STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cary Health and Rehabilitation	6590 Tryon Road Cary, NC 27518

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13289 Based on observation, and interviews with resident and staff, the facility failed to provide housekeeping services to ensure a clean bathroom for a bathroom which was jointly shared by multiple residents. This was for one (Resident # 5) of four sampled residents who were interviewed regarding services at the facility. The findings included: Resident # 5 was admitted to the facility on [DATE]. A review of Resident # 5's quarterly Minimum Data Set assessment, dated 12/2/24, revealed Resident # 5 was cognitively intact and continent. During interviews held with Resident # 5 on 2/24/25 at 10:12 AM and again on 2/25/25 at 8:35 AM, Resident # 5 expressed concerns related to his bathroom being cleaned so that he could use it. Resident # 5 reported the following information. He resided in a room which shared a bathroom with two other residents who had an adjoining door to the bathroom from their room. One of the other residents, who used the bathroom, needed adaptive devices (a riser) over the toilet and this resident also had some confusion. When this resident would use the bathroom, the resident at times would leave fecal matter on the floor, on the toilet, and other places in the bathroom. He had trouble getting staff to clean the bathroom so that he could use it and feel that it was clean. He had talked to staff about the problem. About two weeks ago, the resident from the adjoining room had used the bathroom and there was a lot of feces on the toilet. He had asked NA (Nurse Aide) # 10 to clean the toilet so that he could use it. No one ever came to clean the toilet, and so he cleaned the toilet himself although it was not his feces. (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview on 2/25/25 at 8:35 AM with Resident # 5, observations were made with Resident # 5 of the condition of his bathroom. The following observations were made. There was brownish black matter on the back of the toilet lid and on the back of the toilet. On a shelf above the toilet, Resident # 5 had stored a personal item he used. Beside his personal item, there was a toilet seat that had been removed from the toilet and had brownish black matter on it. There was a part of the toilet riser's adaptive equipment (a funnel piece) which had brownish black matter on it sitting on the shelf. There was trash behind the toilet. There was brownish black matter on the wall beside the sink and the mirror. The mirror had a large amount of white matter on it. During the observation of the bathroom with Resident # 5 on 2/25/25 at 8:35 AM, the resident reported housekeeping had not come in yet that morning. He also reported that the adaptive equipment for the toilet riser, which was on the shelf, was for the resident who shared the bathroom. He (Resident # 5) was concerned it was kept on the shelf with his personal item. Resident # 5 also reported that the toilet seat was broken and so he had taken it off many weeks ago and used the riser when he needed to use the toilet. He had placed the broken toilet seat on the shelf but no one had cleaned it or removed it. Resident # 5's bathroom was observed again on 2/25/25 at 4:15 PM with the DON (Director of Nursing). The bathroom conditions observed on 2/25/25 at 8:35 AM were still observed on 2/25/25 at 4:15 PM. According to Resident # 5, housekeeping had come in at midday to clean his room, but they had not cleaned his bathroom. The DON reported that the housekeeping staff were contracted workers, and she would report it to the supervisor of housekeeping about the condition of the bathroom. On 2/25/25 at 4:45 PM Nurse # 6 was interviewed and reported the following information. There was a resident who shared Resident # 5's bathroom from an adjoining room. This resident at times would drop his pants on the way to the bathroom and would miss the toilet. He (Nurse # 6) was also aware of an incident in which Resident # 5 had reported he (Resident # 5) had cleaned up the other resident's feces after asking Nurse Aide # 10 to help and no one helped him. He (Nurse # 6) had talked to NA # 10 after the incident and NA # 10 had not realized it was her job to clean obvious signs of feces and then alert housekeeping to disinfect surfaces. Nurse # 6 recalled this incident occurred about a month ago. NA # 10 was interviewed on 2/26/26 at 1:55 PM and reported the following information about the incident in which she was asked to help clean the bathroom. She recalled Resident # 5 asking her for help to get his toilet bowl cleaned when she was walking down the hallway to help another resident. She told him she would tell housekeeping, which she did. She did not know what housekeeping did after she told them. Resident # 5 was not her assigned resident that day and she went to care for another resident. The Housekeeping Director was interviewed on 2/26/25 at 10:00 AM and reported the following information. He had not been aware of the condition of Resident # 5's bathroom the previous day (2/25/25) until the DON had called him after the 4:15 PM observation made by her and the surveyor. The bathroom should have been cleaned and not left in the condition it was throughout the day. If there were broken, dirty items such as a toilet seat sitting up on a shelf used to store personal items, then there should be some type of communication between maintenance and his staff to rectify that issue. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 11:20 AM the housekeeper (Housekeeper #1), who had been assigned to Resident # 5's hall on 2/25/25, was interviewed with the Housekeeping Director and reported the following information. Housekeeper # 1 was aware that one of the residents who used Resident # 5's bathroom at times had explosive diarrhea. He had cleaned the bathroom on 2/25/25 around 7:30 AM or 8:00 AM and did not have time to go back during the day to clean again. He had not cleaned the walls when he initially cleaned the bathroom, and he did not clean any adaptive equipment that was on the shelf that had brownish black matter when he had cleaned. The Housekeeping Director further reported during this interview on 2/26/25 at 11:20 AM that his housekeeping staff were responsible for cleaning small drips of fecal matter. If there were large amounts of stool or emesis then nursing staff were to clean, and then his staff would disinfect. No one had mentioned a problem to him that Resident # 5's bathroom needed more frequent checks and cleaning. After 5:00 PM, there was one of his staff members who worked in laundry. They could also provide housekeeping services to the nursing staff if needed after his routine housekeepers left for the day.

