left alone. Based on observations, interviews, and record reviews, it was determined that Resident #6 was not interviewable. The facility failed to ensure a resident's rights were maintained for a resident residing in SCU with a diagnosis of early Alzheimer's disease with psychosis and constantly disoriented and could not consent to sexual activity (#6). This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation.	D 338		

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D 338	Continued From page 99 The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/14/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED July 2, 2026	D 338		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 4 residents (#7) observed during the medication pass including errors with medications for constipation and a vitamin supplement. The findings are: The medication error rate was 10% as evidenced by 3 errors out of 28 opportunities during the 8:00am/9:00am medication pass on 05/14/26. a. Review of Resident #7's current FL-2 dated 01/22/26 revealed: -Diagnoses included Alzheimer's disease, vascular dementia, cognitive communication deficit, severe protein calorie malnutrition, and	D 358		

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non-displaced fracture of the left femur.
-There was an order for Miralax 17 grams (g) mixed in 4 to 8 ounces of liquid and take once every 24 hours for constipation. (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and the inside of the cap on the bottle has a marking for 17g that should be used to measure the dosage at the top of the white section of the inner cap.)

Observation of the 8:00am medication pass on 05/14/26 revealed:
-The medication aide (MA) retrieved Resident #7's Miralax bottle from the medication cart.
-There was a white inner lining inside of the blue cap on the Miralax bottle.
-There was "17g" imprinted near the top of the white section with an arrow pointing up to indicate the measurement for 17g was at the top of the white inner lining inside the cap.
-The MA poured the Miralax powder halfway below the marking for the 17g dose.
-The MA mixed the Miralax powder in a 5-ounce cup of water and gave it to Resident #7 to take with her oral medications at 8:53am.
-The resident drank all the water with Miralax.
-The MA did not measure the Miralax correctly and the full dosage was not mixed in the cup of water.
-The resident did not receive the full dosage of Miralax.

Review of Resident #7's May 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax, take 17g mixed in 4 to 8 ounces of liquid every 24 hours for constipation scheduled at 8:00am.
-Miralax was documented as administered daily from 05/01/26 - 05/14/26.

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D 358	Continued From page 101 Observation of Resident #7's medications on hand on 05/14/26 at 12:58pm revealed: -There was a bottle of Miralax with a large portion of the prescription label torn off but part of the label with the resident's last name and part of her first name was still on the bottle. -The instructions and dispensing date had been torn off. Interview with the MA on 05/14/26 at 12:46pm revealed: -She measured the Miralax dosage using the white inner cap. -She usually measured the Miralax powder below the "17g" marking. -She had not noticed the marking for 17g pointing to the top of the inner white lining of the cap. -She thought the marking for 17g was the groove below the "17g". -Resident #7 had not complained of any issues with constipation and had regular bowel movements. Interview with the Memory Care Director (MCD) on 05/14/26 at 1:16pm revealed: -The MAs were supposed to use the white inner lining of the Miralax cap to measure the correct dosage. -There was a marking to measure 17g imprinted on the white inner lining of the cap. -He was not aware the MA was not using the correct marking to measure Resident #7's Miralax. -Resident #7 was not currently having issues with constipation; he was having regular bowel movements. Interview with the Care Services Director (CSD) on 05/14/26 at 1:26pm revealed:	D 358		

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D 358	Continued From page 102 -The MAs has been trained to use the 17g marking on the white inner lining inside the lid of the Miralax bottle. -Resident #7 had no current issues with constipation. Interview with the Administrator on 05/14/26 at 2:26pm revealed: -She relied on the facility's nursing staff to oversee the MAs. -The MAs should administer medications as ordered. Telephone interview with Resident #7's primary care provider (PCP) on 05/14/26 at 3:56pm revealed: -Not receiving the full dosage of Miralax could cause the resident to be constipated -Resident #7 had no recent complaints or issues with constipation. Based on observations, interviews, and record review, it was determined that Resident #7 was not interviewable. b. Review of Resident #7's physician's orders dated 02/13/26 revealed: -There was an order for Bisacodyl 5mg enteric coated (EC) take 2 tablets (10mg) once daily for constipation. (Bisacodyl EC is a stimulant laxative used to treat constipation. Bisacodyl EC has an enteric coating to protect the stomach from irritation and to ensure the active ingredient reaches the colon to exert its effect. Crushing the Bisacodyl EC tablets can cause stomach irritation and decrease the effectiveness of the medication. Bisacodyl EC should not be crushed or chewed.) -There was an order that all crushable medications may be crushed.	D 358		

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D 358	Continued From page 103 Observation of the 8:00am medication pass on 05/14/26 revealed: -The medication aide (MA) prepared morning medications for Resident #7, including two Bisacodyl EC 5mg tablets. -The MA crushed all of Resident #7's oral tablets, including the two Bisacodyl EC 5mg tablets, mixed them in chocolate pudding, and administered them to Resident #7 at 8:52am. Observation of Resident #7's medications on hand on 05/14/26 at 12:50pm revealed: -There was a supply of Bisacodyl EC 5mg tablets dispensed on 05/06/26, with instructions to take 2 tablets (10mg) once daily for constipation. -There was no warning on the prescription label not to crush or chew the medication. Review of Resident #7's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Bisacodyl EC 5mg take 2 tablets (10mg) once daily for constipation scheduled at 8:00am. -Bisacodyl EC was documented as administered daily from 05/01/26 - 05/14/26, except on 05/13/26 when the resident spit out the medication. -There was no information noted on the eMAR to indicate the medication should not be crushed. Interview with the MA on 05/14/26 at 12:46pm revealed: -She usually crushed Resident #7's medications because the resident had swallowing problems and there was an order to crush her medications. -The eMAR usually had a notation if a medication could not be crushed. -The MAs also had a medication reference book and they used to have a "do not crush" (DNC) list	D 358		

