STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345143	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Siler City Center	900 W Dolphin Street Siler City, NC 27344

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345143	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Siler City Center	900 W Dolphin Street Siler City, NC 27344

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews with the Responsible Parties (RPs), PACE (Program of All-Inclusive Care for the Elderly) Nurse Practitioner, psychiatric Nurse Practitioner and staff, the facility failed to protect a cognitively impaired male resident's right to be free from sexual abuse (Resident #2) perpetrated by a cognitively impaired male resident (Resident #1). On 9/1/25 Nurse Aide (NA) #1 overheard Resident #2 laughing from the hallway and proceeded to the room he shared with Resident #1 as this was an unusual behavior for Resident #2. When NA #1 stepped into the doorway of the room, she observed Resident #2 lying on his back in bed with his penis exposed on the left side of his brief as Resident #1 stood beside the bed grasping Resident #2's penis with his hand as he moved his hand in an up and down motion. The residents did not have the cognitive capacity to consent to sexual relations or express an adverse psychosocial outcome. A reasonable person would have been traumatized by being sexually abused by a resident in their home environment resulting in feelings such as anger, fear, anxiety, and/or humiliation. This deficient practice affected 1 of 3 residents reviewed for abuse (Resident #2). Immediate Jeopardy began on 9/1/25 when Resident #2, who did not have the cognitive capacity to consent, was sexually abused by Resident #1. Immediate Jeopardy was removed on 9/5/25 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential of minimal harm that is not Immediate Jeopardy) to ensure education is completed and monitoring systems put into place are effective.The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, major depression and dementia with other behavioral disturbance. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 had severe cognitive impairment and displayed other behavioral symptoms not directed towards others on one to three days during the seven-day look back period. Resident #1 was independent with eating, bed mobility and transfers but required assistance from staff for all other Activities of Daily Living (ADL) and was able to ambulate independently. Resident #1 received an anticonvulsant medication. Resident #1's active care plan, last revised on 8/7/25, included focus areas for a behavior of hoarding items, wandering into other residents' rooms, physical and verbal behaviors and refusal of care. Resident #1's care plan did not identify any sexually inappropriate behaviors. Resident #2 was admitted to the facility on [DATE] with diagnoses that included dementia and adjustment disorder with mixed anxiety and depressed mood. A review of Resident #2's active care plan, last revised 6/2/25, included focus areas for behaviors of pacing, wandering into other residents' rooms, rummaging, throwing/smearing bodily waste, disrobing in public and physical and verbal behaviors. Resident #2's care plan did not identify any sexually inappropriate behaviors. An annual MDS assessment dated [DATE] indicated Resident #2 had severe cognitive impairment and displayed physical and verbal behavioral symptoms as well as other behavioral symptoms not directed towards others, rejection of care and wandering on one to three days during the seven-day look back period. He was independent with eating, bed mobility, and transfers but required assistance from staff for all other ADL and was able to ambulate independently. Resident #2 was coded as being always incontinent of bowel and bladder and received an antidepressant medication. A review of Resident #2's nursing progress notes revealed that on 8/26/25 he was holding the front of his pants, saying I am burning. The PACE provider was notified and ordered a urinalysis. A review of Resident #2's physician orders included an order dated 8/28/25 for Fosfomycin (an antibiotic) 3 grams by mouth one time only for urinary tract infection (UTI). The incident report completed by the Unit Manager on 9/1/25 at 8:50 AM, revealed that when the NA #1 walked by the room she saw Resident #1 on Resident #2's side of the room by his bed. The NA entered the room and witnessed Resident #2 masturbating and Resident #1 was helping him and touching him inappropriately. The NA called out to stop, which Resident #1 did and returned to his side of the room. Neither one of the residents was able to give a description of what occurred. There were no injuries identified during skin assessments. The two residents were immediately separated and placed on one-to-one monitoring. The physicians, RPs for both residents, Administrator, Director of Nursing (DON) and local law enforcement were notified of the incident. The Initial Allegation Report dated 9/1/25, completed by the Unit Manager, read there was an allegation of resident-to-resident sexual abuse between Resident #1 and Resident #2, who resided in the memory care unit. Staff immediately intervened and separated the residents for safety, and both were placed on one-to-one observation. The local law enforcement was