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13289 Based on observation, record review, and interviews with staff, Psychiatric Nurse Practitioner, Responsible Party (RP), and the Police Detective, the facility failed to protect the right of two cognitively impaired residents (Residents # 1 and # 7) to be free from abuse. On the evening of 2/6/25 Resident # 2 returned from an outing and was observed by staff to show signs of being inebriated. That evening he was also observed at the bedside of Resident # 1, who was cognitively impaired and who did not have the ability to invite him into her room. After his removal from Resident # 1's room by staff, Resident # 2 was observed in Resident # 1's room a second time with the curtain pulled so that he and Resident # 1 were out of view. During this second incident, Nurse Aide # 1 and Nurse # 1 entered the room and walked around the curtain and witnessed Resident # 2 with his hand under Resident # 1's right leg lifting it up while Resident # 1's brief was open on the right side exposing part of her private area. Resident # 2 was seated in his wheelchair at Resident # 1's bedside at the time with his hand between Resident # 1's thighs to the point that only above his wrist was visible. Resident # 1 was in her bed clenching her brief which was unfastened on the right side and with part of her private area exposed. Resident # 1 was saying No, no, no. Resident # 1's RP reported during interview that if Resident # 1 could have spoken about what had occurred to her, it would have made her sad and cry, and furthermore Resident # 1 would have called out to God asking why it had happened to her in her old age after she had lived through hard times. In addition, Resident # 6, who had a history of aggressive and volatile behaviors, was observed by staff standing over her cognitively impaired roommate (Resident # 7) and pulling her hair. At the time, Resident # 7 was observed screaming and crying. A reasonable person would expect to be safe from abuse in their home and could experience trauma, fear and anxiety. This was for two (Residents # 1 and # 7) of two sampled residents reviewed for abuse. Example #2 was cited at a lower scope and severity of G. The findings included: Resident # 2 was admitted to the facility on [DATE]. The resident's diagnoses included muscle weakness and right leg below knee amputation. Resident # 2's annual MDS (Minimum Data Set) assessment, dated 1/28/25, coded the resident as cognitively intact. The resident was also coded as totally independent with bathing, dressing, and transfers. The resident was assessed to be able to walk 150 feet with supervision. The resident's age was less than [AGE] years of age. On 2/6/25 at 1:12 PM a nurse documented in a progress note that Resident # 2 signed out with a friend for a leave of absence at 1:10 PM. He left the facility in stable condition. On 2/6/25 at 7:29 PM the DON (Director of nursing) entered the following information in a progress note. At 6:15 PM Resident # 2 had been noted to be in a female resident's room and her brief was undone. Resident # 2 was removed from the room and placed on one on supervision. Appropriate staff, family, police, and physician were notified. Investigation with the police and detectives resulted in Resident # 2 being arrested. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's investigative file revealed Resident # 1 was the resident whose brief was undone when Resident # 2 was found in the room. A review of Resident # 1's record revealed the following information. Resident # 1 had been admitted to the facility on [DATE] and was elderly. Resident # 1's diagnoses in part included a history of stroke, hemiplegia, hemiparesis, anxiety, and heart disease. Resident # 1's 1/21/25 quarterly MDS assessment coded the resident as severely cognitively impaired and as being totally dependent on staff for her dressing and hygiene needs. She was also assessed to need substantial to maximum assistance to turn in bed and was dependent on staff for transfers. Resident # 1's care plan, updated on 1/31/25, included the information that the resident was dependent on staff for intellectual; physical, and emotional needs secondary to her hemiparesis, hemiplegia, and a language barrier. Review of physician orders revealed a hospice consultation was ordered for Resident # 1 on 2/3/25. Further review of Resident # 1's record revealed the DON made a nursing entry on 2/6/25 at 8:42 PM that was entered as a late entry. The DON documented the following information within the entry. At 6:15 PM a male resident was noted going in Resident # 1's room and upon nursing staff entering the room Resident # 1's brief was found open on the right side and the male resident was observed touching the resident. All appropriate parties were notified. The police were notified for investigation. The family members were notified, and Resident # 1 was sent to the hospital for evaluation. Review of 2/6/25 hospital ED (emergency department) notes revealed the following notations by the ED physician. Resident # 1 was assessed for possible sexual assault and found to have no overt signs of trauma. The resident had advanced dementia and had no recall of the event. The physician talked to the family who declined sexual disease testing and declined to send off testing and to