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on the medication cart but she could not find it.
-She was not aware previously that Resident #7's Bisacodyl EC should not be crushed.
-She just checked the medication reference book now and read that Bisacodyl EC should not be crushed.
-Resident #7 had not complained of stomach upset or constipation.

Interview with the Memory Care Director (MCD) on 05/14/26 at 1:16pm revealed:
-There should be documentation on the eMAR if medication was not supposed to be crushed and the MAs should follow those instructions.
-There was no DNC list for medications that should not be crushed at the facility to his knowledge.
-Resident #7's Bisacodyl EC should have been marked on the eMAR not to crush, and it should not have been crushed.

Interview with the Care Services Director (CSD) on 05/14/26 at 1:26pm revealed:
-There was a DNC list that should be stored in the controlled substance notebook on the medication carts.
-The pharmacy used to include DNC in the instructions on the eMARs.
-The MAs also had a current medication reference book available to determine if medication could be crushed.
-Resident #7's Bisacodyl EC should not have been crushed.
-Resident #7 had not complained of stomach upset or constipation issues.

Interview with the Administrator on 05/14/26 at 2:26pm revealed:
-She relied on the facility's nursing staff to oversee the MAs.

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D 358	Continued From page 105 -The MAs should administer medications as ordered. Telephone interview with Resident #7's primary care provider (PCP) on 05/14/26 at 10:58am revealed: -Resident #7's Bisacodyl EC should not be crushed because it was enteric coated. -Crushing Resident #7's Bisacodyl EC tablets could cause stomach upset. -Resident #7 had not complained about any stomach issues. Based on observations, interviews, and record review, it was determined that Resident #7 was not interviewable. c. Review of Resident #7's primary care provider (PCP) order dated 05/12/26 revealed an order for Vitamin D3 5,000 units 1 tablet once a day with food. (Vitamin D3 is a vitamin supplement used to treat Vitamin D deficiency. Vitamin D3 is a fat-soluble vitamin and should be taken with food for maximum absorption and to prevent stomach upset.) Interview with the medication aide (MA) on 05/14/26 at 8:50am revealed: -Resident #7 had not eaten breakfast that morning. -Resident #7 usually slept in and did not eat breakfast. Observation of the 8:00am medication pass on 05/14/26 revealed the MA prepared and administered Vitamin D3 5,000 units to Resident #7 at 8:52am while the resident was in bed. Review of Resident #7's May 2026 electronic medication administration record (eMAR)	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 106 revealed: -There was an entry for Vitamin D3 5,000 units 1 tablet once daily with food scheduled at 8:00am. -Vitamin D3 was documented as administered on 05/14/26. Observation of Resident #7's medications on hand on 05/14/26 at 12:45pm revealed: -There was a supply of Vitamin D3 5,000 units tablets dispensed on 05/12/26. -The instructions were to take 1 tablet once daily with food. Second interview with the MA on 05/14/26 at 12:46pm revealed: -Breakfast was usually served around 8:00am. -If a medication was ordered with food, she had one hour before or one hour after the scheduled time to administer that medication. -Resident #7 usually got up every morning around 10:00am and she refused to eat breakfast. -She had not notified Resident #7's PCP that the resident did not take Vitamin D3 with food because she thought there was a one-hour timeframe to administer medications. -Resident #7 had not complained of stomach upset. Interview with the Memory Care Director (MCD) on 05/14/26 at 1:16pm revealed: -Medications ordered with food should be administered when the resident was eating or just after the resident finished eating. -If Resident #7 refused to eat breakfast, her Vitamin D3 should be administered with a snack such as applesauce so it was not administered on an empty stomach. -Resident #7 had not complained of stomach upset.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092206	A. BUILDING: _____ B. WING _____	R 05/18/2026

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D 358	Continued From page 107 Interview with the Care Services Director (CSD) on 05/14/26 at 1:26pm revealed: -Medications ordered with food should be administered near at mealtime or within 30 minutes after eating food. -If a resident was not eating a meal and should receive medication with food, the MAs should notify her. -She would notify and discuss it with the PCP. Interview with the Administrator on 05/14/26 at 2:26pm revealed if a resident had an order to receive a medication with food and did not eat a meal, the MAs should provide a snack for the resident when the medication was administered. Telephone interview with Resident #7's PCP on 05/14/26 at 3:56pm revealed: -Resident #7 did not eat a lot but if she was not eating breakfast, the Vitamin D3 could be changed to be taken with lunch. -Resident #7 had some acid reflux symptoms which could be related to receiving Vitamin D3 on an empty stomach. Based on observations, interviews, and record review, it was determined that Resident #7 was not interviewable.	D 358		