pursue sexual assault nursing examination. Resident # 1's family member reported the resident was starting hospice and she just wanted to focus on her being kept comfortable. Review of the facility's investigative file revealed typed statements the DON had obtained from Nurse Aide (NA) # 1 and Nurse # 1 during the facility's investigation. NA # 1's statement read as typed, [Resident # 2] had returned from being out with friends/family, he appeared to have been drinking, as we were passing dinner trays noticed he went into [Resident # 1's] room. Myself and the nurse removed him from the room and redirected him to his room across the hall. As we were continuing to pass trays, we saw him enter her room again and we went down the hall to get him again. As we entered the room, we noticed that she was uncovered, and his right hand was under her leg with her brief undone. The nurse yelled at him to stop, and we immediately removed him from the room back to his room, reported it to supervisor. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NA # 1 was interviewed on 2/24/25 at 4:55 PM and reported the following information about the incident. She had not often cared for Resident # 2 before 2/6/25. Resident # 2 had returned to the facility around 6:00 PM or 6:30 PM on 2/6/25 after being out to celebrate his birthday. When he returned, she could smell fumes on him and he appeared to be drunk. While the staff were passing out trays he sat in the hall and was not going to eat. She went to check on Resident # 1 after Resident # 1 had already been served her tray. When she went to Resident # 1's room to check on her, she found Resident # 2 in Resident # 1's room. He was seated in his wheelchair. Resident # 1 was in her bed. Resident # 2 was messing with her tray and at the same time he was pulling down her gown. At the time she (NA # 1) first saw Resident # 2 pulling Resident # 1's gown down, the gown was above Resident # 1's waist. Resident # 1's brief was on and intact. At the time, the privacy curtain was open. Resident # 1's covers were down, but that was not unusual because she did not always like the covers on her. She (NA #1) told Nurse # 1, who told Resident # 2 to leave the room. Nurse # 1 also told the supervisor about the situation. Resident # 2 did leave the room and went into the hallway. She (NA # 1) continued to take up trays, but she kept an eye on Resident # 2. As she was taking up dinner trays, she noticed that Resident # 2 had disappeared. She went and got Nurse # 1 and informed her. They went back to Resident # 1's room. At that time the door was open and the curtain was closed where you could not see Resident # 1 in her bed. They entered and rounded the curtain together. She (NA # 1) saw Resident # 2 in his wheelchair and Resident # 1 was in her bed. Resident # 2 had his hand under Resident # 1's right leg lifting it up. Resident # 1's brief was open on the right side to the point that part of her private area was exposed. Nurse # 1 yelled for Resident # 2 to get out of the room. He stopped lifting Resident # 1's leg and left the room. Nurse # 1 sent Resident # 2 to his room and notified the supervisor again, who called the DON. At the time when Resident # 2 was found in Resident # 1's room the second time, she was moaning in a way that she usually moaned. She (NA # 1) stood guard over Resident # 1 to protect her after the second incident, and another person was stationed to stand guard over Resident # 2's room where he was. Prior to the incident, no one had mentioned to her, and she was not aware of any incidents in which Resident # 2 allegedly was touching any other resident inappropriately. During an interview with the Administrator on 2/28/25 at 10:11 AM, the Administrator reported that no staff member had reported during their immediate interviews following the incident that Resident # 2 was touching Resident # 1 in anyway during the first incident on 2/6/25 when Resident # 2 was found in Resident # 1's room. The surveyor agreed to interview NA # 1 again for clarification. A second interview with NA # 1 on 2/28/25 at 11:11 AM was conducted with the Administrator per a three-way telephone call. NA # 1 reported the following information. In recalling the events weeks after the initial event had occurred, she may have been recalling the touching of the gown incorrectly when she first spoke to the surveyor. The touching of the gown was possibly during the second incident. She could recall for certainty that in the first incident she was surprised to see Resident # 2 in Resident # 1's room and he had been eating something off the resident's tray at the time. He had been removed from the room. NA # 1 further reported Resident # 1 could move and slide down in bed and that at times her gown would ride up from her movement in the bed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the statement from Nurse # 1 as typed by the DON read as follows: [Resident # 2] appeared to be drunk when returned from LOA (leave of absence) with family as he went down the hall, he went into [Resident # 1's] room and myself and a CNA (certified nursing assistant) removed him to his room and told him that we would help her. We went on about passing trays and about 10 minutes later saw him go into the room again. We immediately went down the hall and into the room, I yelled for him to get out. He was sitting in his wheelchair beside the bed, her brief was undone, and his right hand was under her leg and unable to see where it was at. We immediately removed him and placed him in his room with someone watching him 1:1 per supervisor. Nurse # 1 was interviewed on 2/25/25 at 11:27 AM and reported the following information. She usually worked throughout the facility and did not care for Resident # 1 and Resident # 2 all the time. On the date of the incident, she had been at the desk when Resident # 2 had returned from an outing. He walked in with a walker and had a prosthesis on at the time. By looking at his eyes and his walk, it appeared he was inebriated when he returned. He went to his room. Later dinner trays came out on the hall. At that time, she recalled Resident # 2 being in his wheelchair without his prosthesis. While dinner trays were on the hall, NA # 1 got her to go to Resident # 1's room because Resident # 2 was in the room. When she entered the room, Resident # 1 was looking at the television. Resident # 2 was seated in his wheelchair in her room. Resident # 1's bedside table was between Resident # 2 and Resident # 1 at the time. Resident # 2 was eating dessert in Resident # 1's room and said he was talking to her. She informed Resident # 2 that the resident did not speak his language, he was not to help feed her, and he needed to leave the room. Resident # 2 did leave. She (Nurse # 1) informed Nurse # 3 (the supervisor for that evening) and she (Nurse # 1) then continued to help with tasks on the hall. Approximately ten minutes later she and NA # 1 met in the hall and went back to check on Resident # 1. At the time, the privacy curtain was pulled where you could not see Resident # 1 from the doorway. They could hear Resident # 1 saying very softly and not loud enough to hear down the hallway, No, no, no. They rounded the curtain. Resident # 1 was in her bed clenching her brief which was unfastened on the right side. Part of her private area was exposed. Resident # 2 was in his wheelchair and closer to her bed than previously. His hand was between her thighs to the point that only above his wrist was visible, and therefore she could not see exactly where his hand was touching. She told him to get out of the room right then and put him in his room. She ran to tell Nurse # 3. One on one was placed with both residents. Prior to the incident, she had only been working in that section of the facility about every two weeks and therefore was not often assigned to care for Resident # 2. She knew Resident # 2 had fresh tendencies and he would say he had multiple girlfriends, but she had never witnessed him touching another resident inappropriately. She did not recall anything in report about any special monitoring Resident #2 needed around other residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There was no statement from Nurse # 3 (the nursing supervisor) in the investigation file. Nurse # 3 was interviewed on 2/24/25 at 4:02 PM and reported the following information. She had not witnessed either incident. She did know that Resident # 2 had returned that evening and appeared to be inebriated. That evening NA # 1 had told Nurse # 1 about an incident in which Resident # 2 was in Resident # 1's room with his hand under her covers. Nurse # 1 had relayed this to her (Nurse # 3). Resident # 2 and Resident # 1 had immediately been separated and Nurse # 1 had reported it to her (Nurse # 3). She (Nurse # 3) immediately went to a private area to call the DON about the incident. At that time, the DON had already left work and was planning to return to the facility. Immediately after she got off the phone and was returning to the unit, she saw Nurse # 1 and NA # 1 power walking-running to her. They reported there was a second incident in which Resident # 2 was found in Resident # 1's room and this time it was her understanding that Resident # 2 had been in Resident # 1's bed. She (Nurse # 3) was told that Resident # 2 had been on top of Resident # 1 and Resident # 2 was violating her while Resident # 1 was saying, no, no, no. Resident # 2 had been removed by them and put back in his room before Nurse # 1 and NA # 1 came to her. Nurse # 3 stated it had seemed like a minute since the first report and all she had done was go call the DON before the second incident with Resident #1 and Resident #2 was reported to her. She immediately called the DON back again after the second incident, and the DON was on her way. The Administrator called and talked to her (Nurse #3) and told her to call the police which was done. She checked Resident # 1's blankets to make sure she was not bleeding but she did not tamper with her brief until emergency services and the police could arrive. Staff did stay one on one with Resident # 2 and Resident # 1. The DON, who was the person to record Nurse # 1 and NA # 1's statements, was interviewed on 2/24/25 at 12:00 PM, 1:30 PM, and again on 5:10 PM and reported the following information. Resident # 1 had appeared to be drinking when he returned to the facility on [DATE]. NA # 1 and Nurse # 1 were his assigned caregivers. Nurse # 3 was the supervisor that evening. Nurse # 3 was not the witness to the actual events. Resident # 2 had never been in bed with Resident # 1, and as in the recorded statements, Resident # 2 was found seated in his wheelchair beside Resident #1. He had his hand underneath her leg. The staff could not tell exactly where Resident # 2 had been touching Resident # 1 with his hand. Resident # 1 had been sent out to the hospital and found to have no trauma or penetration. NA # 3 was interviewed on 2/25/25 at 11:40 AM and reported the following information. She routinely cared for Resident # 1 and Resident # 2. Resident # 2 was usually in his room or the dining room when she was assigned to him. She had not seen him in other residents' rooms. In taking care of Resident # 1, Resident # 1 did not use her call bell to call for assistance. Resident # 1 had communication problems. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator was interviewed on 2/26/25 at 3:30 PM and again on 2/28/25 at 10:11 AM and reported the following information. On 2/6/25 Resident # 2 returned from his outing and appeared inebriated. Staff did find him in Resident # 1's room one time prior to the actual incident and he should not have been in her room. Resident # 2 was not touching Resident # 1 or her clothing in any way during the first incident. He was removed from Resident #1's room. A short time later when the curtain was observed pulled, two staff members entered at the same time. As they rounded the corner of the pulled curtain, one of the staff members had a phone and obtained a photograph of Resident # 2 touching Resident # 1. The photograph was not taken to disrespect or slow the removal of Resident # 2 from Resident # 1. It was taken quickly to provide evidence so that the police could arrest Resident # 2 and remove Resident # 2 from the facility. As one staff member took the photograph, the other staff member was pulling the resident away. Resident # 2 had never been on top of Resident # 1. At the time, as shown in the photographic evidence, he was in a wheelchair beside her. He did not have his prosthesis on and it would have been impossible for him to have been in Resident #1's bed. The Administrator was also interviewed regarding the difference in some of the statements given by the staff to the surveyor. The Administrator reported the following information regarding this. Statements had been obtained that night directly following the incident at a time when things were fresh in his staff members' mind. The two witnesses were Nurse # 1 and NA # 1, and their recall at the time was that the resident [Resident #2] had not been touching the resident [Resident #1] or the resident's clothing in anyway during the first incident. Nurse # 3 had not witnessed either incident and Nurse # 3 had been very shaken up about things and there had been a lot of discussion about what had occurred. The Administrator felt like the details had become conflated over time and was not sure why Nurse # 3's interview about what occurred was different than what Nurse #1 and Nurse Aide #1 reported at the time of the incidents. On 2/26/25 the Administrator provided a copy of the photograph that had been provided to the police on 2/6/25. Review of the photograph revealed the following observation. Due to the angle of the photograph, it did not depict any of Resident # 1's private area or Resident # 1's brief. The photograph was taken from the perspective of someone at the foot of the bed. Resident # 2 was seated in his wheelchair with his wheelchair parallel and right next to Resident # 1's bed. His wheelchair was positioned so that he was seated facing Resident #1. Resident # 1 was in bed with the head of the bed slightly elevated and the majority of her right thigh was exposed. The majority of Resident # 2's right forearm was under Resident # 1's right thigh pointed in the direction of her private area. The exact placement of Resident #2's hand was not visible in the photograph. The police detective, who was investigating the assault, was interviewed on 2/27/25 at 3:51 PM and reported the following information. The call came into the police at 6:53 PM and they arrived at 7:17 PM. The police detective confirmed Resident # 2 was in his room and under surveillance by facility staff when police arrived. Staff reported that Resident # 2 did not normally associate with Resident # 1 and on that evening Resident # 2 had reported to staff that Resident # 1 was wanting her dinner tray removed. On the evening of 2/6/25 Resident #2 was removed from the facility and jailed. (continued on next page)

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	345403	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cary Health and Rehabilitation	6590 Tryon Road Cary, NC 27518

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident # 1's RP (Responsible Party) was interviewed on 2/24/25 at 12:38 PM and again on 2/28/25 at 9:20 AM and reported the following information. Resident # 1 had recently been placed on hospice before the incident of 2/6/25. She (the RP) had received a voice mail on 2/6/25 around 8:00 PM from the DON and returned it around 8:15 PM. The DON informed her that Resident # 1 had been assaulted by another resident. The DON further told her Resident # 1 was fine, and as a precaution the facility was sending Resident # 1 to the hospital to be checked. She had been told that staff had entered Resident # 1's room and the resident, who had assaulted Resident # 1, had been in a wheelchair at the time. Family members had been very involved in Resident # 1's care and would visit regularly. Family had noted a male resident sitting in the hallway near doorways and looking into rooms when they visited. She and the family were not aware of any incidents prior to 2/6/25 where anyone had entered Resident # 1's room and touched her inappropriately before 2/6/25. The RP reported Resident # 1 had lived through the hard times during the depression years and through war times. Due to the resident's medical status, she could not speak up for herself regarding what had happened. If the resident could have spoken up for herself and understood what had happened to her, the RP reported Resident # 1 would have been sad, cried, and prayed a lot. The RP further reported Resident # 1 would have asked God, At my old age why did this happen? Why God, why me? The Administrator was informed of immediate jeopardy on 2/27/25 at 11:00 AM and presented the following corrective action plan. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. At approximately 6:15 PM on 02/06/2025, Resident #2 was found to have his hand under the gown and between the legs of Resident #1 in Resident #1 room which was the B bed (closer to window) with privacy curtain pulled. Resident #1 brief was unfastened and hospital gown she was wearing was around her waist but witness statements do not state that Resident #1 was exposed and was covered by hospital gown. Resident #2 was immediately removed from Resident #1 room and placed on 1:1 supervision. Police were contacted and arrived on scene to conduct investigation. Resident #2 was placed under arrest for 2nd degree felony sexual offense and misdemeanor sexual battery. Resident #2 was formally discharged from the facility due to action and arrest with notification to family to collect his personal belongings. As of 02/27/2025, Resident #2 continues incarceration with $10,000.00 jail bond per detective assigned to this case. This was the first incident with Resident #2 being noted to have any touching of Resident #1 or having any contact with Resident #1's clothing per immediate interview with on-site clinical team of Certified Nursing Assistant (CNA) and Licensed Practical Nurse (LPN) who were assigned to both Resident #1 and Resident #2. Based on those immediate interviews, we were not aware of any inappropriate touching and Resident #2 was immediately placed on 1:1 observation when touching was identified. Resident #1 was monitored for psycho-social needs with no concerns identified during bathing and/or incontinent care. Resident #1 did not present with any recall of the adverse event and did not present with any facial grimacing or signs of fear or distress at any time after the event occurred. Resident #1 was relocated to a private room on 02/12/2025 which was when a private room became available. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Medical Director was notified. Both resident's Responsible Parties were notified. A physical exam to include a skin assessment was conducted by assigned staff LPN for Resident #1 following the adverse event on 02/06/2025. No signs of bruising or trauma were indicated. As an additional precaution, the facility sent Resident #1 to the hospital emergency department for an additional exam. The resident's daughter declined extensive testing as she wished Resident #1 to return to the facility and wanted to keep Resident #1 comfortable. Resident #1 returned at approximately 3:45 AM on 02/07/2025 and no signs of trauma or penetration were identified. Adult Protective Services (APS) was contacted and determined that a formal investigation was not warranted as Resident #2 was no longer a potential threat to Resident #1. Allegation of abuse was submitted to North Carolina Division of Healthcare Service Regulation (NCDHSR) at 7:38 PM on 02/06/2025. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. On 02/06/2025, nursing managers completed skin assessments on residents with a brief interview of mental status (BIMS) of 8 or below and abuse questionnaires for residents with a BIMS of 9 or greater. Abuse and neglect education was provided to staff on 02/06/2025 by the Director of Nursing. A Resident Council meeting was held on 02/07/2025 to ensure residents understood sexual abuse and to report any allegation of sexual abuse. Signage was discussed during the meeting and then posted in all common areas on 02/07/2025 as a reminder to Residents and Staff and vendors IF YOU SEE SOMETHING, SAY SOMETHING. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 02/06/2025, the Facility Administrator and Director of Nursing re-educated current staff (including contracted services) on Abuse/Neglect policy and procedures with emphasis on signs and symptoms of sexual abuse and ways to prevent sexual abuse. This also included timely reporting for Administrator and/or Director of Nursing to provide formal notification to NCDHSR within the required 2-hour window. Education included examples of what to look for including inappropriate touching or unwanted advances. This included covering unwanted intimate touching of any kind especially of breast or perineal area, all types of sexual assault, forced observation of masturbation and/or pornography, taking sexually explicit photographs and/or audio/video recordings of a resident and maintaining or distributing them. Residents should be monitored for bruises or grip marks, dismissive attitude about any injuries, uncommunicative or unresponsive, unreasonably fearful or suspicious, lack of interest in social contact, unexplained changes in behavior Education forms were signed by trained staff for the verbal education that was provided. Existing staff who were not present on the evening of 02/06/2025 or on 02/07/2025 were required to undergo abuse and neglect training prior to their return to work. This subset of staff were directed to contact unit managers prior to return to work and a list of all employees was cross-referenced and checked off as education was completed. All new hire staff are required to undergo abuse and neglect training during new-hire orientation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Facility Administrator and Director of Nursing determined on 02/06/2025 to monitor facility performance in an ongoing pursuit of quality control. The Social Worker will interview five residents with a brief interview of mental status (BIMS) of eight or greater per week for twelve weeks to inquire if they have felt abused or have witnessed or suspected abuse or neglect. Skin audits will be conducted by Director of Nursing or designee for 5 randomly selected residents with a BIMS of 8 or below. Immediate action to be taken for any positive findings. Results of these audits/interviews will be brought before the Quality Assurance Performance Improvement (QAPI) Committee monthly with the QAPI Committee responsible for ongoing compliance. Facility Administrator and Director of Nursing conducted an Ad hoc QAPI on 02/07/2025 with the Interdisciplinary Team (IDT) which includes Executive Director, Director of Nursing, Medical Director, Social Services Director, Activities Director, Dining/Nutrition Supervisor, Minimum Data Set (MDS) Team of RN and LPN, Rehabilitation Director, Housekeeping/Laundry Supervisor, Maintenance Supervisor, LPN Unit Manager, Business Office Director and Human Resources Director to review the event and conduct a root cause analysis for group discussion. Resident #2 was known to be very social and outgoing and friendly with all residents and staff. The root cause was determined to be that although staff did not have any reasonable expectation that this event had the likelihood to occur, it is possible for anyone at any time to make a poor decision with little to no consideration of consequence. In the monthly Quality Assurance and Performance Improvement (QAPI) Meeting, the Interdisciplinary Team (IDT) will review all resident to resident abuse allegations to ensure appropriate interventions are in place and the individualized resident-specific Plan of Care is updated for 8 weeks. The Administrator will report the results of the monitoring to the QAPI committee to review audits and make recommendations to assure compliance is maintained on an ongoing basis. The QAPI Committee will determine the need for further intervention and auditing beyond three months to ensure compliance is sustained on an ongoing basis. Compliance Date - 02/08/2025 Alleged date of IJ removal date: 02/08/2025 2. Resident # 6 was admitted to the facility on [DATE] with diagnoses of dementia, restlessness, agitation, hypertension, depressive disorder, anxiety, insomnia, muscle weakness, and cognitively communication problems. A review of Resident # 6's care plan, updated on 11/21/24 and which was in place until her final discharge on 12/23/24, revealed the following information. Resident # 6 independently bathed, toileted, and transferred herself. She was continent. She had exit seeking behaviors. She displayed inappropriate behaviors which included agitation, screaming, inappropriate language, and resistance to care. She had the potential to be verbally and physically aggressive. Resident # 6's care plan directed staff to monitor, document, and report when a resident posed a danger to others. The care plan also indicated a psychiatric consult would be done as indicated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to the care plan, Resident # 6 had been on psychoactive medications since 3/20/24. Review of progress notes revealed a notation by the Social Worker on 11/25/24 at 2:17 PM noting that Resident # 6 had returned to the facility on [DATE] after being at the hospital for aggressive and combative behaviors. The Social Worker noted she was continuing to look for appropriate long- term placement in a secured memory care unit. On 11/25/24 the Psychiatric NP noted she visited the resident, and the resident was calm at the time. The Psychiatric NP noted there had been an issue with noncompliance with the resident taking her medication. The psychiatric NP also noted that because of the resident's history of aggression and the potential for future volatility plans were underway to transfer her to a psychiatric facility for a higher level of care. On 11/27/24 at 1:15 PM Nurse # 2 documented the following information in a nursing entry. Resident # 6 was being sent to the ED (emergency department) for combative behavior. Both the NP (Nurse Practitioner) and management had been advised with orders to send the resident out. The family was also notified. There were no specific details in the nursing note about what had occurred. Review of EMS (Emergency Medical Services) records, dated 11/27/24, revealed the following information by the paramedic. Facility staff stated the pt. (patient) refused to take any of her medications since being discharged from [name of hospital] for the same behavior several days ago. They stated she was striking her roommate and facility staff as well as throwing 'tea and coffee' at them. Pt would not answer questions or speak with EMS, except [TRUNCATED]

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13289 Based on observation, record review and interviews with resident and staff, the facility failed to ensure a system was in place to avoid placing an item on a resident's tray which she preferred not to have. This was for one (Resident # 4) of three sampled residents reviewed for food choices. The findings included: Resident # 1 was admitted to the facility on [DATE]. Review of Resident # 4's admission Minimum Data Set assessment, dated 1/26/25, revealed the resident was cognitively intact. Review of physician orders revealed Resident # 1 was ordered a regular diet. The Dietary Manager was interviewed on 2/26/25 at 8:55 AM and provided a copy of the way Resident # 4's tray card printed from their system. Observation of the resident's printed dietary card revealed near the top of the card, there was a notation which read, No Potatoes. The Dietary Manager reported the following information. Resident # 4 had a dislike to potatoes. As noted on her printed tray card, it showed as a disklike and she should not be served potatoes. He was aware of one time when she had gotten the potatoes and thought it had not happened again. Resident # 4 was interviewed on 2/26/25 at 12:50 PM and reported the following information. The texture and smell of potatoes make her nauseated and she had received them multiple times since she had been admitted to the facility. The Nurse Aides were aware of the problem, and it had been reported to the dietary department, but the potatoes were still served to her even after the problem had been reported to the dietary department. Nurse Aide (NA) #8 was interviewed on 2/26/25 at 2:20 PM and reported the following information. Resident # 4 had received potatoes on her tray even though staff in the kitchen had been told. She knew that NA # 9 had directly spoken to the kitchen staff about the problem. She had also witnessed other residents receive items on their tray that per their tray card they were not supposed to be served. This had happened in recent weeks. NA # 9 was interviewed on 2/26/25 at 2:40 PM and reported while she had worked with Resident # 4, she (NA # 9) knew Resident # 4 had received potatoes on her tray three times and she had spoken to the kitchen staff about the problem because the resident did not like them and was not supposed to be served them. The Administrator was interviewed on 2/26/25 at 5:50 PM and reported there should be a person on the dietary tray line checking the tray cards and the trays to make sure that foods which residents disliked were not served to them.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13289 Based on observation, record review, and staff interviews, the facility failed to ensure a resident received a beverage on her tray per her preference. This was for one (Resident # 8) of three residents reviewed for dietary preferences. The findings included: Record review revealed Resident # 8 was admitted to the facility on [DATE] after sustaining a hip fracture. Review of Resident # 8's 2/21/25 admission Minimum Data Set assessment, dated 2/21/25, revealed the resident was cognitively intact. Review of physician orders revealed the resident was ordered a regular diet. Lunch observations were made on 2/25/25 starting at 12:00 PM. During this lunch time observation Resident # 8 was observed in her room. She had completed eating her lunch meal and stated the food was good, but the dietary department had not served any drinks on her tray. It was observed there were no cups on the meal tray. She further reported that she had some water in a Styrofoam cup at her bedside which she had before the lunch meal tray was served, and therefore she had drunk the water with her meal since the dietary department had not sent anything else to drink. She would have preferred to have had tea with the meal. Directly following this observation and interview, Nurse # 5 was asked to view Resident # 8's tray and validated that no beverage had been served with the resident's 2/25/25 lunch meal. The dietary menus were reviewed with the Dietary Manager on 2/26/25 at 8:55 AM. A review of the menu with the Dietary Manager revealed tea of choice should have been served with lunch trays on 2/25/25. According to the Dietary Manager food items and beverages are printed on a tray card which includes residents' preferences. Nurse Aide (NA) #8 was interviewed on 2/26/25 at 2:20 PM and NA # 9 was interviewed on 2/26/25 at 2:40 PM. Both Nurse Aides, who worked on Resident # 8's hall, reported there had been problems in recent weeks they had observed with meal tray items not matching meal tray cards. The Administrator was interviewed on 2/26/25 at 5:50 PM and reported there should be a person on the dietary tray line checking the tray cards and the trays to make sure that items were correct on the trays before they were served to residents.